

Delivering Care Closer to Home: Meeting the Challenge



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Foreword by the Minister of State for Health Services



Implementing the Local Visions developed by local NHS staff and service users for the NHS Next Stage Review will require real and sustained change to the way that services are designed, delivered and improved.

A central theme to the 'High Quality Care for all NHS: Next Stage Review Final Report' is the need to bring care closer to home, to ultimately deliver better care for patients. This was also a central focus of the 2006 White Paper 'Our health, our care, our say', and of a number of pilot projects and demonstration sites initiated after its publication. As the various projects have matured, it has become clear that a health and care economy-wide approach is needed for an effective and sustainable shift of care, that is more convenient for patients.

This is precisely the approach of the Strategic Health Authority (SHA) visions; so now is a good moment to support local implementation by gathering together the growing body of knowledge about how to bring care closer to home.

The ambition is not to create a single 'magic formula' for shifting care – just as the SHA visions differ according to different regional and local circumstances, so the response to the strategic need to shift care will vary according to local circumstances. There is, however, a strong argument for bringing together in one place some of the insights and resources already available to support local organisations to bring care closer to home.

A handwritten signature in black ink, appearing to read 'Ben Bradshaw'.

Ben Bradshaw MP
Minister of State for Health Services
July 2008

Chapter 1: The Challenge

The strategic need for change

- 1.1** The strategic case for a shift in care closer to home – and into homes – has been widely accepted for some time and was a focus for ‘Our health, our care, our say’ in 2006. The demographic profile of England is changing. The proportion of older people is growing and we are living longer, often with long-term health and care needs. For example, a fifth of the population of England is over 60, the over 85s are the fastest growing segment of the population, set to double in number by 2020, and there are expected to be 4.5m people aged over 85 in 2025 (International Longevity Centre). In England, 15.4 million people have a long-term condition and due to an ageing population, it is estimated that the number of people with at least one long-term condition will rise by 3 million to 18 million by 2025. In this demographic landscape, health and care services that are not actively incorporating measures to provide early intervention and prevention will struggle to cope with future demand.
- 1.2** Less tangibly, but no less significantly, social attitudes are evolving, with growing expectations that services are more responsive and work with users, focusing on *their* priorities rather than service-defined outcomes.
- 1.3** As the pattern of demand alters and we start to see a greater emphasis on managing and living with long-term needs, compared with the more traditional emphasis on curing disease entwined with a shift towards ‘co-production’ of health and care outcomes, the provision of supportive and enabling care closer to home (including at home) will come to seem normal, and, for many, necessary.
- 1.4** Acute services will still be an absolutely vital part of the pathway, but it will be possible and for many people preferable, for an increasingly large proportion of the care pathway to be situated outside of a hospital setting, making greater use of community urgent care services and of ambulance services, whose potential as a hub and a connector has not yet been fully realised. The potential for new technology, with its mobility, flexibility and rapid transfer of information to support far greater levels of service in home and community settings is real and immense, as we are already starting to see in telecare services, and in the transfer of diagnostic services into the community.

Key challenges, local settings

- 1.5** Recognising a strategic need and opportunity to shift care closer to home is not, of course, the same thing as delivering the necessary changes. Two principles are fundamental to shifting care effectively and substantially:
- **Working across the whole health and care economy;**
 - **Recognising that the local context is critical in defining priorities and maximising the strategic benefits and effectively managing costs.**
- 1.6** It follows that there cannot be a single route-map or blueprint for shifting care that applies equally well to all localities and care settings. From discussions with a range of stakeholders including clinicians, Primary Care Trusts (PCTs), SHAs and Local Authorities and the third sector, it is possible to identify a number of themes or domains most of which are likely to be relevant to most local areas as they face up to the challenge.
- 1.7** Many of these themes were brought together in a King's Fund simulation exercise, commissioned by the Department of Health (DH), working with the East of England health and care economy. The objective was to understand the process and impacts of shifting care, focussing on the interactions and behaviours of individuals and organisations. The report is available from www.kingsfund.org.uk/publications/kings_fund_publications/windmill_2007.html.
- 1.8** In addition to the need to take a whole-system approach, the critical elements of the challenge that emerged were:
- **Challenge one – Bringing care closer to home in a way that both involves people as partners in designing services and delivering their care, and which reaches all of the population, addressing inequalities;**
 - **Challenge two – Ensuring that services closer to home form part of integrated care pathways for users, making effective links between health, social care and other services;**
 - **Challenge three – Building commissioning capacity and capability, working with communities to establish the outcomes that matter to them and the most appropriate ways of meeting them;**

- **Challenge four** – The development of leadership, both clinical and managerial, to grasp the strategic opportunities, work with local communities to co-design change, and to see change through;
- **Challenge five** – Developing community premises and estates that are fit for the future as well as the present;
- **Challenge six** – Workforce- putting in place the roles, skills and planning to facilitate services that support people at home and in the community;
- **Challenge seven** – Making greater use of technology to provide more care in community settings and at home.

- 1.9** The relative importance of the elements of the challenge will vary from area to area and so, therefore, will the responses needed from local health and care economies. The same fundamental need for services as described in 'Our NHS, Our Future' – Fair, Personalised, Effective and Safe will, however, apply everywhere. Many SHA visions state the importance of shifting care closer to home and set out how SHAs will meet this challenge. Further information is available at www.ournhs.nhs.uk.
- 1.10** In relation to shifting care closer to home, we know that it is absolutely vital, in working with local people and service users to plan shifts in care, and to be clear about how quality and safety are to be ensured and enhanced under any new service arrangements. The evaluation of the care closer to home demonstration sites showed that there was no evidence of any problems with quality or safety when care was moved out of hospital, and also highlighted that clinicians had a strong focus on ensuring that such services were safe and of high quality.
- 1.11** Commissioners and provider organisations will also want to be assured that services moving closer to home offer good value for money. This may not always mean a cheaper service than is provided in a more traditional setting, but it does mean being clear about the service in terms of outputs and outcomes for the investment you are making. This can be particularly challenging for community services where we know there is a lot to be done to improve information systems, metrics and contracting practice.

- 1.12** With those themes in mind, this document offers resources and insights gleaned from academic research, service improvement initiatives, and front-line services, to help commissioners and providers as they design and refine their strategic responses to the need to shift care closer to home.
- 1.13** It would be fair to say that much of what we know and has been said about shifting care closer to home falls into the categories of either the very general and strategic or into the highly specific (for example, shifting particular services along a pathway or incorporating early intervention more effectively into existing processes). What has been lacking is a description of the terrain between the general and the specific, an account of how a shift in care could be played out across a whole health and care economy, and what the implications might be for specific services and organisations. This document and the resources it links to offers a response to that need. It is not a complete picture nor could it be for the reason set out above- each local area will need to plot its own course to achieve a shift in care.

Equality Impact

- 1.14** The Department of Health is committed to promoting equality and diversity. This document does not assess the equality impact of the proposals, but the Department of Health is committed to assessing the impact of these policies over the course of the year. In particular 'High Quality Care for all: NHS Next Stage Review Final Report' sets out the commitment on the Department to publish appropriate Equality Impact Assessments over the coming months, developed in consultation with key stakeholders.

Chapter 2: Local Change and Sharing the Learning

Introduction

- 2.1** The spectrum of activity covered by the idea of 'shifting care closer to home' is very broad, from relatively straightforward switches in the location of services to wholesale redesign across a large area.
- 2.2** The range of services that can be included in a shift of care closer to home is also extensive; indeed most areas of practice across health and social care will need to respond to the changes in demography, attitudes and technology that are driving the move of care closer to home.
- 2.3** There are a number of sources of information and examples that we can draw on in describing this landscape. This chapter offers a set of case studies that look at a number of dimensions of shifting care, from specific pathways to whole-system changes. In order to clarify the range of dimensions that care closer to home can cover, we have classified it in the following way:
- **when** – the focus on the shift to early intervention, prevention, and approaches to promote independence are critical;
 - **where** – so care is delivered closer to home and is more convenient;
 - **who** – includes shifts in roles and patterns of work;
 - **what** – includes changes to care pathways.
- 2.4** Key to enabling change will be the early and sustained engagement and involvement of public, patients and other stakeholders, a key challenge which we also highlight in Chapter 3.

Case histories

- 2.5** Set out below are some examples of where health economies have shifted care closer to home – a range of approaches covering the different parts of the patient pathway. Further examples can be found at www.dh.gov.uk/en/Healthcare/Ourhealthourcareoursay/index.htm

WHEN – Self-care and shift to earlier prevention and approaches to promote independence

2.6 'High Quality Care for all: NHS Next Stage Review Final Report' [DH 2008] sets out a new priority for the NHS – working with local partners, every PCT will commission comprehensive well-being and prevention services, customised to meet the specific needs of their populations. Local areas are already addressing this priority, including the *Partnerships for Older People Projects (POPPs)*. These include 29 sites aimed at large-scale system reform across health and social care to support older people in healthy and active living and to enable older people to remain independent and in control of their own lives for as long as possible. These projects are aimed at creating a sustainable shift in resources and culture away from crisis-based institutionalised care towards 'preventative' care for older people within their own homes and communities, supporting more older people to maintain or improve their general health, well-being and independence through earlier targeted interventions rather than intervention at the point of crisis. Further information on the POPPs is available at www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/PartnershipsforOlderPeopleProjects/index.htm

Knowsley Partnerships for Older People Pilot – 'I know a man who can' (IKan) team

A proactive, preventative approach to health and well-being was developed in Knowsley through the formation of an IKan team initially targeting the most deprived local areas. The team generated an integrated, broad based approach to supporting the well-being of older people and encouraging appropriate timely service take up by older people, based on an understanding of their needs and wants, offering them an understanding and positive experience of the system, and encouraging them to seek timely intervention in the future. The team visit the older people in the target areas and offer a range of practical services including tele-care, befriending, environmental assessment and falls avoidance information, health checks, benefit checks, useful information and advice and links and signposting to other activities available in their area, as well as access to a dedicated handy-person service.

WHERE – Closer to home and more convenient

2.7 The sites from the 'Care Closer to Home demonstration project' covered the spectrum of shifting care and included a variety of approaches. The project reviewed and evaluated thirty sites, across six clinical specialties (dermatology, ear, nose and throat (ENT), gynaecology, general surgery, orthopaedics and urology), and the various forms of service change and their effectiveness around shifting care. It also highlighted the importance of clinical leadership in developing services.

An integrated dermatology service for Hull – Hull Teaching PCT (tPCT)

Hull tPCT was one of the dermatology Care Closer to Home sites and continues to build and develop dermatology services closer to home. The tPCT vision, of commissioning an integrated service model, is working with local providers, patients and the local population to implement a hub and spoke multi disciplinary dermatology model across Hull.

Through the hub and extended spoke service, patients will be able to access a skilled multidisciplinary team with the necessary expertise and appropriate dermatology treatments, enabling patients to have a choice of where to access services:

- 1 stop clinics for lumps and bumps.
- Self management programmes in the community.
- Nurse led operations.
- Expansion of practitioners (GP's, Nurses and Pharmacists) with specialist interest providing care within an integrated and seamless service model.

As a result of these developments the tPCT expects to deliver approximately 7,000 appointments in new community premises across the city. Parking and dispensing will be available on site. For further information contact Toni Wardale at

Toni.Wardale@hullpct.nhs.uk

The Shifting Care Closer to Home Demonstration sites – report of the specialty subgroups is available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079728

WHO – Shifts in roles and patterns of work

2.8 Changing roles and patterns of work can play a key part in shifting care closer to home, improving the quality of care for patients, as illustrated by the example from Cornwall and the South West set out below.

Reducing Avoidable Emergency Admissions – Cornwall & Isles of Scilly PCT – Community Matron Service

The Community Matron service in Cornwall was started in July 2004, to provide expert intensive case management services to people with multiple long-term conditions and complex needs in Cornwall. Part of its aims were:

- To improve quality of life for patients, carers and their families.
- To improve health and cost outcomes by supporting patients and carers to more effectively manage their long-term conditions in the community.
- To prevent avoidable, unplanned admissions and interventions.
- To support and facilitate rapid, safe discharge.

Each of the Community Matrons is allocated to a specific practice or group of practices.

Resources Used and Productivity Gain:

Community Matrons manage around 200 acute events each month, the majority of which (63%) lead to patients returning to their previous level of functioning and only 4% are admitted to an acute hospital.

Results have shown:

- An average of 33 hospital admissions are avoided per month, giving a minimum cost saving of £76k.
- A 59% reduction in hospital admissions among very high impact users.
- 23 facilitated early discharges in 5 months, a cost saving of nearly £19k.
- 2,567 bed days saved against national trim points in 6 months.
- On average, 62 occasions per month when medication reviews have led to reduced costs.

- A beneficial impact on primary care capacity and workload, an average of 459 GP contacts are saved a month.
- An average of 377 visits by District Nurses saved per month.

For further information contact Helen Lydon, Lead Community Nurse;
email: Helen.lydon@CIOSPCT.cornwall.nhs.uk

Partnership approach to Minor Injuries Units, South West area

South Western Ambulance Service NHS Trust has taken up a new role, running the Portland Minor Treatment Unit and the Weymouth Minor Injuries Unit in Dorset.

This has meant integration of primary care and ambulance NHS staff within a community healthcare setting, and local health leaders were keen to work together in this partnership approach to meet the healthcare needs of local residents.

Patients are reaping the benefits of a more personal and responsive service now that both of these locally-based community healthcare services are now staffed with a more diverse team.

The multi-skilled workforce at these two Units now includes fully qualified Nurse Practitioners, Triage Nurses and Emergency Care Practitioners (paramedics with extended diagnostic and treatment skills).

This modern integrated way of working has enabled continuous improvements in healthcare provision for both Units, and staff are able to share and develop their skills through working together on a daily basis.

WHAT – transformation of care pathways

2.9 Transforming patient pathways, where patients are able to access care close to home rather than more traditional methods of access in acute care is also making things better for patients, as shown in this example from Manchester.

Reducing admissions – Technology that enables a fast, accurate diagnosis of heart problems by telephone – The Greater Manchester and Cheshire Cardiac and Stroke Network

Working with NHS Lancashire and South Cumbria Cardiac Network; The Greater Manchester and Cheshire Cardiac and Stroke Network; and Southampton PCT, services are reporting that providing cardiac care in GP surgeries is freeing up acute emergency healthcare resources. Using an innovative handheld 12-lead electrocardiogram (ECG) device, has dramatically cut the number of people having to go to hospital for symptoms of chest pain. The technology, developed by Manchester-based Broomwell HealthWatch, allows patients with symptoms of chest pain, or possible heart problems, to receive a full 12-lead ECG test at their local GP surgery within minutes, instead of having to travel to a hospital or A&E department and wait up to two weeks for results.

Data from 1 NHS pilot showed 82% of patients receiving ECGs did not need to go to hospital (neither A&E nor outpatients) following the test. This led to earlier detection of heart problems, giving rapid reassurance, and reducing stress and anxiety.

Joe Rafferty, NHS North West director of Commissioning, said: “Using telemedicine to bring essential health services closer to patients in a primary care setting is beneficial to both patients and the NHS, and I think a service such as this has the potential to make a great deal of difference to health services across the UK.”

Further information is available at:

www.gmccardiacnetwork.nhs.uk/

www.lsccardiacnetwork.nhs.uk/National%20Key%20Documents/Cardiac_Telemedicine.pdf

Involving patients, public and stakeholders

2.10 Approaches taken involving stakeholders range from a community wide aspect, where patients and the public in the Huntingdonshire area were consulted on the future of their services, to a more focussed approach with a range of stakeholders around particular services (e.g. Somerset chronic obstructive pulmonary disease (COPD) service).

Involving Patients and the Public – Seeking sustainable health services for the people of Huntingdonshire

During 2006/07, extensive work took place with hospital clinicians, GPs and patient representatives from the Huntingdonshire area to develop proposals for public consultation on the future of services provided by Hinchingsbrooke Health Care NHS Trust.

Patients and local people were involved throughout including during a pre-consultation phase which incorporated a number of public meetings and the establishment of a range of options with clinical, staff side, patient and management representatives to review four potential options for the future and develop proposals for consultation.

During consultation a further seven public meetings were held, alongside opportunities for one to one discussions with local people, attendance at a range of community groups and displays at local libraries where residents were able to seek further information from PCT representatives.

As a result of the consultation, the Cambridgeshire PCT Board endorsed proposals for a shift of clinically appropriate services into the community, enabling the hospital to focus on the more complex care that only it can provide. An implementation programme is now underway involving a £2.2 million investment in community services, which will secure a sustainable future for services on the hospital site alongside more localised and accessible community-based services for the Huntingdonshire population.

Further information is available from: Karen.mason@cambridgeshirepct.nhs.uk

Involving the community – ensuring the patients voice is heard

In 2007/08, the countywide PBC consortium in Somerset (WyvernHealth.com) put forward proposals for the redesign and improvement of COPD services. The commissioning proposals responded to identified gaps and inequity in current provision and were targeted at optimising care in the community and reducing avoidable hospital admissions. A PCT manager and local Lead GP led a 12 month project to commission the new service through a competitive tendering process, involving people with COPD at each stage.

Patients were involved in producing the specification and in the provider selection process. The service was launched at an interactive event, with patients, carers and health professionals hosted in collaboration with the British Lung Foundation and PCT in February 2008. Feedback from the event has been used to shape patients information leaflets and care management plans. In the future, patients will be involved in the contract performance review meetings and patient feedback will continue to shape the future service over the over the next 3 years.

More information is available from: Annabelle.walker@somersetpct.nhs.uk, or at the PCT website: www.somersetpct.nhs.uk/Services or at

www.wyvernhealth.com/Documents/pathways/urgent_care/COPD_briefing.doc

Learning from the Health Reform Demonstration Systems

2.11 In order to understand further how the challenges are being tackled at local level, the DH Care Closer to Home team focussed on four areas from the Health Reform Demonstration Systems (HRDS) project, and a report will be published in September 2008. The HRDS programme consists of 18 volunteer “systems” from large and complex local Health and Social Care and third sector communities, drawn from all Strategic Health Authority (SHAs), covering all major areas of reform, sponsored by the SHA Chief Executives. More information about the NHS Initiative is available at www.osha.nhs.uk/page.php?id=255

Health Reform Demonstration Systems – Bristol

Bristol Health Service Plan (BHSP) covers the population of Bristol, North Somerset and South Gloucester and all NHS organisations are signed up to the vision, with the objectives amongst others being providing care closer to the patients' home, providing effective local health services by harmonising primary care, social care and local hospital services, and developing specialist services and networks for a wider group.

There was a clear patient carer and public involvement strategy which spans involvement from the start e.g. discovery interviews, members of the council of governors and service development groups, a Patient and Public Involvement (PPI) network group and plans to provide stakeholder events to inform and participate at the decision points.

2.12 Further information on these projects as well as other help and resources are listed in the Annex.

Chapter 3: Supporting change

Supporting implementation

3.1 In the previous chapter, we saw how a number of projects had approached shifting care closer to home. In this chapter, we look at the national enablers in terms of policy, research and innovation that can be used to shift care closer to home locally and highlights a number of these and further case studies to assist in meeting the specific challenges.

CHALLENGE ONE – Bringing care closer to home in a way that both involves people as partners in care, and which reaches all of the population, addressing inequalities

3.2 There are several initiatives which can help to develop care closer to home, involving and empowering people and giving them real control over their care, increasingly working with patients, not for them. Such initiatives can also provide opportunities to address some of the health inequalities that disadvantaged groups face.

Involving Patients and the Public

3.3 Patients and the public are routinely asked for their views, about their experience of services, to contribute to the improvement of services. In the future, this good practice needs to be systematically embedded across the NHS, especially in the way services are commissioned. In particular, this will require PCTs to build and sustain enduring ways of securing the ongoing involvement of people and communities. Crucial to this is to embed feedback on outcomes of changes and building in opportunities for patients and the public to be involved in reviewing the performance of services.

3.4 This systematic approach to collecting and acting on patient views needs to become increasingly sensitive to the needs of those who are easily overlooked or who feel excluded. Increasingly, the use of innovative forms of public engagement and social marketing will secure the involvement of people and communities in commissioning decisions.

- 3.5** There are no quick fixes in securing the desired changes and work is required on a number of fronts to deliver improved outcomes for involvement, including:
- Legislation, tools and system architecture that support involvement and responsiveness;
 - Development and support that helps the NHS increase its capacity and expertise;
 - Identification and promotion of evidence based practice and other development resources.
- 3.6** To help strengthen the impact of engagement in commissioning, Local Involvement Networks (LINKs) have been set up to provide communities with an opportunity at a variety of levels to be involved, and feel a greater sense of ownership.
- 3.7** These and other initiatives will enable commissioners and providers to gain a fundamental understanding of the needs and experiences of people and communities. Examples of this in action can be seen in Tameside at a local level, and Liverpool who took a PCT-wide approach.

The Tameside Opening Doors for Older People project

The Tameside Opening Doors for Older People project is a borough-wide model of early intervention targeting older people who do not receive social care services, or who would like information, advice or support at home to help them retain their independence and well-being.

The first strand of the project uses volunteers who make contact with people in their own homes. They complete a 40 point weighted questionnaire called the Community Options for Remaining Active (CORA) Check and Support service and then, depending on scoring, the volunteers make referrals, signpost to services or act as navigators.

The project has good links across a wide range of organisations, both statutory and voluntary.

Since starting in May 2007, the project has dealt with 932 referrals and has carried out over 497 CORA Check and Support visits.

From the people that have already been visited, the top services that people have been signposted to are:

- home and garden maintenance services
- personal transport
- falls prevention
- talk therapies and counselling
- health care, exercise and health classes

This information will feed into the second strand of the project which is concerned with developing and enhancing services for older people.

Liverpool's Big Health Debate

The PCT has devised a strategy that brings services back to the heart of the community – informed by a wide-ranging year-long engagement exercise called The Big Health Debate, which involved over 11,000 people – Liverpool patients, GPs and other stakeholders. Over the next seven years the PCT will be investing £100m into new or refurbished buildings and hundreds more staff.

The first phase was based on a self-completed questionnaire along with several visits to community groups and neighbourhood committees and over 10,000 responses were received and a number of topics were generated for further investigation.

The second phase used the output of the first phase in a deliberative event workshop with 150 participants, allowing the topics to be discussed in more depth and produced a series of priorities and trade-off statements.

The third phase, completed in May 2007, employed a marketing research technique known as conjoint analysis on a sample of over 600 frequent users of primary care services, and focus groups with those often not consulted including homeless people, the travelling community, visually impaired people, and Black and Minority Ethnic (BME) communities. This enabled a quantification of the trade-offs of four attributes; differing opening hours, maximum travel times, willingness to see a GP other than their usual GP, and a differing range of services. Further information about the Big Health Debate is available at www.liverpoolpct.nhs.uk/bhd/default.asp or contact Sue Hickey, Project Officer, Stakeholder Engagement Directorate, Liverpool PCT [Email: sue.hickey@liverpoolpct.nhs.uk]

Information Prescriptions

- 3.8** Quality information empowers people to make choices that are right for them. Information plays a crucial role in supporting people with long-term conditions to take care of themselves and improve their quality of life. The development of information prescriptions are fundamental in filling this gap to ensure people get the right information at the right time. Information prescriptions will point people to sources of information about their health and care – for example information about conditions and treatments, care services, benefits, and support groups. They include addresses, telephone numbers and website addresses that people may find helpful and where they can go to find out more.

The information prescription will be given to people and their carers by health and social care professionals (for example GPs, social workers and district nurses). The aim of information prescriptions is to empower people to manage their care more effectively, to help them stay more independent and to feel more in control. Information prescriptions also aim to improve equitable access to the quality information people want and need by standardising the process of giving people information, making the delivery of information systemised and routine. The report of the year-long pilot will be available in Summer 2008. More information is available at: www.informationprescription.info

Other examples of shared decision making include:

Individual Budgets

- 3.9** Another initiative that has demonstrated giving people real control over their own care is the social care individual budget pilots. Thirteen pilot sites have recently piloted Individual Budgets, with the aim of providing greater choice and control for people needing support, and to place the person who is supported at the centre of the process. People were enabled to design their own support with the knowledge of what finance is available, and to manage the funding to provide that support.
- 3.10** Individual Budgets are intended to benefit everyone who might receive services from the local authority's social services department, or through any of the other included streams of income. The pilots covered older people, people with physical disabilities, sensory impairment, learning difficulties, long-term neurological conditions and mental health needs, and young people undergoing transition. Further information is available at www.individualbudgets.csip.org.uk/index.jsp
- 3.11** Learning from the experience in both social care and other health systems, and in response to the enthusiasm we have heard from local clinicians, the 'High Quality Care for all: NHS Next Stage Review Final Report' [DH, 2008] set out that DH would explore the potential of personal budgets, to give individual patients greater control over the services they receive and the providers from which they receive services. With a view to national roll out, DH will launch a national pilot programme in early 2009, supported by rigorous evaluation.

Patient Self-referral

3.12 The Department of Health in partnership with six sites, has recently piloted self-referral to musculoskeletal physiotherapy, to empower patients and give them more control over their treatment.

3.13 The pilots are evaluating the impact of introducing self-referral, in particular to look at widening of access for patients to musculoskeletal physiotherapy, which would include seeking the views of patients, GPs and physiotherapists. The results of the analysis from the pilot sites and from the workshop indicate that patient self-referral to Allied Health Professions (AHP) services has the following benefits for patients:

- High levels of service user satisfaction and confidence;
- More responsive and attractive to patients with acute conditions affording them wider access;
- Empowers patients to self-care/self-manage to meet their needs;
- Associated with lower levels of work absence.

3.14 Further information is available at

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081067

End of Life Care

3.15 Recent surveys on people's attitudes to death and dying have shown that the majority of people, ranging from 56-74%, would prefer to be cared for, and be allowed to die, at home. However, only around 18% of deaths occur at home, with a further 17% occurring in care homes (which for many is their home), whilst the majority of deaths, around 55%, occur in hospital. In the Summer of 2008, the DH will publish a national End of Life Care Strategy, this country's first. Key elements of the Strategy will be to emphasise the importance of involving people and their carers in decisions about their care, and to improve the provision of services in the community, so that more people are able to be cared for, and die, in the place of their choice.

3.16 Care at the end of life was also one of the eight Pathways which the SHAs have looked at in taking forward the NHS Next Stage Review. One example of how this

area of care is to be taken forward is from the South East Coast Next Stage Review vision, 'Healthier People, Excellent Care', which makes a number of pledges relating to end of life care provision in the locality:

- By 2012 all providers will use recognised standards of best practice including the Gold Standards Framework, the Liverpool Care Pathway and the Preferred Priorities for Care;
- By 2015 a visiting service to help patients needing pain control for terminal illnesses will be available everywhere; and
- The NHS in Kent, Surrey and Sussex will work with staff, public and partners to raise awareness of end of life issues.

Access to Medicines

3.17 Ask about medicines week (AAMW), which the DH has provided funding for over the last few years, is an organisation whose main aim is to develop initiatives which empower members of the public to ask questions of professionals about the medicines prescribed for them and hence be pro-actively involved in their treatment and for there to be shared decision making. It is expected that this will result in patients taking their medicines as prescribed. The AAMW campaign in 2006 focused on older people and the one in 2007 focused on children. The 2008 campaign will be aimed at mental health patients.

3.18 DH established Medicines Partnership in 2002 to promote the concept of concordance – or shared decision making – to help patients take their medicines better and to help them get the most from their medicines. Medicines Partnership is now part of the National Prescribing Centre and continues to develop initiatives to help health professionals change their models of consultation so that there is shared decision-making with patients, taking into account their values and beliefs.

CHALLENGE TWO – Ensuring that services closer to home form part of integrated care pathways for users, making effective links between health, social care and other services

3.19 Time and again people tell us they want services to be more joined up. Links between care in hospital and care from different providers in the community

need to be seamless with people getting the right care, in the right place at the right time from the right person. An example of this is in action set out below.

Partnerships for Older Peoples Project (POPPs) – Poole Locality Health and Well-being Project for Older People

Poole have created two teams of health and social care staff to work with other community groups / local churches etc to identify vulnerable older people at an early stage and provide relevant support to keep them well, independent and out of hospital. The Primary Care Trust (PCT) seconded two Community Matrons to the Team.

POPPs have had a significant impact on partnership working, organisational culture, and ways of working. Senior nurses and senior social workers are now mainstreamed as integrated teams, with both nurses and social workers line managing partner professions. A new joint Intermediate Care Assistant post, combining traditional home care and health care roles has been mainstreamed.

There have been decreases both in the number of people admitted to hospital in an emergency from the POPP areas, and in the occupied bed days resulted from such admissions. Social Service performance indicators suggest that more intensive support is being given to people in their own home.

3.20 Social enterprises, together with the wider third sector, have proved themselves to be effective at developing innovative and flexible solutions. They have a significant contribution to make to health reform, particularly around primary and community care. DH is supporting **social enterprises** in health and social care through its work with **social enterprise pathfinders**, and its £100 million Social Enterprise Investment Fund. Further details can be found at www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Socialenterprise/index.htm

3.21 Some of the social enterprise pathfinders are exploring delivering integrated care and the learning will be shared across health and social care, so that others can benefit from their experience. These include:

Milton Keynes Health and Social Care Services are providing health and social care services including older people's services, children's services, adults out of hospital services, and integrated mental health and learning difficulties services.

Devon Health Living Community are developing cluster multi-disciplinary primary care teams integrated with the voluntary sector, providing advice on early intervention services for patients.

Based in Rushcliffe, **Principia Partners in Health** is a coalition of GP practices, community professionals, community pharmacy and local people. Principia are providing primary care, including extended hours access, and community services to a population of 118,000.

Delivering Connected Care in Hartlepool is providing integrated health and social care services, bringing these together with housing, education, employment, community safety and transport, in an area of high deprivation.

The **Forest of Dean Health Enterprise Trust** is providing community health and social services in a rural area, including the operation of existing community hospitals.

- 3.22** The third sector makes a substantial contribution to the delivery of high quality health and social care services. In 2007, it was estimated that around 35,000 Third Sector Organisations (TSOs) were providing health and/or social care throughout England (DH Third Sector Market Mapping Report). TSOs have a valuable understanding of clients' needs and are often better placed to respond more flexibly to those needs. Further information is available at www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Socialenterprise/index.htm
- 3.23** **The Transforming Community Equipment & Wheelchair Services Programme** (TCEWS) has collaboratively designed a radical new model for delivery of community equipment in England which places service users and carers at its heart and which makes best use of the strengths of the third and private sector.
- 3.24** The new system will not change the way a user or carer, who needs state support, is assessed. The new system will however change the way that equipment is provided with accredited retailers exchanging equipment for a prescription. The 'prescription' enables a state funded user to obtain their equipment free of

charge. This model of service delivery will give state supported users the choice that they have not previously enjoyed.

Piloting Integrated Care Organisations

3.25 'High Quality Care for all' aims to empower clinicians to provide more integrated services for patients by piloting new integrated care organisations (ICOs) bringing together health and social care professionals from a range of organisations – community services, hospitals, local authorities and others, depending on local needs. The aim of these ICOs will be to achieve more personal, responsive care and better health outcomes for a local population (based on the registered patient lists for groups of GP practices). DH will invite proposals shortly.

Ambulance Services

3.26 Ambulances can play a key role in making effective links between health, social care and other services. Ambulances provide a mobile service, and their potential to transport people to a wider range of services other than Accident and Emergency (A&E) is beginning to be recognised. Avoidable attendances at A&E can be reduced by ambulances linking people with GPs in hours and out of hours services, Minor Injury Units (MIUs) and Walk-in Centres (WiCs), specialist centres, falls teams, community nurses, and many other services. At the same time, ambulance staff roles are being developed to enable them to treat more patients themselves at the scene and in their homes. Emergency Care Practitioners, for example, are able to treat a broad range of minor injuries and conditions, including supporting patients with long-term conditions such as diabetes and asthma, stitching minor wounds, and offering health promotion advice.

3.27 The following example below of the integrated hub in Gloucester demonstrates how ambulance services can use their existing skills and infrastructure to act as a link point for services, and support appropriate care pathways to ensure patients get the right care at the right time.

Great Western Ambulance Service Trust

Integrated Hub for out of hours health and social care (Gloucestershire)

The new Hub for health and social care in Gloucestershire offers a single point of access out of hours through a telephone referral system. The Hub links to a wide range of health and social care services, enabling access to emergency domiciliary care and residential homes out of hours, and helping to reduce avoidable hospital admissions.

There is a diverse range of professional input, including GPs, district and community nurses, social workers, domiciliary care providers, and staff from the mental health sector. Emergency Care Practitioners, nurses and paramedics who provide clinical services for the ambulance trust are also linked in to help find the most appropriate pathway to care for patients.

Links have also been made with other services, including District Nursing and the Fast Assessment Team, who are responsible for carrying out full next-day assessments.

The project represents a new direction in the provision of services in Gloucestershire, with social care and ambulance staff working side-by-side to support out of hours primary care services, and the Hub may now be extended to include working with the emergency social care duty team and the police.

More information is available at

www.wcas.nhs.uk/publications/pdf/Changing_Face_of_Ambulance_Services.pdf

Year of Care for Diabetes project and Community Pharmacy Diabetes Services

3.28 The 'Year of Care for Diabetes' project describes the ongoing care a person with a long-term condition should expect to receive (usually over the course of a year), including support for self-management, which can be costed and commissioned. This approach has been successfully implemented and is being carried out in three pilot sites, with an external evaluation team working to capture how the design, delivery and commissioning of appropriate services can be developed and delivered. For further information about the project, please contact James Thomas at james.thomas@diabetes.org.uk.
www.diabetes.nhs.uk/work-areas/year-of-care

3.29 DH with the endorsement of the National Director for Diabetes is working with the Royal Pharmaceutical Society and The National Pharmacy Association to develop a Commissioning toolkit for community pharmacy diabetes services, A resource to support the integration of pharmacy into care pathways for diabetes. This toolkit is being developed to support pharmacists and their representatives to promote the appropriate integration of pharmacy services into care pathways for diabetes. The date of publication is expected to be by the Autumn 2008.

Pilot scheme aiming to integrate health and social care

3.30 An £11m pilot scheme creating systems to integrate health and social care assessment and planning is to be launched. Local authority-led consortia will be selected to produce IT systems for a "common assessment framework for adults". The schemes should enable health and social care organisations to share information on assessment and care planning, ending the need for details to be faxed, and making it easier for patients to take control of their own care, as service users will be able to indicate their health and social care needs to one professional. A call for interest in the scheme will be launched in July.

Integrated Care Network

3.31 The Integrated Care Network (ICN) provides information and support to frontline NHS and Local Government organisations seeking to improve the quality of provision to service users, patients and carers, by integrating the planning and delivery of services. More information is available at:

www.integratedcarenetwork.gov.uk/icn

CHALLENGE THREE – Building commissioning capacity and capability, working with communities to establish the outcomes that matter to them and the most appropriate ways of meeting them

World Class Commissioning

3.32 World Class Commissioning (WCC) will be a key enabler in delivering the vision of the health and social care system. It is about delivering better health and wellbeing for the population, improving health outcomes and reducing health inequalities. WCC will also hold PCTs to account for the involvement of a full range of informed clinicians in strategic planning and service development to drive improvements in health outcomes.

3.33 Key to WCC will be the Joint Strategic Needs Assessment (JSNA) which places greater emphasis on assessing and prioritising investments to support the shift from treatment and diagnosis to prevention and the promotion of well-being, as PCTs move towards a more strategic and partnership approach to commissioning for outcomes. The JSNA describes a process that identifies current and future health and well-being needs in light of existing services, and informs future service planning taking into account evidence of effectiveness. The JSNA process and WCC assurance system are underpinned by community engagement; actively engaging with communities, patients, service users, carers and providers including the third and private sectors to develop a full understanding of needs, with a particular focus on the views of vulnerable groups to ensure that those who find it hardest to advocate or are seldom heard, are encompassed in strategic planning processes. Further information on WCC is available at: www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm

Further information on the JSNA is available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_081097

Joint Commissioning

3.34 Joint commissioning is a key method to drive more integrated care using mechanisms such as, Local Area Agreements and Health Act Flexibilities. The Commissioning Framework for Health and Well-Being (DH, 2007) set out a vision for commissioning which would involve shared strategic needs assessing informing decisions across health, social care and local government.

Local Area Agreements (LAAs)

3.35 LAAs set out the priorities for a local area agreed between central government and a local area (the local authority and Local Strategic Partnership) and other key partners at the local level. They incentivise action across local partnerships to deliver change on the ground, particularly improved health for the most disadvantaged. Reducing health inequalities is central to LAAs. Priorities are identified through the Joint Strategic Needs Assessment.

Practice-Based Commissioning (PBC)

3.36 Practice-based commissioning has enabled primary care professionals to redesign services that better meet the needs of their patients. PBC has an important contribution to reducing health inequalities by improving the nature and shape of services to help ensure that the greatest priority is placed on those whose needs are greatest. Patients can benefit from a greater variety of services from a larger number of providers in settings that are closer to home or more convenient for them. By giving practices the ability to develop new services for patients within a framework of accountability and support, PBC will improve access, and extend patient choice. An example of redesign in Waltham Forest is set out below.

Improving patient care in Waltham Forest

In Waltham Forest, a local practice redesigned the patient pathway to run a carpal tunnel service in primary care so patients can now go to two purpose-built modern primary care centres based in the community. Both centres are easily accessible by public transport and offer a reasonable number of free parking facilities. A GP with a Special Interest now undertaken all carpal tunnel procedures/ Patients are happy with the service, which has provided patients quicker and easier access to treatment and the new service positively impacted on achievement of the 18-week target and referral to treatment milestones.

Further information and examples relating to practice-based commissioning are available at: 'Practice based commissioning: early wins, early lessons', www.nhsalliance.org

3.37 'High Quality Care for all' has committed to stronger support to practice-based commissioning, by providing incentives for a broader range of clinicians to get involved in PBC, so that it brings family doctors together with other community clinicians and with specialists working in hospitals to develop more integrated care for patients.

Community Tariff Pilots

3.38 Respondents to the 2007 'Options for The Future of Payment by Results' consultation identified community services (such as district nursing and podiatry) as a priority area for pricing development. A dozen health economies were

accepted as payment development sites and they are locally trying out different approaches to counting, pricing and paying for community services. We plan to learn from these local initiatives and share their successes and the issues they have had to overcome across the NHS. For further information please contact: peter.howitt@dh.gsi.gov.uk

Support to Commissioners

NHS Institute for Innovation and Improvement Supporting Care Closer to Home

3.39 The NHS Institute for Innovation and Improvement have refreshed their suite of approaches designed to help PCTs as commissioners to meet the challenges of shifting care:

- **Prioritising Commissioning Opportunities** is aimed at strategic decision making and provides a guide to prioritising opportunities.
- **Project Delivery for Commissioners** is a guide to the steps to success in project management in pathway redesign.
- **Commissioning Patient Pathways Guide** takes a broad overview of commissioning for patient pathways exploring the commissioning functions and the activities involved in pathway redesign through a simple matrix with hints and tips.

They are all available through the website at www.institute.nhs.uk/commissioning

- **The Opportunity Locator** helps PCTs analyse their local data to identify millions of pounds worth of activity currently undertaken in an acute setting that could be delivered in the community, highlighting those areas likely to bring the greatest benefit to patients and this is available at www.institute.nhs.uk/opportunitylocator.

3.40 The **National Third Sector Commissioning Programme**, which is run by the Improvement and Development Agency (IDeA) on behalf of the Office of the Third Sector (Cabinet Office) improves commissioners capability across the public sector to work effectively with third sector organisations. Further information is available at: www.idea.gov.uk/idk/core/page.do?pageId=6583598#contents-2j

CHALLENGE FOUR – The development of leadership, both clinical and managerial to grasp the strategic opportunities, and to work with local communities to co-design change and to see change through

3.41 The development of leadership across organisational boundaries will be vital, in the future, to ensure care is delivered around the patient, and to deliver care closer to home. In addition, the private and third (voluntary groups, charities and social enterprise) sectors have important roles to play in modern public services – it is vital they are included when planning local leadership skills training in the public sector.

Kent County Council are leading the way with an innovative leadership development programme that draws on the county and district council, police and fire services, health, voluntary organisations and a range of regional bodies. The scheme recognises that all sectors are facing common issues such as increasing customer expectations, demands for flexibility and pressures to achieve value for money. More information is at www.idea.gov.uk/idk/core/page.do?pageID=7116953 or coral.ingleton@kent.gov.uk

Leadership

3.42 There are a number of existing programmes that support leadership development for the public sector, such as 'Leading for Change'. There are also a number of initiatives recently announced in 'High Quality Care for all' that are focussed on developing leadership within the public sector, to ensure that change happens. It includes a number of broad proposals regarding leadership:

- (i) Identification of the core elements of any approach to leadership;
- (ii) Start leadership development early and continue throughout all clinical and non clinical careers;

- (iii) Establishment of a Leadership Council which will be responsible for overseeing all matters of leadership across healthcare with a particular focus on standard setting;
- (iv) The NHS Medical Director and National Clinical Directors will work with senior clinicians to ensure that clinical leadership becomes a stronger force in the NHS.

CHALLENGE FIVE – Developing community premises and estates that are fit for the future as well as the present

3.43 'Our health, our care, our say' set out the case for community hospitals – namely that evidence shows that there are a number of benefits in having community hospitals, one of which is that they provide better recuperative care than District General Hospitals (DGHs). There are eleven leading causes of hospital bed use in the UK, eight of which are for illnesses or conditions for which could be treated more effectively in a community setting. This could lead to fewer hospital admissions. 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.

Community hospitals

3.44 'Our health, our care, our community: investing in the future of community hospitals and services' published in July 2006, implemented the principles of the 'Our Health, our care, our say' White Paper to make care more local and convenient, getting the areas of greatest need the services they deserve. It gave details of the design principles that PCTs' proposals should meet in order to be granted capital funding, and set out plans for a new generation of state-of-the-art community hospitals and services.

Community Health Partnerships

3.45 Central to care closer to home is the need for seamless joint delivery for the user of services. Community Health Partnerships (CHP) develops, creates investment in and helps deliver innovative ways to improve health and local authority services. CHP recently published a toolkit for those interested in using the Local

Improvement Finance Trust (LIFT) initiative, which CHP deliver – called ‘Future-proofing Care Outside Hospital’. The toolkit highlights developments that have seen new medical facilities built alongside leisure centres, gymnasiums, libraries and benefit advice centres – with a number of GPs explaining how their practices and patients have benefited. It also includes case studies showing the benefits in terms of co-location of services, convenience for patients, integration of NHS and local authority provision, urban regeneration and enhanced morale among staff. The toolkit and further information are available at:

www.communityhealthpartnerships.co.uk/publications

3.46 Examples of where the LIFT initiative has contributed towards delivering care closer to home are below.

People in Wigan needing renal dialysis faced an 80-mile round trip until Wigan Health Centre was built.

‘I have noticed a huge change in my life, in terms of how I feel and the time I have been given back by no longer having to travel for my treatment.’ Patient from Wigan

Peel Hall Medical Practice is based in Wythenshawe, Greater Manchester. Until the LIFT development, there was a piecemeal scattering of GP practices in the area, with none at the heart of Wythenshawe. Practice development in the area was poorly planned. Now the centre can hold dedicated clinics for diabetes, CHD, asthma, weight management. There are two dedicated nurses’ rooms. There is no hot-desking. Surgeries can be run at different times without causing disruption.

‘Patients tell us that the range of service is much better than before. We don’t have to send people elsewhere so much’. Dr Ash Bakhat is a partner with Peel Hall Medical Practice, Wythenshawe, Greater Manchester, which he joined in 1995.

Community Pharmacies

3.47 Community pharmacies based in the communities that they serve are beginning to play a bigger part in health improvement services improving health and reducing health inequalities, supporting self-care and providing healthy lifestyle advice so people can look after themselves better and lead more independent lives.

CHALLENGE SIX – Workforce – putting in place the roles, skills and planning to facilitate services that support people at home and in the community

- 3.48** To achieve a fundamental shift of care closer to home from hospital to community settings, we have to ensure that we have a workforce willing and able to provide care across different settings, which can also help address the needs of seldom heard groups.
- 3.49** The Government believes more support is needed for people who are newly prescribed a medicine to treat a long term condition. In the Pharmacy White Paper – ‘Pharmacy in England, building on strengths delivering the future’, a commitment was made that Government would discuss with NHS Employers and Pharmaceutical Services Negotiating Committee, how such a support service may best be introduced within the community pharmacy contractual framework. Pharmacists can also play a key role in integrating care as shown in Devon.

Karen Acott is a pharmacist partner at **Wallingbrook Health Centre in Devon** (which also houses a dispensary). She runs the dispensing business and meets the pharmaceutical industry representatives. She is also responsible for human resources and training and development of three accredited checking technicians. She runs migraine, epilepsy and chronic pain clinics. Karen also reviews the medicines and notes of patients recently discharged from hospitals and talks through with them any alteration of doses, etc. She has recently become an independent prescriber and this will help her in her migraine, epilepsy and chronic pain clinics.

Further information and examples are set out in the White Paper – ‘Pharmacy in England building on strengths, delivering the future’ at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083815

Practitioners with a special interest

- 3.50** The national framework for pharmacists with special interests (PhwSIs) was published in September 2006. Pharmacists now have the opportunity to provide innovative services in convenient locations for people with long terms conditions and those, for example, who require monitoring and adjustment of their anticoagulant treatment, or services related to substance misuse and sexual health.

- 3.51** The PhwSI approach makes good use of the skills available in community pharmacy. The recent Pharmacy White Paper also points to development of health community clinical pharmacy teams, where pharmacists, including PhwSIs and consultant pharmacists, will collaborate to improve the use of medicines and achieve better outcomes for patients.
- 3.52** In September 2008, a series of speciality frameworks will be launched to underpin the accreditation of practitioners with special interests. This work has been taken forward by the Royal College of General Practitioners with the involvement of the Royal Pharmaceutical Society of Great Britain.
- 3.53** In April 2007 the Department published guidance 'Implementing Care Closer to Home, Convenient Quality Care for Patients', to support commissioners for the provision of more specialised care at home with the emphasis on the role of PwSIs. This updated national guidance aims to provide practical support to commissioners for the provision of more specialised services closer to home with the emphasis on the role of PwSIs. It also includes new robust governance arrangements for GPs and Pharmacists with Special Interests to ensure the services in which they work are safe, of a high quality and better able to meet patients' needs in the communities in which they are located. The guidance is available at: www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH_074419
- 3.54** The report 'A High Quality Workforce: NHS Next Stage Review' published in June, recognised that achieving high quality care for patients requires an effective team of professionals, across clinical, managerial and supporting roles. The report contains a number initiatives that will support and develop the workforce to deliver care closer to home, including the following.
- 3.55** Frontline staff have the talent to look beyond their individual clinical practice and act as practitioners, partners, and leaders. DH will work with the NHS, the professions, the professional regulators and other interested key parties to support clinicians in developing the three core roles. The local visions in every region show the changes the NHS needs to make to improve the quality of care for patients. This means the career pathways and education that underpin their skills will also need to change. DH will work with leaders of the profession to ensure that medical education and training supports the development of identified characteristics in tomorrow's expert medical practitioners. Over the next

three years, in close engagement with the Royal Colleges the professional regulators, the wider medical profession, universities, commissioners and employers, DH will want to see the development of a new reformed postgraduate training pathway for doctors, which will be key to delivering care closer to home. In light of the increasing demand for primary and community care services, SHAs will be expected to expand GP training programmes so that in future, at least half of doctors going into specialty training will be training as GPs.

3.56 The Modernising Nursing Careers programme also includes a pathway approach to nursing careers to better align careers with the full range of the needs of the public and patients, in health and in ill-health, supported by an educational framework and a recognised career structure. The future framework for nursing careers will promote a greater diversity of careers, in different settings, across traditional boundaries.

Skills for Health (SfH) and Skills for Care (SfC)

3.57 Skills for Care has been closely involved, with Skills for Health, in developing the seven Common Core Principles to support self-care, to help social care staff support people who use services to live more independently, stay healthy and make the most of their lives by managing their conditions. For example, SfC have currently funding 50 New Types of Worker (NToW) projects encouraging a range of large and small employers to look how the sector can deliver services differently. The results of these innovative projects will be shared on the newly launched NToW website at www.newtypesofworker.co.uk.

3.58 More information is available at:
www.skillsforcare.org and www.skillsforhealth.org.uk

CHALLENGE SEVEN – Making greater use of technology to provide more care in community settings and at home

3.59 Our work has identified initial issues in the use and spread of technology both in delivering care to patients and sharing information with organisations.

Information provision, information sharing and the use of innovative technologies

3.60 Information provision, information sharing and the use of innovative technologies have an important contribution to make in supporting the delivery of care closer to home. NHS Connecting for Health (NHS CFH), through the NHS National Programme for IT (NPfIT) is modernising information technology to underpin service transformation and enable better, safer care, aiming to provide patients with more choice and health professionals with more efficient access to patient information. The three aspects set out below are of particular value in supporting the delivery of care closer to home.

Information provision

3.61 Patient access to up to date information about services will become increasingly important as new services are introduced and the variety and number of providers increase. NHS Choices contains information on hospitals aimed at helping patients make informed choices about where to go for treatment and includes overall service quality (as rated by the Healthcare Commission), infection rates, waiting times and readmission rates for a number of common treatments. The website also contains information on GP practices, health conditions and treatments, and healthy living. The range of information on NHS Choices will gradually be extended to provide further support for patient choice. The NHS Choices website will also provide more information about all primary and community care services, so that people can make informed choices. NHS Choices is available at www.nhs.uk/Pages/homepage.aspx

Information Sharing

3.62 Care closer to home requires effective information sharing and improved communication between primary and secondary care. The **Common Assessment Framework (CAF)** will contribute towards better co-ordination between health and social care services, and DH funding has been allocated for 2008-11 to initiate demonstrator projects which aim to establish CAF processes underpinned by interoperable IT and to evaluate the feasibility, costs, benefits and risks of this approach. There will be evaluation of these projects prior to any further rollout. In addition, during 2008-09 there will be a series of projects aiming to enable the secure sharing of assessment and other care information between agencies in health and social care:

- Four local council pilot projects, which aim to connect different social services information systems to the NHS Personal Demographics Service to enable social services staff to trace NHS numbers and ensure that jointly managed patients/ service users, can be identified accurately. The four sites are Cheshire, Torbay, Slough and Greenwich.
- Links to the Newham Whole Systems Demonstrator project, which aims to provide holistic care to people with long-term-conditions, and includes implementing the exchange of CAF messages between NHS and social care systems. This will enable health and social services professionals to share assessment and care planning information.

Further information is available at:

www.connectingforhealth.nhs.uk/systemsandservices/hscip/adopters

Telehealth

3.63 Introducing telehealth services poses new challenges for health information systems including offering patients a choice of technology to meet their specific needs; providing equity of access, particularly for older users who are more likely to need care; and building clinical capacity in the community by enabling more effective and efficient care pathways. NHS CFH is supporting the development of technologies for effective and scalable health services delivered closer to home. Amongst other things, NHSCFH are fostering the development of technology standards for interoperability and managing a technology demonstrator programme to show how modern Information and Communications Technology (ICT) can be applied to improve the patient experience and meet the information needs of community based clinicians, including mobile access to the NHS Care Records Service. Further information is available at:

<http://www.connectingforhealth.nhs.uk/factsandfiction/patientcases/telehealth>

Whole System Demonstrator sites

3.64 A number of Whole System Demonstrators have been developed to explore the possibilities opened up by truly integrated health and social care working supported by advanced assistive technologies such as telehealth and telecare. The sites will lead to a better understanding of the level of benefit associated with such developments, and fast track change by addressing the key implementation barriers and providing solutions for the wider NHS and social

care. Three sites are up and running and large scale evaluation based implementation commenced April 2008.

Current Landscape

- 3.65** As the system evolves to become far more strongly driven by commissioning and choice, and as the number and type of providers of NHS services (including independent and third sector providers) rises, the need (and incentives) to offer users high-quality services that also provide convenient access will also increase.
- 3.66** The development of services that are 'closer to home' and that are strongly rooted in the preferences as well as the specific clinical or care needs of people will therefore be a key element of the health and care system's response to future demand.
- 3.67** There are real challenges in a more diverse landscape. A particularly important need- to meet the requirements of commissioning and choice- will be for greater transparency and clarity about the outcomes and costs of services. This will not be easy for many community services, as they have not traditionally been given the same level of support in developing the necessary information systems and metrics as other parts of the system. DH is leading a number of projects to start to address these needs through the **Transforming Community Services Programme** which will:
- Identify and spread evidence based clinical practice in partnership with the NHS Institute for Innovation and Improvement;
 - Examine the suitability of different organisational models for community service providers;
 - Introduce a new standard contract for NHS funded community services;
 - Promote best practice in the use of information for managers, clinicians, regulators and patients;
 - Develop a national dataset in partnership with the NHS Information Centre to support commissioning of community services.
- 3.68** This will ensure that all stakeholders have access to timely information about community services, with a particular focus on quality and clinical outcomes. The strong track record of many primary and community services in getting to know

their users and building strong relationships with them will be a real benefit as they start to operate in an environment in which informed choice is a far stronger force.

Quality

3.69 'High Quality Care for all' puts quality at the heart of everything the NHS does. To this end, to enable the shift of care closer to home, the report committed to developing a number of initiatives around quality, including piloting a quality framework for community services, and developing clinical dashboards to indicate quality. The aim being that every provider of NHS services should systematically measure, analyse and improve quality.

Regulation

3.70 It is vital that we work to ensure that essential quality and safety requirements are met in all settings (primary, community, and secondary) and by all types of providers (whether private, voluntary, NHS, or social enterprise). This level playing field should mean that providers can set up in the way that best meet the needs of the public in that area and that PCTs and individuals can be assured that services meet the essential requirements. It will also be important for members of the public to have access to more information to help them to compare all the organisations they could choose to receive a particular service from. Therefore, the report sets out that the new Care Quality Commission will ensure compliance with registration requirements for safety and wider quality that all health and adult social care providers will be expected to meet in order to be permitted to deliver services. It will provide independent information and assurance that systems for safety and quality are in place and working well, and it will help providers identify areas in need of improvement. It will also regulate safety and quality for all GP and dental practices. This would mean that, for the first time, any organisation providing primary medical or dental care will be subject to a consistent set of quality standards.

Choice and Competition

3.71 Some further information about the roles and functions of commissioners and system managers (including NHS, social enterprise and third sector organisations as well as independent sector, practice-based commissioners and primary care) is

set out in The Operating Framework for 2008/09, 'Principles and rules for Cooperation and Competition'. This includes a clear statement of principles and rules for cooperation and competition based on the 'core' system management principles- transparency, objectivity, proportionality, non-discrimination, subsidiarity, consistency, and no double jeopardy.

3.72 This should be read in conjunction with the 'Framework for Managing Choice, Cooperation and Competition' Framework and the 'PCT Procurement Guide for Health Services', both published in May. The Framework supports SHAs and PCTs in understanding the roles, responsibilities, values and behaviours required for the effective management of choice and competition within the NHS. The guide supports NHS commissioners in deciding whether and how to procure health services through formal tendering and market-testing exercises.

Further information relating to the Operating Framework is available at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

'Principles and rules for Cooperation and Competition' is available at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081098

'Framework for Managing Choice, Cooperation and Competition' is available at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084779

'The PCT Procurement Guide for Health Services' is available at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084778

'Code of Practice for the promotion of NHS-funded services' is available at:

www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_083572

Chapter 4 – New tools to support delivery

4.1 There are many useful tools that already exist to support delivery of care closer to home. However, feedback from the NHS and its partners, and clear messages from some of the demonstrator sites, were that further help and advice would be welcomed by commissioners and others looking at shifting care. For example, the speciality subgroups of the CCH demonstration programme recommended that a toolkits could be developed to ensure greater clinical input from specialty teams to inform the commissioning cycle and ensure that local commissioners have the information they need to develop integrated services. Listed below are products that have been commissioned specifically to assist the NHS and its partners to deliver care closer to home. Some are available now, and some will be available over the next few months and obtainable through www.dh.gov.uk.

Value for money/Business cases

4.2 The Department, Yorkshire and Humber SHA, the York Health Economics Consortium and the Public Health Observatory are working together to support several PCTs to design and test out a methodology for assessing the impact of shifting care. Focusing on diabetes and COPD the PCTs will over the next nine months generate a process and a series of tools for evaluating the wider economic impact of interventions, based on existing plans in progress which restructure and enhance their community teams as a multi-disciplinary rapid response service. The intention is to pilot the model of delivery and build the case for spread across the PCT. The outcomes will be shared with the NHS early 2009.

18-week website

4.3 Although some of the projects we have come across were set up specifically to deal with shifting care, and others were to meet the 18-week Referral to Treatment Target (RTT), they have produced useful insights into shifting care closer to home. The 18-week website now includes case studies on shifting care. These can be found at: www.18weeks.nhs.uk/content.aspx?path=/achieve-and-sustain/Specialty-focussed-areas

Dermatology and Urology – Resource Packs

4.4 The aim of these reports is to provide support and information for commissioners to consider and use when commissioning services for people with skin conditions and urological complaints for a local health community. The work seeks to facilitate a whole systems approach to deliver integrated services ensuring timely access, high quality care (close to home where appropriate) and value for money. These two reports are available at: www.primarycarecontracting.nhs.uk/1.php

Ambulance Services

4.5 Key resources in relation to ambulance services include 'Taking Healthcare to the Patient: Transforming NHS Ambulance Services' [DH, 2005] and 'The Changing Face of Ambulance Services in England' [South West Ambulance Service NHS Trust, 2008]. 'Taking Healthcare to the Patient' sets out the conclusions from an overarching review of NHS ambulance services in England, which were supported by DH. The review sets out how ambulance services can be transformed from a service focusing primarily on resuscitation, trauma and acute care, towards becoming the mobile health resource for the whole NHS – taking healthcare to the patient in the community.

4.6 The potential role of ambulance services in bringing services closer to home – and of contributing to the prevention of hospital admission is not being realised. The report recognises the potential of ambulances to support primary care services, help integration across urgent care, and avoid unnecessary attendances at A&E.

4.7 Areas where we could see significant impact include:

- Ambulance control centres (clinical hubs) providing SPA (single point of access) – telephone clinical assessment and the deployment of appropriate resources where necessary to source care closer to home;
- To manage and provide minor treatment centre facilities;
- Capacity to support primary care services, e.g. supporting patients in primary care, provision of diagnostics at home, visiting Primary Care patients on behalf of GPs;
- Health promotion – a big untapped resource for, among others, smoking cessation and coronary heart disease awareness;

- Integration of services e.g. working with community hospitals around admissions, and joining up health and social care through regionally based capacity management systems operated by ambulance service clinical hubs;
- Avoiding unnecessary admissions / service utilisation through mobile treatment units, greater use of minor injuries and approved pathways of care.

4.8 'The Changing Face of Ambulance Services in England' was launched at the Ambulance Services National Conference and Exhibition in June and highlights a number of initiatives taking place across England to provide improved access to services, pathways of care for patients and information and resources for healthcare professionals. It identifies examples where Ambulance Services information systems could be better used as enablers to improve pathways of care and make evidence based commissioning decisions

4.9 'A vision for emergency and urgent care – The role of ambulance services' was recently published by the Ambulance Service Network and illustrates how ambulance services have a vital role to play in addressing these challenges and ensuring all patients get the right care, in the right place at the right time. The report outlines how ambulance services will work with the commissioners and providers of health and social care to save lives, improve health and tackle inequalities. The report includes a number of case studies where ambulance services are already making the most of the opportunity to shift care, for example:

Helping patients better manage chronic conditions in the West Midlands

West Midlands Ambulance Service is developing a new service to help patients with long-term illnesses like heart disease to better manage their condition and to reduce the number of emergency admissions. Patients are given a simple handset which is personalised to fit their individual condition. Every morning, the patient provides information on a range of issues, such as their blood pressure, weight, whether they have taken their medication, how far they can walk whilst breathing normally, or whether their ankles are swollen. The handset is then plugged into a telephone socket so that the information can be transmitted to a 'hub' within the ambulance service control centre. If the data isn't received, or if it is outside the patient's normal parameters, an alert is generated. The patient may then be rung and reminded to use their handset, or a paramedic or other member of the ambulance service may be sent to provide care in the patient's home.

'Taking health care to the patient' is available at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4114269

'A vision for emergency and urgent care – The role of ambulance services' is available at: www.nhsconfed.org/ambulances

'The changing face of Ambulance Services in England' is available at:

www.wcas.nhs.uk/publications/pdf/Changing_Face_of_Ambulance_Services.pdf

Conclusion

4.10 In this document we have tried to get the measure of what bringing 'care closer to home' means; and it is clear that this is a theme running through much of the current work to improve services locally. As the SHA Visions for the NHS Next Stage Review show, it will continue to do so in the future. There is much we can learn from one another's experience in trying to make services more convenient and better-suited to the (increasingly long-term) needs and preferences of people in the future as well as the present. In some cases, there are models of care and pathways that can be replicated with relatively little change. More usually, however, the experience of other health and care economies serves to inform rather than replace the thinking of others, becoming part of the local process of discussion and debate. So, while there cannot be a single blueprint of how to

bring services closer to home and closer to people in their daily lives, we in the NHS and social care can and should work and learn together to make care closer to home a reality for our local populations. This document will, we hope, be of use to local health and care economies as they continue on their journeys to bring care closer to home.

ANNEX

Further Help/Resources

Chapter One – The Challenge

Our NHS Our Future: NHS Next Stage Review – Interim Report

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_079077](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079077)

NHS Next Stage Review: Our Vision for Primary and Community Care

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_085937](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085937)

Commissioning Framework for Health and Well-being

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_072604](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604)

Our health, our care, our say: a new direction for community services

www.dh.gov.uk/en/Healthcare/Ourhealthourcareoursay/index.htm

Health Inequalities – Progress and Next Steps

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_085307](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085307)

High Quality Care for all: NHS Next Stage Review Final Report

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_085825](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825)

A High Quality Workforce: NHS Next Stage Review

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_085840](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085840)

The National Health Service Constitution

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_085814](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085814)

King's Fund Report – Shifting Care Simulation

www.kingsfund.org.uk/publications/kings_fund_publications/windmill_2007.html

Next Stage Review Leading Local Change and SHA visions

www.ournhs.nhs.uk/wp-content/uploads/2008/05/286501_nhs_next_stage_review_acc1.pdf

International Longevity Centre-UK

www.ilcuk.org.uk

Chapter Two – Local Challenge – Sharing the Learning

Case studies on shifting care

www.dh.gov.uk/en/Healthcare/Ourhealthourcareoursay/index.htm

Partnerships for Older Peoples Project

www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/PartnershipsforOlderPeopleProjects/index.htm

POPPs Promoting independence toolkit

www.cat.csip.org.uk/index.cfm?pid=597

Care Closer to Home Demonstration Projects – University of Manchester evaluation and Speciality Subgroups Report

www.npcrdc.ac.uk/Evaluation_of_Closer_to_Home_Demonstration_Sites.htm

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_079728

Case Study – Hull

For further information contact Toni Wardale at Toni.Wardale@hullpct.nhs.uk

Case Study – Cornwall Community Matrons

For further information contact Helen Lydon, Lead Community Nurse,
Email Helen.lydon@CIOSPCT.cornwall.nhs.uk

Case Study – Manchester

www.gmccardiacnetwork.nhs.uk/

www.lsccardiacnetwork.nhs.uk/National%20Key%20Documents/Cardiac_Telemedicine.pdf

Case Study – Huntingdonshire

Further information is available from: Karen.mason@cambridgeshirepct.nhs.uk

Case Study – Somerset

More information is available from: Annabelle.walker@somersetpct.nhs.uk or at the PCT web site: www.somersetpct.nhs.uk/Services or at www.wyvernhealth.com/Documents/pathways/urgent_care/COPD_briefing.doc

Health Reform Demonstration Systems

More information about the NHS Initiative is available at:
www.osha.nhs.uk/page.php?id=255

Chapter three – Supporting Change

Challenge One

End of Life Care Strategy

The strategy will be available on the DH website shortly.

Individual Budgets

Further information on the pilots is available at:

www.individualbudgets.csip.org.uk/index.jsp

Further information on individual budgets in 'High Quality Care for all' is available at:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

Self-referral report

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081067

Case study – Liverpool

www.liverpoolpct.nhs.uk/bhd/default.asp

Case study – POPPs

www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/PartnershipsforOlderPeopleProjects/index.htm

Information prescriptions

A resource pack is available at:

www.informationprescription.info

And information on the accreditation scheme

www.dh.gov.uk/accreditation

Challenge Two

Third Sector Organisations (TSOs) and Social Enterprise Investment Fund

www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Socialenterprise/index.htm

Third Sector Market Mapping Report

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065411

Case Study – PoPPs

www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/PartnershipsforOlderPeopleProjects/index.htm

Diabetes Year of Care

For further information contact James Thomas at:

james.thomas@diabetes.org.uk

or

www.diabetes.nhs.uk/work-areas/year-of-care

Integrated Care Network

www.integratedcarenetwork.gov.uk/icn

Challenge Three

World Class Commissioning

www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm

Joint Strategic Needs Assessment

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_081097

National Third Sector Commissioning Programme

www.idea.gov.uk/idk/core/page.do?pageId=6583598#contents-2j

NHS Institute for Innovation and Improvement

www.institute.nhs.uk/commissioning and www.institute.nhs.uk/opportunitylocator

PBC Case Study

‘Practice based commissioning: early wins, early lessons’ is available at:

www.nhsalliance.org

Community Tariff Pilots

For further information please contact: peter.howitt@dh.gsi.gov.uk

Challenge Four

Case Study – Kent County Council

www.idea.gov.uk/idk/core/page.do?pageID=7116953 or coral.ingleton@kent.gov.uk

Leadership – Next Stage Review

High Quality Care for all: NHS Next Stage Review Final Report [DH, 2008]

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_085825](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825)

Challenge Five

Community Health Partnerships

www.communityhealthpartnerships.co.uk/publications

Challenge Six

The White Paper – Pharmacy in England building on strengths, delivering the future

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAnd
Guidance/DH_083815](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083815)

Implementing Care Closer to Home, Convenient Quality Care for Patients

www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH_074419

Skills for Health/Skills for Care

www.newtypesofworker.co.uk.

www.skillsforcare.org and www.skillsforhealth.org.uk

A High Quality Workforce: NHS Next Stage Review

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_085840](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085840)

Challenge Seven

NHS Choices

www.nhs.uk/Pages/homepage.asp

Adopters

www.connectingforhealth.nhs.uk/systemsandservices/hscip/adopters

Telehealth

www.connectingforhealth.nhs.uk/factsandfiction/patientcases/telehealth

High Quality Care for all: NHS Next Stage Review Final Report [DH, 2008]

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_085825](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825)

System Management

The NHS in England: The Operating Framework for 2008/09

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_081094](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094)

'Principles and rules for Cooperation and Competition'

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_081098](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081098)

'Framework for Managing Choice, Cooperation and Competition'

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_084779](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084779)

'The PCT Procurement Guide for Health Services'

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_084778](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084778)

'Code of Practice for the promotion of NHS-funded services'

www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_083572

Chapter Four – New Tools

18-weeks website

More information on 18-week pathways and shifting care are available at:
www.18weeks.nhs.uk/content.aspx?path=/achieve-and-sustain/Specialty-focussed-areas

Dermatology and Neurology Toolkits

These two reports are available at:
www.primarycarecontracting.nhs.uk/1.php

'Taking Healthcare to the Patient: Transforming NHS Ambulance Services'

[www.dh.gov.uk/en/Publicationsandstatistics/Publications/
PublicationsPolicyAndGuidance/DH_4114269](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4114269)

'A vision for emergency and urgent care – The role of ambulance services'

www.nhsconfed.org/ambulances

'The changing face of Ambulance Services in England'

www.wcas.nhs.uk/publications/pdf/Changing_Face_of_Ambulance_Services.pdf



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