In each issue of the *Journal of Community Nursing*, we investigate a topic affecting our readers. Here, we ask...

Why is care closer to home failing and what does it mean for community nurses?

District nurd.

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It's a famous maxim that the definition of insanity is repeating the same action over and over while expecting a different result.

Reluctant as we are at JCN to accuse the government of succumbing to collective madness, it is hard to reconcile the deluge of policy documents stating that care needs to be moved away from hospitals and into the community, with the fact that primary care services still appear woefully underfunded. While health ministers talk endlessly about prevention and health promotion, community and district nurses leave in their droves through burn-out and lack of opportunity, and patients with complex needs continue to take up acute beds, leaving hospitals oversubscribed with chronically ill patients who can't be discharged.

While insanity might be a slightly hysterical way to describe how those in government have repeatedly claimed to prioritise the community while cutting back on resources, it certainly smacks of doublespeak.

So, where did it all go wrong? And what needs to be done to put it right?

WHAT IS CARE CLOSER TO HOME?

The phrase 'care closer to home' has been around for some time now, making an early appearance in the government's cuddly titled document *Our Health, Our Care, Our Say*, which outlined a reduced reliance on hospitals: 'Our strategy is to put people more in control, to make services more responsive, to focus on those with complex needs and to shift care closer to home' ('Our health, our care, our say' — assets.publishing.service.gov.uk).

There was a focus on treating and preventing long-term conditions in the community to release pressure on hospital beds, and of course, hidden in the detail, the usual preoccupation with budgets: 'The same procedure in primary care can cost as little as one-third compared to secondary care'.

Care closer to home as a policy gained more traction following publication of the *Five year Forward View* in 2014, with its plan for 'a future that sees far more care delivered locally', and which encouraged 'efforts to deliver more healthcare out of acute hospitals and closer to home, with the aim of providing better care for patients' ('Five Year Forward View' — www.england.nhs.uk).

So far so good. But many years later, why are we are still reading reports that primary care services are in crisis, with patients unable to be discharged from hospital because of a lack of community services ('Sick man of Europe: why the crisis-ridden NHS is falling apart' — www.theguardian.com)?

FOLLOW THE MONEY

Since the pan.

Gail Goddard
Floating district nurse manager and senior lecturer; Queen's Nurse

Despite the government's repeatedly stated aim to shift resources away from the acute sector to the community, it appears that this is simply not happening. In fact, the trend in funding seems to be travelling in the opposite direction. Analysis from the King's Fund has shown that over the past five years, while all areas of healthcare experienced growth in budgets, the areas that experienced the highest rises were acute and ambulance services, while community services… you've guessed it, experienced the least amount of budget growth ('Moving care closer to home: three unanswered questions'— www.kingsfund.org.uk). Far from prioritising primary care, the government seems to be intent on ploughing more resources into acute services

KNOWLEDGE IS POWER

Funding isn't the only reason that care, rather than getting closer to home, seems to be moving further away. Poor data is another factor.

While there is a plethora of information available on acute services, such as which types of patients are treated in hospital, the range of interventions used and most importantly, patient outcomes, the same level of data on community services simply does not exist. In the community, data tends to focus on the number of appointments delivered but is woefully inadequate when it comes to the profile of the actual patients and their outcomes, with many having complex comorbid conditions that require a range of health and social care interventions.

Writing in *Digital Health*, Danielle Jefferies outlines how this leads to what has been termed as a 'cycle of invisibility' where primary care leaders are effectively commissioning blind without being able to evaluate treatments or accurately assign resources ('How data can help make "care closer to home" a reality'— www.digitalhealth.net).

BOOTS ON THE GROUND

As all community nurses know, staffing is another ever-present issue in primary care. Recently, the King's Fund pointed to high staff vacancy rates and endemic workforce shortages in the community. But while the number of hospital nurses has actually grown over the past 10 years, district nurse and health visitor numbers in particular are heading in the opposite direction ('Moving care closer to home: three unanswered questions'— www.kingsfund.org.uk).

Unfortunately, this may only be the tip of the iceberg, with other reports painting a much starker picture, estimating that community nurse numbers may have fallen by almost 50% since 2009, an unsustainable figure in any profession, let alone one that is supposed to be leading the way in a new era of preventative care ('England's community nurse

workforce down almost 50%' — www.nursinginpractice.com).

All of which mean that while care closer to home is a snappy slogan, the reality is that a systemic shortfall in funding and resources has left it practically undeliverable.

HOW CAN WE FIX IT?

According to the King's Fund, all is not lost, with the think-tank coming-up with a range of solutions that mean that care closer to home could yet become a viable policy, including ('Making care closer to home a reality' — www.kingsfund.org.uk):

- If care closer to home is to work, staff such as community nurses need to be equipped to deliver it. The health and care system is currently focused on hospitals, with acute care becoming increasingly specialised. However, patients are presenting with increasingly complex conditions, which need integrated rather than specialist care
- The whole healthcare system needs more generalism in staffing and skill-sets, alongside multidisciplinary teamwork. This means trusting community nurses to assess risk and help people to live at home. It will also require funding, both to attract skilled staff and for education and training
- Currently, so-called 'expert' specialist training is often concerned with acute conditions. However, education needs to focus as much on the assessment and prevention skills required in the community as it does on hospital specialisms.

In short, what is required is a fundamental shift in attitude, where primary care is valued as much as what is often regarded as the more 'glamourous' acute sector. Also, this change cannot always come from staff on the ground such as community nurses and social care staff; the impetus must come from the top, with government ministers and healthcare leaders committing to the vision for primary care that is so often trumpeted in policy documents and white papers.

To be fair to the government, its recently published workforce plan did contain an ambition to grow primary care staff numbers in an effort to 'enable the service ambition to deliver more preventative and proactive care across the NHS'. The plan sets out target to grow these roles 73% by 2036–37' ('NHS Long Term Workforce Plan' — www.england.nhs.uk).

Will it work? Who knows, after all 73% is a big number. But without some significant changes, care closer to home will be just another half-remembered government rebrand (remember CCGs anyone?).

WHAT CAN YOU DO TO BRING CARE CLOSER TO HOME?

As usual, it falls to community nurses themselves to show that if it's done with passion and innovation (and the right resources) care closer to home could actually be a force for good.

Writing about an integrated care service in Buckinghamshire, chief nurse Carolyn Morrice described how a group of nurses took the initiative in the care for older people by identifying and managing their health needs before they hit crisis point and required hospital admission. Crucially, the service includes a liaison nurse who provides a point of contact to offer support to patients while contacting relevant services. As Morrice writes, 'these nurses are knowledgeable about the normal ageing process and disease progression and can identify areas of concern, for example in the physical, psychological, social, environmental or financial aspects of an individual's health and welfare' ('Nurses leading the way to integrated care' — www.england.nhs.uk).

So, not rocket science then. Just good old-fashioned nursing expertise backed-up by supportive management. Perhaps instead of endlessly consulting management 'experts' and writing white papers, NHS leaders ought to take inspiration from the work community nurses are actually doing on the ground, day in, day out. It might sound like a crazy idea, but instead of constant tinkering and reorganisation, what nurses really need is the support to do the job they are already doing, but with the time, resources and support to do it better.

From community nurses across the UK, the message to ministers might be — worry less about snappy slogans such as care closer to home and more on getting your own house in order.

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