



**LET'S BE A COMMUNITY:** ENHANCING  
TREATMENT AND WELLBEING OF PATIENTS  
WITH PARKINSON'S DISEASE THROUGH  
COMMUNITY SERVICES

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# Policy Brief

## Introduction

It is acknowledged that the NHS needs to reduce costs and simultaneously change the way treatment and care are provided to focus on the needs of individual patients and offer wider choice and options for people with complex health and care needs.

## A multifaceted issue

People living with Parkinson's Disease (PD) face significant physical, psychological, social and financial burdens and PD treatment in hospital-based clinics is expensive for the NHS.

## Research – enquiry and solutions

Researchers Dr Reda Lebcir and Dr Eren Demir at the University of Hertfordshire, developed a model on a computer to represent the activities of diagnosis and treatment of patients with PD. For example, where these activities take place and who carries them out. The model includes community services, not usually a setting for treating PD patients, and is used to determine where NHS PD clinics can improve the experience of care and treatment for patients while also reducing costs by increasing community-based clinic appointments.

## Importance of the solution

The number of people affected by PD is increasing in the United Kingdom (UK) driven by an ageing population. The treatment of the disease is complex, resource intensive, and expensive; as there is currently no cure and treatment is given for life. The current model of treatment and management of PD in hospitals is expensive and unsustainable given the financial pressures on the NHS. There is, therefore, a need to find innovative ways to improve the operational efficiency and reduce costs. More importantly, the disease creates significant physical and psychological burdens and constraints for patients. These need to be given important consideration in treatment decision making to enhance quality of life and wellbeing for patients and their families. The challenge is to create care pathways which improve efficiency while enhancing patients' quality of life and care experience.

## Going deeper into our Research Findings

People with PD generally prefer seeing health professionals at local community clinics rather than hospitals as this involves shorter easier journeys, less of a time commitment, and makes them feel empowered to better self-manage their condition.

## Key Findings

Our model facilitates moving treatment from hospital to community settings improving treatment provision and patients' experience, and making efficiency savings, in line with the following findings:

- 1.** Treatment in community services plays a positive role in alleviating the symptoms of PD which are exacerbated by social isolation.
- 2.** People with PD can visit local, convenient, community services reducing anxiety, travelling time, and costs to them.
- 3.** The total number of doctors and nurses Full Time Equivalent required to treat people with PD decreases by a third.
- 4.** The increase in community service costs is more than offset by the decrease in hospital costs.
- 5.** The overall total cost for treating people with PD is reduced by around 10%.





They also find community services to be a friendly environment in which staff are committed to the delivery of customised care which takes account of their personal needs and circumstances. Reconfiguring services to suit this preference will reap benefits for the NHS in terms of improvements in a number of operational and cost performance indicators.

From an operational perspective, the workload of specialist doctors and nurses in hospitals eases due to the decrease in appointments for people with PD. The total number of Full Time Equivalent (FTE) doctors and nurses in hospitals decreases as activity levels go down. Conversely, the number of visits to community services will increase leading to requirements for higher staff FTEs in the community. However, overall, fewer clinical staff are needed which creates a cost saving.

The shift to community services leads also to cost efficiency improvement. Overall PD treatment costs, which include both hospital and community services costs, will be reduced driven by a considerable reduction in hospital based treatment. This is true despite increased community treatment up-take as the unit cost of treatment in hospitals is much higher than in community services

#### **Policy Implications**

There is a need for a more holistic approach to care for people with PD as the shift towards community services must take into account the capacity and resource constraints of existing services and the needs and preferences of the people attending the services. A holistic process will avoid saturation of community services by taking account of the existing capacity where decisions are made about the number of patients to refer to these services. The approach also provides good information about the level of future demand for these services providing policy makers with a clear prediction of the level of investment required to meet future demand.

Greater integration between the different organisational structures (hospitals, community services, General Practitioners) will improve the experiences of people with PD who use the services. Community and hospital services are not necessarily governed by the same umbrella organisation, therefore full communication and coordination between organisations is imperative for the success of PD services. This could be achieved by aligning clinical management systems between the organisations and/or giving local authorities responsibility for the coordination of PD care.

Good communication between NHS care providers and people with PD is key to the success of relocating patients to community services. Information about the benefits of receiving some treatment in community should be readily available in multiple formats and well signposted to draw attention to all the options. This will enable freedom of choice for the patients to decide where to be treated alleviating some of the difficulties associated with travelling long distances to hospital appointments and reducing, consequently, the burden on people with PD, their families and carers.

The model demonstrates that shifting PD patients from hospital to community services can generate efficiency gains for the NHS and enhance the quality of life and wellbeing of patients. To achieve the above benefits, policy makers, practitioners, and patients' groups should work together to improve existing community services, determine the level of unmet demand for these services, and, consequently, set up new ones where these are needed. This will require increased investment in community services to recruit, train and retain specialist staff. This investment will be more than offset by the savings in hospital spending making the policy cost effective for the NHS and beneficial for patients, families, and carers. Further analysis is required to determine how community services can be best integrated within the NHS and social services for better patients' care.