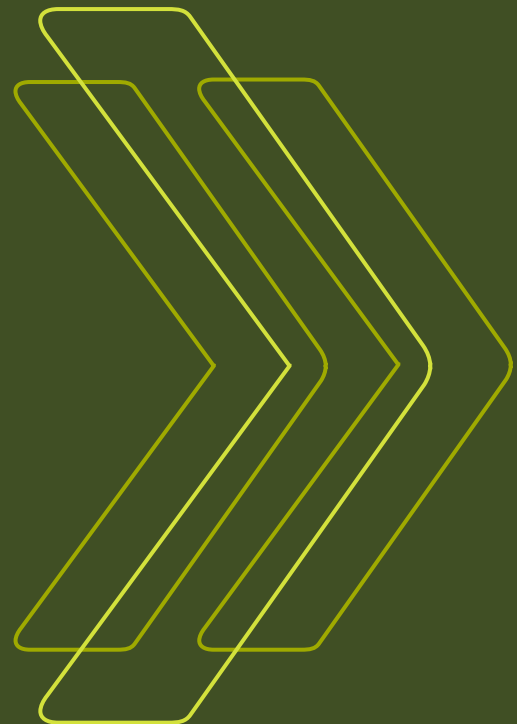The King's Fund>

Ideas that change health care

Reimagining community services

Making the most of our assets

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A brief summary of our argument

This report is a call to action on community services. The longstanding ambition to strengthen these services has not been realised. Growing financial and workforce pressures are having an impact on the ability of service providers to meet the needs of the population and to make a reality of the vision set out in the *NHS five year forward view* (Forward View) (**NHS England** *et al* **2014**).

We argue that a radical transformation of community services is needed. This means increasing the share of the NHS budget allocated to these services and making use of all the assets in each local community wherever these are to be found. It also means breaking down silos between services and reducing fragmentation in service delivery. The focus must be on improving population health as well as integrating care.

This report differs from some previous analyses of community services by adopting a broad definition of their scope. We include services commissioned by the NHS and local authorities as well as related services delivered by the third sector, the private sector, carers and families. Taken together, these services comprise a wide range of assets and there are many opportunities to use them more effectively to meet the population's needs.

Every area of England should exploit these opportunities, recognising the time it will take to increase the share of the NHS budget allocated to community services. This should include pooling health and social care budgets, redoubling efforts to integrate services, and fully engaging the third sector, the private sector and others in transforming care. NHS primary care and community health services should be at the centre of these efforts.

There are examples everywhere of work to bring community services in from the cold, for example in the new care models set up to implement the Forward View and the primary care home pilots. The challenge facing the NHS and its partners is to move beyond these pockets of innovation and to make community-based care

the central focus of the health and care system. The direction has been set by the Forward View and a credible implementation plan – similar to those for general practice and mental health – must be developed to achieve system-wide impact.

The elements of what community services should look like are well understood and we summarise these elements in 10 design principles set out in this report. How they are applied will vary from place to place depending on the population's needs and how services are currently organised and funded. Each area should identify leaders to take forward this work and should engage staff and communities in the work that needs to be done.

Every area should also revisit its sustainability and transformation plan (STP) to ensure that plans are credible and will bring about improvements in care. This means recognising that it is not realistic to release resources from acute hospitals to invest in services in the community when hospitals are working under intense pressure. It also means identifying the funding and staffing needed to make a reality of new models of care and creating time and support for this to happen.

Early evaluations of the new care models show that strengthening services in the community may moderate, and in some cases reduce, demand for hospital care. The care models are examples of a future in which primary care teams, integrated community teams and others work together to meet the needs of patients and service users. These care models have benefited from additional funding and the ability to release staff to work on service improvement.

Changes to mental health services since the 1970s indicate that changes on the scale of those described in this report can be delivered but they will take time, resources and sustained leadership to be realised. The goal should be to bridge the gulf between the rhetoric and the reality of care in the community by delivering a higher proportion of care at home or closer to home, reducing fragmentation in service delivery and improving overall population health. The government and national NHS bodies must give the same attention to community services as they have given to acute hospital services over a long period of time.

Introduction

What we mean by community services

This report focuses on services in the community defined both narrowly and broadly. The narrow definition encompasses those services typically provided by organisations with responsibilities in this area (including combined and standalone community NHS trusts, social enterprises, private providers and local authorities). Most of these services are commissioned by the NHS, but some public health services – such as school nursing, health visiting and sexual health services – are commissioned by local authorities. The broader definition also includes related services delivered in community settings such as general practice, social care and mental health as well as the contribution of the private sector, third sector organisations, carers and families.

Table 1 **Examples of services falling under the two definitions of community services used in this report**

Narrow definition of NHS community health services	Wider definition of community services
- Child health services - Community matron services - Community occupational therapy - Community paediatric clinics - Community palliative care - Community physiotherapy - Community podiatry - Community specialist nurses (for example for diabetes, heart failure, incontinence or tissue viability) - Community speech and language therapy - District nursing - Falls services - Health visiting - Intermediate care - School nursing - Sexual health services - Wheelchair services	- A wide range of voluntary sector support services - Ambulance services - Care homes - Community mental health services - Community optometry services - Community pharmacies - Dental services - Domiciliary social care - General practice - Hospices - Informal care from family members and unpaid carers - Macmillan nurses - Minor injuries units and urgent care centres - Public health services - Supported housing

Note: These lists are not exhaustive.

Why community services matter

The King's Fund has argued that services in the community, defined broadly, must be developed and strengthened to provide care appropriate to the needs of the population now and in the future (**Ham** *et al* **2012**; **Imison 2009**). This means integrating services around people's needs and giving greater emphasis to population health (**Ham** *et al* **2015**). Our arguments have been echoed in the *NHS five year forward view* (Forward View) and in sustainability and transformation plans (STPs), which are the local delivery plans for the Forward View (**Ham** *et al* **2017**; **NHS England** *et al* **2014**).

The challenge is how to realise this ambition when demand for care and support is increasing as a result of the growing and ageing population and changes in the disease burden, especially for people with multiple health and social care needs. Funding pressures on the NHS and cuts in public spending on social care and public health have accentuated this challenge. As the system grapples to improve financial and operational performance in acute trusts, the direction of attention and funding has shifted further away from community services and public health. There is a growing disconnect between the rhetoric and the reality of community-based care, with carers and families stepping in to fill the gaps left by statutory services.

Funding pressures have had a significant impact on services based in the community. Our previous research suggests that community health service budgets are not keeping pace with rising demand, impacting on the availability and quality of care in some cases (**Robertson** *et al* **2017**; **Maybin** *et al* **2016**). Local authority spending on public health has fallen in real terms, and some services such as sexual health services are seeing significant cuts as a consequence (**Buck 2017**). Until recently, the share of NHS funding going into general practice has declined even though demand has risen (**Baird** *et al* **2016**) and measures of patient satisfaction and access to general practice have fallen in recent years (**Wellings and Baird 2017**). The number of older adults receiving publicly funded social care fell by 26 per cent between 2009 and 2013/14 (**Humphries** *et al* **2016**).

There are also severe workforce shortages in key groups of the community workforce – most notably in district nursing, where numbers have halved – presenting a significant challenge to plans to expand community services (**Imison** *et al* **2017**; **Maybin** *et al* **2016**). Workforce shortages are also problematic in wider

services in the community, for example in general practice where there are severe recruitment and retention issues (**Baird** *et al* **2016**).

Service pressures have given rise to a widespread perception that some community services are at a tipping point and are struggling to meet current needs, let alone adapting to deliver the ambitions set out in the Forward View and sustainability and transformation plans. We and others have argued that the government must provide sufficient funding to stabilise and sustain these services (**Robertson** *et al* **2017**; **Baird** *et al* **2016**; **Humphries** *et al* **2016**; **Maybin** *et al* **2016**).

Equally important is to make better use of the wide range of assets in the community and at the same time break down silos between services and reduce fragmentation in service delivery. 'Community assets' are the positive capabilities within communities that can be used to promote health. These could include the full range of statutory services, voluntary and community sector organisations, private sector organisations, support groups, social networks, individuals, buildings and community spaces.

The contribution of community services

National data on community health services is patchy at best. Estimates suggest that there are around 100 million patient contacts in community health services each year (**Gershlick and Firth 2017**) and a further 340 million consultations in general practice (**NHS England 2013**). By comparison, there are around 117 million contacts in hospital accident and emergency (A&E) departments, outpatient clinics and inpatient care (**NHS Digital 2017c**, **2016a**; **NHS England 2017a**).

It is not possible to obtain an accurate figure for the total number of staff currently working across community health services, but it has previously been estimated that they account for around one-fifth of the total NHS workforce (**Department of Health 2008b**). There are a further 126,000 whole-time equivalent staff working in general practice (**NHS Digital 2017b**).

Community health services accounted for around 12 per cent of NHS England's total £99 billion spending in 2014/15 (this figure includes spending on continuing care) and primary care accounted for a further 23 per cent (this figure includes spending on general practice, as well as prescribing and related primary care spending). Specialised services and non-specialised acute care accounted for

54 per cent of spending in the same year (**Lafond** *et al* **2016**). All the figures above should be viewed with caution due to limitations in available national data on activity, workforce and spending.

These numbers do not reflect the vast amount of additional activity, staffing and spending on community services defined broadly. For example, local authorities spent £16.97 billion on adult social care in 2015/16 (**NHS Digital 2016b**), there are around four times as many beds in care homes and nursing homes as in NHS hospitals (**Ham** *et al* **2017**) and the total adult social care workforce has been estimated at 1.11 million whole-time equivalent staff (**Skills for Care 2017**).

A significant contribution is also made by unpaid carers. Around 6.5 million people provide unpaid care for older and disabled friends or relatives in the United Kingdom, and the value of this support has been estimated to be worth £132 billion per year, equivalent to the entire NHS budget (**Buckner and Yeandle 2015**).

How community services need to transform

Transforming community services – to coin a phrase – requires system-wide changes in which community-based care defined broadly becomes the central focus of planning and provision at all levels. The changes that are needed are now well understood and many are in place in the new care models programme and related initiatives. Community-focused approaches were also explored through Realising the Value – a programme set up to support the Forward View's vision to develop a new relationship with people and communities (**Finnis** *et al* **2016**). The challenge facing the NHS and its leaders is to sustain these initiatives and extend them into the mainstream of care in partnership with colleagues in local government, the third sector and the private sector.

As this happens, the emphasis needs to be on doing things differently rather than delivering more of the same. This means drawing on the energies and ideas of staff providing care and on the experience of people and communities needing care. It also means supporting champions of change wherever they can be found.

Innovative GPs, nurses and other clinicians will be at the forefront in some areas and local government and community leaders in others. The third sector and private sector can also contribute, building on the examples of hospices and care providers

that have pioneered innovative models in housing, domiciliary care and residential care. The leaders of NHS community services are well placed to play their part and will need support from regulators and politicians to try out new ways of working rather than maintaining the status quo.

Lessons from the past

In working on this report, we were struck by the many previous attempts by successive governments to give greater priority to community services, extending back to the 1960s. Recent policy commitments such as those set out in *Our health, our care, our say* (Department of Health 2006) and *High quality care for all* (Department of Health 2008a) under the last Labour government and, more recently, the Forward View (NHS England *et al* 2014) offer a foundation on which to build. As systems move from planning to implementation in developing new models of care, it will be important to learn from previous NHS change programmes, such as the reform of mental health services, and to focus on how care can be improved rather than on structural or organisational solutions.

Removing barriers and seizing opportunities

As we found during the fieldwork for this report, complexity in how services are commissioned and how they are provided gives rise to duplication and overlap as well as opening up gaps between the teams delivering care. The wide range of public and private providers involved in providing care and the use of tendering and procurement by commissioners do not help in the development of well-integrated services that are able to meet needs in the round.

There are many opportunities to simplify and co-ordinate how services are commissioned, for example through clinical commissioning groups (CCGs) and local authorities working together to pool budgets and use innovative forms of contracting to support more integrated models of provision. There are also opportunities for providers to work differently by taking forward work on new care models and scaling them up through STPs and emerging accountable care systems and organisations. The focus on place-based systems of care and the growing interest in accountable care systems and population health offer further opportunities to transform community services and to make a reality of the ideas set out in the Forward View.

The organisation of this report

We explore these and other issues in this report by reviewing the history of policies to reform community services (section 1). This leads into a description of how services are organised and delivered and how effectively services are working, both nationally and in three parts of the country (sections 2 and 3).

We then go on to outline how services need to change to meet future needs, drawing on a review of the literature, stakeholder workshops and examples from across England and other systems (section 4). We propose 10 design principles that should inform the future planning and provision of care.

One of the lessons from the past is that insufficient attention has been given to the implementation of policies to reform community services. This report therefore concludes by outlining what needs to be done to avoid repeating this mistake (section 5). It draws on previous work by The King's Fund, including our review of how mental health services have been transformed (**Gilburt** *et al* **2014**), to identify how we can 'flip' care from hospital to the community by building on assets in the community wherever these are located (Bisognano and Schummers 2014).

Many of the arguments in this report are not new but they have taken on renewed importance at a time of continuing austerity in public services and growing demand arising from demographic changes. By shining a light on community services and the many opportunities to develop and strengthen their contribution, we hope they will receive the attention they deserve in government, and among national bodies and local leaders who have responsibility for these services. Now is the time for community services to come in from the cold alongside continuing efforts to improve hospital and specialist services.

1 The policy context: a brief history

The ambition to deliver more and better health services in the community is not new. Throughout the history of the NHS, a series of policies have sought to strengthen and co-ordinate health services outside hospitals and community services have been subject to multiple structural changes and reorganisations. In this section, we summarise these policies. We focus predominantly on policies that relate to NHS community health services, but also touch on developments in primary care and social care where these are particularly pertinent. We do not focus on policies that are limited to certain age groups or conditions.

Community services policy during the first 50 years of the NHS

When the NHS was established in 1948, local authorities retained responsibility for community health services, GPs retained their independent contractor status (as they do today) and hospital services became the responsibility of government. In the same year, the National Assistance Act gave local authorities responsibility for social care, creating the divide between health and social care that remains intact today.

The 1960s saw a series of long-term plans for developing hospital and community services. *The hospital plan for England and Wales* (Ministry of Health 1962) emphasised the need to expand community services and assumed that hospital use and costs could be kept under control by doing so (Webster 1996). A similar plan for local authority services highlighted wide variation in community provision (Ministry of Health 1963). Soon after, the report of the Seebohm Committee (Home Office 1968) called for better co-ordination between social care and other health and welfare services, reflecting growing concern about fragmentation.

The 1960s also saw a focus on the organisation of general practice, including calls in the Gillie Report for GPs to be supported by a wider primary care team and closer integration with other services (Central Health Services Council 1963).

The NHS underwent major structural reorganisation in 1974, and community and public health services were transferred from local government to the NHS. This was intended to tackle fragmentation between community services and hospitals and primary care, but created a new fault line between community health services and social care. Area health authorities were created, and joint planning and consultative committees were set up to support collaboration with local authorities.

The White Paper *Working for patients* (HM Government 1989) led to further reorganisation, with community service providers increasingly establishing themselves as standalone NHS trusts. It was hoped that this would help to shift attention and resources towards community services.

Policies in the 1980s and 1990s also emphasised the importance of teamworking in primary care – there were proposals to develop primary care teams, with GPs working alongside health visitors, community nurses and other professionals (Department of Health and Social Security 1987).

There was also important reform to the social care sector during this period. A review highlighted the fragmentation of services and problems resulting from divided responsibilities and unclear accountabilities (Griffiths 1988). It recommended that local authorities should take responsibility for assessing community care needs and setting priorities, but not necessarily for direct service provision. These views were echoed in the White Paper *Caring for people* (Department of Health 1989), leading to significant growth in independent sector social care provision.

Mental health and learning disabilities

There has been a major shift in how care is provided for people with mental health conditions and learning disabilities over recent decades. The Mental Health Act 1959 signalled the intention to expand community services and run down psychiatric hospitals, reflecting medical and social changes that allowed people to be supported in the community. Policies in the 1960s and 1970s supported this change, but financial constraints meant that few community services were developed.

Significant changes, including large-scale closures of asylums, took place from the late 1980s onwards. New funding arrangements supported this shift, transferring resources from hospitals to local authorities as beds were closed. Over the following decades, new services were developed in the community – including early intervention teams, assertive outreach teams and home treatment teams – leading to a substantial increase in the community mental health workforce.

Similar changes have taken place in services for people with learning disabilities, resulting in a large-scale shift of care from institutional to community settings.

Sources: **Gilburt *et al* 2014**; Ham 2009

Community services policy over the past two decades

There was further reorganisation in the late 1990s – most community health services were merged into primary care trusts when they were introduced. The objective was to integrate primary and community health services and work more closely with local authorities (**Department of Health 1997**).

Fragmentation of NHS and local authority services remained a concern. The Health Act 1999 introduced new ways for the NHS and local government to work together to commission and provide services – including by pooling budgets, lead commissioning arrangements, and options for the closer integration of service provision.

The NHS plan: a plan for investment, a plan for reform (2000)

The NHS plan: a plan for investment, a plan for reform (**Department of Health 2000**) set out a wide-reaching programme of reform and significant funding increases. It included proposals to redesign primary and community services, including

500 'one-stop' primary care centres and investment in intermediate care. The ambition was to reduce hospital use through providing community alternatives. Significant funding was made available to support these changes. It also introduced care trusts – single bodies to commission and provide primary, community and social care – but relatively few were set up.

Our health, our care, our say: a new direction for community services (2006)

The White Paper *Our health, our care, our say: a new direction for community services* (Department of Health 2006, pp 6–7) called for 'a radical and sustained shift in the way in which services are delivered', away from a hospital-focused approach towards a proactive community-based approach. It highlighted the need to shift resources to primary and community services, committed to review trends in primary care trust budgets and set targets for the transfer of resources. It also called for 'a shift in the centre of gravity of spending' (Department of Health 2006, p 9) towards prevention. It focused on developing existing structures rather than any major structural or organisational changes, and many of the proposals centred on changes to service delivery.

The extensive proposals covered nearly 50 policies and initiatives, including to:

- allocate a larger share of resources to primary, community and preventive care

- shift services from hospitals into the community

- integrate services

- offer better access to GPs and community services

- offer better support for people with long-term conditions

- focus on prevention

- create a bigger role for the independent and voluntary sector.

High quality care for all: NHS next stage review (2008)

The report *High quality care for all: NHS next stage review* emphasised the key role of community services, stating that 'we now need to give greater freedom to those working in community services' to improve care (Department of Health 2008a, p 62).

This built on proposals outlined in the 'commissioning a patient-led NHS' initiative – a letter sent in 2005 from the-then chief executive of the NHS, Nigel Crisp, which signalled that community health services should in future be contracted out rather than managed directly by primary care trusts (Department of Health 2005).

High quality care for all supported this approach, advocating the separation of the provider and commissioner functions of primary care trusts, and arguing that new organisational and governance models were needed to support the NHS to deliver 'flexible, responsive' community services. It suggested a range of organisational models, including NHS foundation trusts, social enterprises, non-NHS organisations and arm's-length provider organisations. This led to further organisational change, implemented through the Transforming Community Services programme (described below).

NHS next stage review: our vision for primary and community care (2008)

The report *NHS next stage review: our vision for primary and community care* (Department of Health 2008b) included plans for greater choice of GP, personalised care plans for people with long-term conditions, and pilots of individual budgets. It also emphasised the need for primary and community services to take a central role in tackling health inequalities, including by working with wider services such as schools, housing and pharmacies. It encouraged a greater pooling of resources by primary care trusts and local authorities, and the development of new tariffs to encourage more community provision. It also announced pilots of 'integrated care organisations' – multi-professional groups based around GP practices.

Transforming community services: enabling new patterns of provision (2009)

Building on the *NHS next stage review*, the Department of Health produced guidance to support the changes proposed. *Transforming community services: enabling new patterns of provision* required primary care trusts to come up with a strategy for community services and to identify future organisational models separating their commissioner and provider functions (Department of Health 2009).

As noted in a King's Fund report at the time, this was an important opportunity to redesign services to better meet the needs of the population and address years of inattention to and underinvestment in community health services (Imison 2009).

However, the timescales attached to the guidance were tight and, in reality, the programme was mostly concerned with structural changes rather than with how services could be improved (Edwards 2014).

Transforming community services led to a range of different organisational models: in some parts of the country, community services were established as standalone NHS trusts; in others, they were taken on by existing NHS trusts already providing acute or mental health services; others were established as charities and social enterprises; and some were taken over by private sector providers. The main outcome of the policy was the transfer of services from one organisational form to another, and it is widely seen as a missed opportunity to improve community services.

Any Qualified Provider (2011)

The Any Qualified Provider policy was intended to allow patients to choose from any provider – including an NHS, private or voluntary sector provider – that met agreed NHS quality standards and costs. The Department of Health put mandatory requirements in place that all commissioners open a small number of services on this basis, targeting certain community services, including podiatry and musculoskeletal services. Responsibility for Any Qualified Provider implementation transferred to CCGs when they were formed. The policy led to greater plurality of provision in a limited number of community services, but overall uptake was limited.

Health and Social Care Act (2012)

The Health and Social Care Act 2012 introduced legislation to extend the role of competition within the NHS and to devolve decision-making (*see* Ham *et al* 2015). The commissioning system was reorganised, with budgets previously held by primary care trusts split between the newly formed CCGs, NHS England and local government. Commissioning of most community health services became the responsibility of CCGs, while public health services – including community services such as sexual health, health visiting and school nursing – were transferred to local government, and others – including primary care, screening services and specialised services – were transferred to NHS England.

Better Care Fund (2013)

In 2013, the government announced a pooled fund of £3.8 billion between CCGs and local government (the Integration Transformation Fund, now called the Better Care Fund) and 'integration pioneer' sites were chosen to develop and test approaches to integrated community care (**Local Government Association and NHS England 2013**).

The Care Act (2014)

The Care Act 2014 created a new legal framework for adult social care services. A duty was placed on local authorities to collaborate and integrate with other public services, such as the NHS and housing.

Recent developments in community health services policy

The Forward View (**NHS England** *et al* **2014**) set out a vision of how NHS services need to change to meet the future needs of the population, arguing for a greater emphasis on prevention, integration and putting patients and communities in control of their health. It also called for a shift in investment from acute care to primary and community services.

The Forward View argued that 'the traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and co-ordinated health services patients need' (**NHS England** *et al* **2014**, p 6) and set out several 'new care models' designed to address this. Fifty areas were selected as 'vanguard' sites to lead and test the development of these models.

Three new care models focus particularly on services in the community:

- multispecialty community providers (MCPs) – GPs come together in networks and collaborate with other health and care professionals to provide more integrated services outside hospitals

- primary and acute care systems (PACS) – a single organisation or group of providers takes responsibility for delivering the full range of primary,

community, mental health and hospital services to their local population, improving the co-ordination of services and moving care out of hospitals where appropriate

• enhanced health in care homes – NHS services work in partnership with local authorities and care home providers to support people living in these settings.

At the end of 2015, NHS organisations were directed to come together with local partners to develop sustainability and transformation plans (STPs) – five-year 'place-based' plans for local health and care services based on the needs of defined geographical populations. The aim was to encourage local organisations to work together and to support the delivery of the changes set out in the Forward View (Alderwick *et al* 2016).

All 44 STPs, published at the end of 2016, include proposals to redesign primary care and community services (*see* Alderwick and Ham 2017; Ham *et al* 2017). They describe ambitions for the closer co-ordination of health and social care services, GPs working together at scale through networks, multidisciplinary community teams and new roles such as health coaches and care co-ordinators. Many STPs expect that these new ways of working will reduce costs and demand for hospital care.

Some sustainability and transformation partnerships are now working to develop accountable care systems (ACSs). This involves local organisations – including NHS providers and commissioners and local authorities – working together to take collective responsibility for managing resources and improving outcomes for their local populations (NHS England 2017d).

Summary

It is clear from this brief history that the community sector has been subject to continuous reorganisation and structural change. Over more than four decades of policy, there have been repeated attempts to strengthen and better co-ordinate health services outside hospitals, and to integrate them with other parts of the health and social care system. The levers used to strengthen community services have often been structural and organisational, rather than changes to how services are delivered.

A notable exception to this is the approach of *Our health, our care, our say: a new direction for community services* (**Department of Health 2006**). This did not advocate any major reorganisation of services, focusing instead on service redesign and the development of existing structures. The issues described in the White Paper, now more than a decade old, are still highly pertinent in today's health and care system, highlighting the lack of progress in making the 'radical and sustained shift in the way in which services are delivered' that it envisaged (**Department of Health 2006**, pp 6–7).

The biggest impact of policies to move more care into the community has been evident in services for people with mental health needs and learning disabilities. We return to the experience of these services in section 5 to outline what needs to be done to develop community services in the future.

Despite their stated objective to improve the co-ordination and integration of services, a number of the policies described above have in fact led to greater fragmentation – for example, through the division of commissioning responsibilities and the plurality of the provider market in response to policies such as Transforming Community Services and Any Qualified Provider. The result is a complex landscape of community services, which we explore in the next section.

As described in the Introduction of this report, significant financial and operational pressures are increasingly focusing attention and resources on propping up acute services. This has come at the expense of services in the community – including community health, public health and social care services – and risks moving the health service even further away from the goal of strengthening community and primary care services and prioritising prevention. All the more important, therefore, that priority is now given to properly funding these services, as well as reducing complexity, integrating services and making use of all the assets in the community wherever these are found.

1 **2** 3 4 5

2 The current organisation and provision of NHS community health services

In this section, we focus predominantly on NHS community health services but also consider how these services relate to other health and care services in the community. As defined in the Introduction of this report, when talking about 'NHS community health services' we are referring to services typically provided by organisations with responsibilities in this area (including combined and standalone community NHS trusts, social enterprises, private providers and local authorities). Most of these services are commissioned by the NHS, but some public health services are commissioned by local authorities.

NHS community health services cover an extensive and diverse range of activities. Common services are listed in Table 1 (page 6) and range from services targeted at people with high or complex health and care needs – such as district nursing, palliative care and community matron services – to universal health promotion services – such as school nursing and health visiting. Core services sit alongside a plethora of specialist community services designed to target particular groups or pathways (Monitor 2015; Imison 2009). Within any particular service, there may be a number of distinct teams with discrete functions. For example, within child health services there may be many separate services and teams such as health visiting, school nursing, infant feeding co-ordinators, childhood immunisation services and safeguarding teams.

There is no single model of provision for NHS community health services; the range and configuration of services vary depending on the local population, geography and the nature of other local services, as well as local legacy in terms of how services have developed and evolved (NHS Confederation 2009). The national picture is one of variation and often complexity, which we have noted in previous work, for example in our 2009 report on primary care trust provider services (Imison 2009). The sector has previously been criticised as having 'large numbers of small, narrowly defined

and often poorly co-ordinated services', creating complexity and confusion for service users and professionals, and leading to duplication and gaps in local service provision (**Edwards 2014**, p 3).

NHS community health services provide support across a range of needs and age groups, but are most often used by children, older people, those living with frailty or chronic conditions and people who are near the end of their life (**Edwards 2014**; **Imison 2009**). Numerous sources point to both the number and acuity of patients being cared for in their own homes increasing over recent years (**Maybin** *et al* **2016**). Increasing numbers of people living with complex long-term conditions means that more people are likely to need support from community health services in the future.

Beyond the narrow definition of NHS community health services, there is a much wider range of sectors and services that deliver care and support in community settings (see Table 1, page 6 and Figure 1, page 23).

Patients receiving care in community settings often have multiple, complex health needs and depend on many health and social care services to meet these needs. Taking an example of an individual with a high level of needs – in this case someone living at home with diabetes, heart failure, frailty and a leg ulcer – they may require:

- wound management and insulin administration by a district nurse

- support from a specialist nurse to manage their heart failure

- ongoing monitoring and long-term condition management by their GP and practice nurse

- occupational therapy to adapt their home

- specialist input from hospital consultants

- social care support to help them with activities of daily living.

The way that community health services relate to other local services depends very much on the particular type of service in question, and the population group served. For example, a community service such as health visiting or school nursing will interface with a different network from a service such as district nursing or

Figure 1 Where do NHS community health services fit within systems that support health and care?

palliative care. Key related services might include: general practice, acute hospitals, mental health services, community pharmacies, nursing homes, home care agencies, voluntary sector services, schools, social services, safeguarding services, emergency services, housing departments and informal carers. There is a wealth of potential assets available to improve population health in communities if these are utilised and co-ordinated effectively.

Figure 2 What community support might people be in contact with? Individual examples

MS management
- GP
- neurologist
- specialist MS nurse

MS support group
organised by voluntary
sector organisation

District nurses
carry out regular
urinary catheter change

Priya's daughter (16)
helps with Priya's care and attends local
authority-funded respite weekends

Specialist continence nurse
manages complications
with catheter

Community wheelchair service

Community occupational therapist
organises equipment and
home adaptations

Priya is 46 and has multiple sclerosis (MS)

District nurses
administer insulin
injections 3 times a day

Age UK befriending service

Specialist diabetes nurse
addresses poor diabetes control

Community pharmacist
prepares dossette boxes

GP
treats recurrent
chest infections

Carers
visit twice daily for washing,
dressing, meals and medications

**Community speech and
language therapist**
investigates swallowing problems
as cause of chest infections

Community physiotherapist
referred by falls team

Community falls team
addresses recurrent falls

**Michael is 83 and has vascular dementia,
ischaemic heart disease and diabetes**

Public views and preferences regarding health and care services in the community were explored through an extensive publication consultation to inform the White Paper *Our health, our care, our say* (**Department of Health 2006**). This engaged more than 400,000 members of the public through questionnaires, local listening exercises, regional deliberative events and a citizens' summit (**Opinion Leader Research 2006**). It found that people want:

- services to meet the whole of their needs, and to support their overall wellbeing and independence

- care to be joined up across different services

- support to make better choices and take control of their health and wellbeing

- services to focus on prevention and promoting independence

- easy access to help when they need it, in a way that fits around their lives

- more information about services to make it easier to navigate the system

- more services to be available in the community, as long as they are safe, high quality, cost effective and do not make it harder for them to access hospital care

- less local variation in the availability of services.

Who provides and commissions NHS community health services?

NHS community health services have been subject to frequent reform and have undergone a series of structural reorganisations. One of the consequences has been the emergence of a mixed economy of types and sizes of provider organisations, including standalone NHS community trusts, combined community and acute or mental health trusts, social enterprises and private sector providers (**Foot** *et al* **2014**).

In many cases, a single provider is responsible for delivering most of the NHS community services in a geographical area. It is common for there to also be a number of other providers delivering specific services under relatively small contracts (**Monitor 2015**). Recent research, which includes information from 78 per cent of CCGs, found that NHS providers held around half of the total value of community services contracts, while 'other' providers – including community

interest companies, local authorities and social enterprises – held 36 per cent of the total value. A smaller proportion was held by organisations including GPs, opticians and pharmacies – these contracts tended to be of lower value than those held by NHS trusts, suggesting that they are often for single services (**Gershlick and Firth 2017**).

CCGs are responsible for commissioning the majority of adult NHS community services for their local populations. Local authorities are responsible for commissioning children's 0–19 services – which include school nursing and health visiting – and public health services such as sexual health and alcohol and drug services. Intermediate care is made up of a combination of CCG and local authority-funded services. NHS England is responsible for commissioning a handful of community services, including dentistry, offender health, immunisations and national screening programmes (**Monitor 2015**).

Most community services are commissioned under block contracts. These involve a fixed-sum annual payment that does not vary according to activity or quality of care, although a small proportion of the contract value may be paid for on a cost and volume basis, and some may be linked to meeting certain quality goals under the Commissioning for Quality and Innovation (CQUIN) payment scheme. Block community services contracts usually include a number of key performance indicators covering outcomes-based quality measures and activity and process measures. Contracts often include a very large number of key performance indicators, with reports of single community services contracts containing more than 200 (**Monitor 2015**). Despite most services being provided under large block contracts, commissioners frequently manage many small contracts for specific services; CCGs hold an average of 50 contracts for community services, and some have many more (**Gershlick and Firth 2017**).

Funding pressures in NHS community health services

The NHS is facing a prolonged slowdown in funding. Demand is rising faster than funding, and services are struggling to maintain standards of care. All areas of care are affected, with acute hospitals, general practice, mental health and community services all under strain. There are large deficits in the acute provider sector, and key performance targets are now being missed all year round (**The King's Fund 2017c**).

A lack of robust spending data makes it difficult to quantify the level of financial pressure in community health services, but our previous research suggests that budgets are often static or reducing despite rising demand. These services are particularly vulnerable to financial pressures as funding (via block contracts) is not linked to activity and care is less visible than in other settings. This means that, compared with acute services, it is 'easier to squeeze funding but more difficult to see the consequences of doing so' (**Robertson** *et al* **2017**, p 46). Unlike acute hospital trusts, NHS providers of community services have generally not responded to financial pressures by running deficits, but have instead cut costs – for example by taking a more task-focused approach, altering the skill-mix of teams and reducing staffing – which can adversely affect the availability and quality of care (**Robertson** *et al* **2017**).

In addition, pressures in other parts of the health and social care system – notably in other services that support people at home such as general practice and social care (**Baird** *et al* **2016**; **Humphries** *et al* **2016**) – are impacting on NHS community health services. For example, some district nursing services are being put under strain because GPs are having to limit the number of visits they make to housebound patients, and some are undertaking work that was previously done by social care workers because of cuts to local authority funding of social care (**Robertson** *et al* **2017**; **Humphries** *et al* **2016**; **Maybin** *et al* **2016**).

Who delivers NHS community health services?

It is not possible to obtain an accurate figure for the total number of staff working across community health services, but it has previously been estimated that they account for one-fifth of the total NHS workforce (**Department of Health 2008b**). The largest professional group are nurses; according to provisional workforce statistics for July 2017, there were 35,032 full-time equivalent community nurses, including 4,077 district nurses, 2,422 school nurses, 908 community matrons, 531 children's nurses and many other qualified nurses working in community teams who do not have these specialist qualifications. In addition, there were almost 15,000 nursing support staff (**NHS Digital 2017d**). Other staff groups include health visitors, physiotherapists, occupational therapists, speech and language therapists and podiatrists. The workforce numbers listed above are underestimates of the true numbers as they do not include information from all non-NHS providers. This creates problems when trying to examine trends in the data, as the numbers

are effectively deflated by staff transferring to non-NHS providers following the Transforming Community Services policy (**Addicott** *et al* **2015**).

Compared with other sectors of the health service, there are relatively few doctors working in NHS community health services, although this varies between different trusts and specialties. Some community specialties are consultant led – such as community paediatrics and sexual health services. Community-based work is also a common part of consultant roles in some other specialities – including for palliative medicine doctors, diabetologists and geriatricians – but for most consultants, working outside hospitals is unusual. As part of efforts to better integrate care and deliver more care closer to home, new consultant roles are being developed that span secondary, primary and community care. There are examples of community-based consultant roles being developed in a number of specialty areas across the country (*see* **Robertson** *et al* **2014** for examples). However, these remain exceptions to the norm.

Workforce pressures in NHS community health services

There are worrying trends in parts of the community workforce, and shortages in key groups present a significant challenge to plans to expand community services (**Imison** *et al* **2017**; **Maybin** *et al* **2016**). The total number of nurses working in NHS community health services (excluding health visitors) increased by around 50 per cent between 2000 and 2009, but fell by 8 per cent between 2009 and 2014. The number of district nurses has fallen particularly sharply, dropping by almost half between 2000 and 2014 (**Maybin** *et al* **2016**). While some of this fall may be accounted for by the organisational changes described above, this is unlikely to be the sole cause of the drop as the decline pre-dates the Transforming Community Services policy and continued for several years after its implementation (**Maybin** *et al* **2016**; **Addicott** *et al* **2015**). Indeed the trend has continued: the number of district nurses fell by 20 per cent between July 2014 and July 2017 (**NHS Digital 2017d**).

Downward trends in the workforce are not limited to district nursing. Between July 2010 and July 2017, the number of community learning disabilities nurses employed by the NHS fell by 22 per cent and the number of school nurses fell by 18 per cent. Health visitor numbers increased significantly between 2010 and 2015 in response to a government commitment to reverse the decline; however, the increase has not been sustained and numbers have fallen by 18 per cent since their

peak in October 2015 (NHS Digital 2017d). Again, these numbers do not give the full picture as they do not include staff working for non-NHS organisations – some health visitors and school nurses are now employed directly by local authorities.

Workforce shortages are also problematic in wider community services. There are well-documented shortages in the GP workforce (Baird et al 2016), with problems in recruiting and retaining staff. Despite a government pledge to increase the number of GPs by 5,000 by 2020, the number actually fell marginally between 2015 and 2016 (Murray et al 2017).

How much do we know about the services that are delivered?

Relatively little data on NHS community health services is collected and collated at a national level. There has been limited nationally mandated data collection on activity in contrast with hospital care, where every patient episode has been recorded and nationally collated since the development of Hospital Episode Statistics in the late 1980s. Over recent years, the Community Information Data Set (CIDS) was used for local data collection and extraction, but the data was not collated or published nationally (Maybin et al 2016; Foot et al 2014).

However, since November 2017, all providers of publicly funded community services have been required to collect and submit community health data, following the introduction of the Community Services Data Set (CSDS). This builds on the existing Children and Young People's Health Services (CYPHS) data set, removing the 0–18 age restriction. National publication of the data is expected to begin from February 2018. It will provide patient-level information covering direct care contacts and other activity measures, assessment scores, demographic information and diagnoses (NHS Digital 2017a).

There is currently very limited standardised national data on the quality of NHS community health services (Cooke O'Dowd and Dorning 2017). A previous King's Fund report identified several barriers to collecting robust quality data, including:

- the large number of providers

- the diversity of services, settings and clients

- weak IT infrastructure (Foot et al 2014).

There is considerable local activity to gather and use information on activity and quality, and some commissioners and providers collect data based on the Community Information Data Set or regional or locally developed datasets. Some use data from the NHS Benchmarking Network, a member-led organisation that collects data from community service providers, including information on activity, funding, the workforce and care quality (**Maybin** *et al* **2016**; **Foot** *et al* **2014**).

However, there remains a severe lack of robust national data on all aspects of NHS community health services, not only on activity and quality of care, but also on spend. This problem is greatest for care provided by non-NHS organisations, which is concerning given the relatively high proportion of non-NHS providers in this sector (**Foot** *et al* **2014**).

This means that relatively little is known at a national level about the volume, nature and quality of care taking place in NHS community health services, and it remains a poorly understood sector. This is problematic for providers, who are hindered by a lack of robust, comparable national data that would allow them to benchmark their performance; and for commissioners, who lack the data they need to determine whether providers are delivering value for money or to determine costs for new pathways and service improvements (**Foot** *et al* **2014**). The paucity of standardised national data also does little to help the profile of NHS community health services nationally, with little evidence available to demonstrate their scope and value. The introduction of the Community Services Data Set offers an opportunity to address this.

How do NHS community services relate to other health and care services?

As described above, beyond the narrow definition of NHS community services, there is a much wider range of community-based services that deliver care and support to people in their homes and communities. Examples of the type of support that some of these services offer are described in the box below.

Examples of wider community services

Community pharmacy

There are more than 11,500 community pharmacies in England. Their core role is dispensing prescription medications. Many also provide other services such as medication reviews, minor ailments advice, support with long-term conditions management, smoking cessation and sexual health advice.

Pharmacists are the third largest health profession and workforce modelling has shown a future oversupply. Seventy per cent work in community pharmacy. They are highly qualified professionals, and it has long been argued that their skills could be better utilised. There is potential for extended roles to reduce pressure on other parts of the NHS, especially in primary care and urgent care services. This is already happening through extended services in pharmacies, pharmacists working in general practice to diagnose and treat minor ailments and undertake medication reviews, and in care homes to manage medication. There is potential for extended roles to be adopted much more widely (**Murray 2016**).

Ambulance services

Ambulance services are often the first point of contact with the health service for people with urgent care needs, and they are therefore important in determining care pathways. There is a national shortage of paramedics, and a national programme has been set up to train more and upskill current ambulance staff (**National Audit Office 2017**; Evans *et al* 2013).

Paramedics have an extensive and advanced set of skills in assessing and managing acute illness. In some areas, they are taking on additional roles in clinical decision-making and treatment, and pathways are being developed to allow them to refer people directly to community-based support, avoiding hospital transfers. Ambulance services have played a key role in the design and delivery of new care models in some of the vanguard sites, for example in the integrated care hub on the Isle of Wight (described in section 4 on page 69).

Social care

The adult social care system provides care and support in people's homes and in residential or nursing homes. Care often involves help with activities such as washing,

Examples of wider community services *continued*

dressing, meal preparation and taking medications. Most social care is means-tested, involving an assessment of 'eligible' needs and financial resources. Many individuals therefore pay for their own care or 'top up' local authority-funded care. Most social care (more than 90 per cent) is delivered by independent providers, ranging from small family-run businesses to large corporate chains and charities.

Most people receiving social care also have significant health needs, meaning there is a significant overlap between health and social care services. For example, most nursing home residents will require regular support from GPs, community nurses, pharmacists and other health professionals. Many care homes are working with local NHS services to improve connections between them, for example in the enhancing health in care homes vanguards (**Baylis and Perks-Baker 2017**; **Humphries** *et al* **2016**).

Hospices

Hospices support people living with terminal and life-shortening conditions. They deliver expert medical and nursing care and focus holistically on people's emotional, spiritual and social needs. Hospices also support carers, family members and friends while a person is being cared for, and through bereavement. There are more than 220 hospices in the United Kingdom.

Most hospices are run by the voluntary sector. Adult hospices receive around a third of their funding from the NHS and children's hospices receive around 17 per cent, but the majority comes from charitable fundraising. More than 125,000 people give their time to volunteer for hospices each year.

In 2015–16, hospices provided end-of-life care to around 200,000 people across the United Kingdom and bereavement support to 41,000 people. Care is provided by multidisciplinary teams that include nurses, doctors, social workers, physiotherapists, occupational therapists, counsellors, chaplains, complementary therapists, volunteers and others. They often work closely with NHS services, for example with general practice and district nursing services, and can be an important source of specialist advice in the community. Some hospice care is delivered to inpatients, but the majority (around 80 per cent) is community-based, including home care and day care (**Hospice UK 2016**).

Patients receiving care in community settings often have multiple, complex health needs and depend on many health and social care services to meet these needs. Because of this, NHS community health services – such as community nursing and therapy services – commonly need to work with and alongside primary care staff, social care workers and informal carers. However, relationships are often weak, with a lack of communication, co-ordination and information transfer between services (NHS Confederation 2015; Edwards 2014). Many areas are trying to build and strengthen relationships between community health professionals and primary care and social care staff, for example by creating multidisciplinary teams or co-locating services and teams.

There is a particularly important interface between adult social care services – including nursing homes, residential care and domiciliary care – and some NHS community health services, such as district nursing. However, there is a fundamental difference in terms of people's access and entitlements; as an NHS service, community nursing is free at the point of use, whereas social care is means-tested. Public funding for social care has fallen significantly in recent years, and there are concerns over the availability and quality of services, particularly for domiciliary care (Humphries *et al* 2016).

Local arrangements vary in terms of how community health and social care services work together – for example, in some areas, district nurses offer a significant amount of input into nursing homes, but in other cases, district nursing teams have been known to turn down nursing home visits as this work is not explicitly included in their contracts (Robertson *et al* 2017). There is also an important interface between the two around transitions of care, for example when someone comes to the end of an NHS-funded period of intermediate care and reablement, but needs ongoing social care support.

There has been renewed focus on the fault lines between health and social care as a result of growing numbers of people who are ready to be discharged from hospital but can't be because of a lack of community support (delayed transfers of care). The number of hospital bed days lost in this way has risen sharply over recent years (Edwards 2017). Some of this is due to delays in the availability of social care support packages, while some is due to a lack of NHS community support. Regardless of whether the NHS or social care is responsible for a delay, the rapid increase in delays in recent years underlines the serious impact of underinvestment in community-based services across the whole health and care system.

What does this mean for people using services?

It can be complex for service users – and sometimes professionals – to understand who provides what care and to navigate services. This was highlighted in the public consultation for *Our health, our care, our say* – a common complaint was that services were not well co-ordinated and people reported having to repeat information to multiple professionals, having several separate assessments and needing to join up care themselves (Opinion Leader Research 2006).

This complexity and fragmentation may also give rise to duplication and overlap, and gaps between the teams delivering care. Duplication is not only wasteful of resources and staff time, but also wastes the time of patients and carers, while gaps risk leaving people without the care and support they need.

A patient story, described in the box below, illustrates the potential impact of the complexity and fragmentation of community services.

The complexity and fragmentation of community services – a patient story

James is discharged from hospital following an operation to remove a recently diagnosed bowel cancer. The operation has left him with a stoma (an opening in the abdomen that diverts bowel contents directly into a pouch worn outside the body), so he is seen at home by a nurse from the community bladder and bowel team. The nurse supports him with his stoma care, and educates his wife to help him with this.

On one visit, the specialist nurse notices that James has a leg wound that needs dressing. His wife also tells the nurse that she is concerned that he is forgetting to take his medications, as there are tablets left in the previous week's dossette box (prepared by the community pharmacist). The nurse makes a telephone referral to the district nursing team for wound care and medication prompting.

The next day, James receives a home visit from his GP as he has symptoms of a urinary tract infection. During her examination, the GP notices his leg wound. She does not have access to the specialist nursing notes, and can't see that a referral has already been sent. The GP also sends a referral to the district nursing service, this time using an electronic referral form.

The complexity and fragmentation of community services – a patient story *continued*

Both referrals are triaged, and the duplicate referrals are identified at the district nursing caseload allocation meeting. After an initial assessment, the district nurse decides that James requires twice-weekly visits for a wound dressing. However, he will require medication prompting every day. His wife can't do this as she looks after their grandchildren during the week. The district nursing team refers this to the local authority so that a carer can provide the medication prompting. A separate social care assessment is completed.

For the next few months, James receives regular visits from the bladder and bowel nurse, the GP, several different district nurses and many different carers. He is also seen regularly at the hospital oncology clinic. Most of these professionals are unable to see each other's notes. James and his wife keep the various professionals updated on developments.

Note: This fictional patient story has been written to illustrate some of the issues we heard about in our research on community health services.

The financial and workforce pressures described above have implications for people using services, and there is evidence that they are compromising the availability and quality of care in some cases. Our previous work on district nursing found examples of an increasingly task-focused approach to care, staff being rushed and abrupt with patients, reductions in preventive care, visits being postponed and a lack of continuity. As pressures grow, there is a danger that serious failures in care could go undetected because of the relative lack of robust data in community services and the fact that care is often delivered behind closed doors (Maybin *et al* 2016).

Our previous work also highlights the risk that financial and workforce pressures on community services may lead to rising levels of unmet need – in other words, people who need support or would benefit from it, not receiving it. Unmet need is difficult to detect and harder still to measure, particularly given the lack of robust data in this area. This is particularly concerning given the cuts to related services that might otherwise have picked up unmet need – such as social care and voluntary sector services (Robertson *et al* 2017).

It is not possible to fully understand community health services by looking at national information, as there is significant geographical variation in terms of what services are available and how they are provided. To help understand this variation and the different issues at play, the following section describes how community services are organised and delivered in three areas of England.

3 Mapping community services in local areas

In this section, we describe how NHS community health services are organised and delivered in three areas of England. We also consider how they relate to other local services.

The three areas were chosen to represent different geographical areas (covering rural and urban geographies) and a variety of community provider types. In each case study, we focus on the services in a single CCG area. The site profiles provide a descriptive overview of how services are currently organised and delivered, but do not attempt to comment on financial and workforce pressures. Information was gathered by examining published material and conducting telephone interviews with representatives from each site – including from community providers, CCGs, local authorities, GPs and other providers in the area.

In addition to the site-specific interviews, we carried out a small number of interviews with stakeholders with a wider perspective – for example, with representatives from local Healthwatch organisations who had done work exploring community health services – which we draw on in the final part of this section.

Table 2 **Brief overview of the case study sites**

	Birmingham South Central CCG	Hull CCG	South Warwickshire CCG
Area	Birmingham is an urban area and is one of the most diverse and deprived cities in England. Health outcomes and life expectancy are lower than the national average.	Hull is an urban area and is among the most deprived areas in England. Health outcomes and life expectancy are lower than the national average.	South Warwickshire is an affluent and rural area. It has a relatively old age profile. Life expectancy and health outcomes are better than the national average.
CCG	Birmingham South Central CCG covers 55 general practices with a combined registered patient population of slightly more than 300,000 people. The CCG spends around 15 per cent of its budget on community services.	Hull CCG covers 41 general practices with a combined registered patient population of just under 300,000 people. The CCG spends around 13 per cent of its budget on community services.	South Warwickshire CCG covers 35 general practices with a combined registered patient population of slightly more than 280,000 people. The CCG spends around 10 per cent of its budget on community services.
Local authority	Birmingham City Council (which covers a much larger area than the CCG) is a metropolitan district council covering a population of more than one million people.	Hull City Council is a unitary authority covering a population of around 265,000 people. Its boundaries are coterminous with Hull CCG.	Warwickshire County Council (which covers a larger area than the CCG) is a non-metropolitan county council covering a population of slightly more than 550,000 people.
Community health services provider	Birmingham Community Healthcare NHS Foundation Trust, a **standalone NHS community trust**, provides most community health services in the area.	City Health Care Partnership **Community Interest Company** provides most community health services in the area.	South Warwickshire NHS Foundation Trust, a **combined acute and community trust**, provides most community health services in the area.
Other local NHS providers	The 55 general practices in the area are grouped geographically into five networks. There are three main acute trusts in the area covering five main hospitals. There are also three specialist trusts (children's, women's and orthopaedic hospitals). There is one main provider delivering inpatient, community and specialist mental health services.	The 41 general practices in the area range from single-handed practices to large partnerships. Over the past 12 to 18 months, practices have started to come together into networks for the first time. There is one large acute trust in the city. There is one specialist mental health provider delivering inpatient and community services.	The 35 general practices in the area have come together to set up the South Warwickshire GP Federation. South Warwickshire NHS Foundation Trust is the main acute trust in the area. The trust covers four hospital sites. Coventry and Warwickshire Partnership Trust provides mental health and learning disability services, and also provides community services for neighbouring CCGs.

Site 1: Birmingham

Who provides community health services?

The majority of community health services in the Birmingham South Central CCG area are provided by Birmingham Community Healthcare NHS Foundation Trust (BCHC), a large standalone NHS community trust. The trust also provides services to a much larger area, delivering NHS community health services to a population of 1.1 million across Birmingham and the surrounding areas, and specialist services to a population of 5.5 million across the wider West Midlands area.

BCHC is one of the largest dedicated providers of NHS community services in England, delivering care from more than 335 sites (in addition to people's homes). The trust has an annual turnover of around £260 million and employs more than 4,000 full-time equivalent staff. More than 2.1 million patient contacts took place in 2015/16. The trust is set to merge with the Black Country Partnership NHS Foundation Trust and the Dudley and Walsall Mental Health Partnership NHS Trust, creating a single trust with an annual turnover of more than £430 million.

Some community services are delivered by other providers – for example, sexual health services are delivered by one of the large acute trusts in the city in a variety of community locations, and community physiotherapy is also provided by the acute trust and the orthopaedic hospital. There are several hospices providing end-of-life care and many other voluntary and community sector organisations providing other forms of community support.

What services are provided and how are they delivered?

BCHC provides a wide range of services, organised under five divisions.

- **The adults and community division.** This covers most of the core community services for adults across Birmingham. Within this division, there are teams providing long-term condition management and community nursing, community therapy hubs, and a large number of specialist nursing and therapy services, for example for incontinence, tissue viability and lymphoedema.

- **The urgent care division.** This includes intermediate care, palliative respite care, stepdown beds and a rapid-response district nursing service. A number of other services sit within this division, including prison health care, nutrition and dietetics and podiatry.

- **The children and families' division.** This includes health visiting, school nursing, community paediatrics, children's nursing and therapy services, child immunisation and specialist services for children with additional developmental needs.

- **The specialist services division.** This includes learning disability services – such as short breaks, psychology services, physiotherapy, occupational therapy and speech and language therapy – and rehabilitation services – such as inpatient neuro-rehabilitation, equipment services and specialist outpatient clinics.

- **The dental division.** Dental services are delivered across hospital and community settings, and include maxillofacial surgery and other highly specialised work. The trust runs a specialist dental hospital.

A crude count of services listed on the trust's website amounts to 93 separate services. However, this does not give the full picture as some of these have multiple services or teams underneath, while in other cases a single team delivers several of the services listed.

There are 38 community nursing teams across the city, known as 'integrated multidisciplinary teams'. The team members are mainly district and community nurses, assistant practitioners and other support staff. Most of the teams are based in health centres or large GP practices, and a small number are located in separate 'hubs'. Specialist nurses (for example, specialist respiratory, continence and tissue viability nurses) are not embedded within the integrated multidisciplinary teams – they cover the entire city and the teams can call on their specialist expertise when required. There are several 'therapy hubs' across the city, where community physiotherapists and occupational therapists are based. Again, these therapists are not embedded within the integrated multidisciplinary teams.

How are community health services commissioned?

BCHC's services are commissioned by a number of organisations, including:

- Birmingham South Central CCG, Birmingham Cross City CCG and Sandwell CCG

- NHS England, which commissions dental services, specialised services and prison health care

- Birmingham City Council, which commissions public health services and many of the children's services.

Birmingham South Central CCG acts as the lead commissioner for the trust's services across the three CCGs, but there is some variation in terms of the services commissioned for each area. The CCG also has joint commissioning arrangements in place with Birmingham City Council for some community services, including some of the children's services.

Birmingham South Central CCG spends around 15 per cent of its budget on community health services. A single large block contract accounts for around £140 million of the trust's total £260 million revenue. Within this, there are more than 100 separate service lines and a large number of national and local key performance indicators. Not all services are commissioned in this way – for example, the trust's dental services are commissioned under tariff, the child immunisation service is paid per contact, and there are numerous smaller contracts for discrete services.

How do community health services relate to other services?

BCHC has implemented a combined access point for all referrals into its services, for both rapid response and routine care. The combined access point is relatively new, and is still under development. Before it was introduced, access across community services was highly fragmented, with as many as 35 'single points of access' within one division alone.

In some general practices, community nurses, health visitors, podiatrists and others are co-located in the practice. However, this is not consistent and is very much

dependent on the facilities that the practice has – co-location is more common in practices based within larger health centres. The services based within each health centre are determined to some extent by local need (for example, health visitors are more likely to be located where there is a large young population) but are also dependent on local legacy and the space available. It was previously more common for smaller practices to have district nurses and health visitors on site; however, as community teams have been consolidated into larger teams covering locality areas, they have tended to move out of smaller practices to be located with the rest of their team. This means that relationships between primary care and NHS community health services are highly variable across practices; those with co-located community staff have a much greater opportunity for regular informal communication.

Currently, the integrated multidisciplinary teams are aligned to locality areas, but there is an ambition that over time they could be aligned to the GP networks. Community nurses and other trust staff sometimes attend primary care multidisciplinary team meetings to discuss patients with complex needs, but it is not possible for staff to consistently attend all meetings due to the number of different practice meetings and capacity constraints. While the combined access point is working to streamline access and make referrals more straightforward, some GPs have reported that it creates a barrier to direct communication with community professionals, and undermines relationships with district nurses and others. NHS community health services and primary care use separate clinical information systems, and they are not able to access each other's notes. Work is under way to try to address this.

There are several acute trusts in the area, and some work more closely with BCHC than others. In two of the hospitals, advanced nurse practitioners employed by BCHC are based in A&E to avoid admissions by arranging community support directly from A&E. The community integrated multidisciplinary teams are also able to provide some in-reach into the hospitals to facilitate discharge. BCHC works closely with the local mental health trust around the delivery of prison health care, which the two trusts provide in partnership, but there are not well-developed links with mental health services beyond this.

BCHC works with the local authority, for example to address child and adult safeguarding concerns and to tackle delayed transfers of care. Common policies and pathways around discharge have been agreed and adopted across health and social care, and social workers are now embedded within the teams at some of the trust's intermediate care facilities. There are some areas of overlap in service provision between social care and community health care, particularly around respite care, stepdown beds and reablement. Beds are commissioned by both the CCG and the local authority, and there is a mixed pattern of provision by BCHC and multiple nursing home providers.

The trust works with other local organisations to deliver particular services. For example, it has recently been selected as the lead provider for a new early years health and wellbeing service, and will subcontract some elements from local charities to deliver the service in partnership.

How are services changing?

A number of local initiatives have been brought in across Birmingham South Central CCG over recent years, such as the introduction of a dedicated community medical assessment unit with input from consultant geriatricians, and the development of a wellbeing hub based in primary care and delivered in partnership with the voluntary sector.

As described above, BCHC is merging with the Black Country Partnership NHS Foundation Trust and the Dudley and Walsall Mental Health Partnership NHS Trust. There are many other changes under way in terms of how services are organised and delivered, and due to the wide area that BCHC covers, it is involved in a large number of programmes, including multiple MCPs, STPs and evolving accountable care systems.

1 2 **3** 4 5

Site 2: Hull

Who provides community health services?

The vast majority of community health services in Hull are provided by City Health Care Partnership (CHCP) Community Interest Company, which delivers services to around a half a million people. CHCP also provides community services in other areas of England – Knowsley, St Helens and Wigan – and has recently been commissioned to provide the majority of NHS community health services for East Riding CCG (which is next to Hull CCG). The organisation employs around 2,200 staff and has an annual revenue of around £108 million. More than 1.1 million patient contacts took place in 2015/16. Formed as a community interest company in 2010, CHCP is a registered charity, and invests all of its profits into services, staff and local communities. It operates a 'co-owned' model, where all permanent staff can purchase a £1 share.

CHCP provides most of the core community services, including district nursing, long-term condition management, children's services and many more (*see* below). Until recently, CHCP subcontracted all community therapy and reablement services in Hull from a neighbouring community and mental health trust, but since August 2017 it has been providing these directly. It also subcontracts some services from other providers under a lead provider arrangement; for example, it subcontracts the British Red Cross and other voluntary sector organisations to deliver home-from-hospital services.

What services are provided and how are they delivered?

CHCP delivers more than 75 different services in community settings across Hull. There are four main groups of services.

- **Integrated community care and urgent care services.** These cover district and community nursing and long-term condition management; anticoagulation and deep vein thrombosis services; podiatry; a complex wound and tissue viability service; a tuberculosis nursing team; a continuing health care assessment team; and specialist clinics, for example for respiratory conditions, heart failure, bladder and bowel health, and lymphoedema. They also cover specialist palliative care, rehabilitation and therapy services, intermediate care and reablement services, and urgent care services.

- **Primary care, specialist primary care and psychological wellbeing services.** These cover carers' information and support services; a community chronic pain management service; a 'Let's Talk' depression and anxiety service; an eating disorders service; dental services; prison health; primary care services; and sexual health services.

- **Public health services.** For example, a stop-smoking service.

- **Children and young people's services.** These cover community paediatrics and nursing services, the 0–11 service (which includes health visiting, an infant feeding co-ordinator, school nursing, an immunisation team and a safeguarding team) and the 11–19 service.

In 2016, Hull CCG reprocured community services, bringing some services that had previously been commissioned separately, together under single 'integrated services' contracts. CHCP was successful in retaining the contracts, but some significant changes have been made as a result. For example, district nursing and long-term conditions management were previously delivered by two separate teams with significant overlap. These teams have now been brought together, helping to streamline provision. The teams are still separate in the East Riding CCG area, but CHCP is currently working to align delivery models across the two.

Community nursing teams in Hull are organised into three locality teams, aligned to specific geographical areas. Two are based in health centres alongside GP practices, and one is based in a separate facility in the city. Each team includes complex case managers (band 7 nurses), case managers (band 6 nurses), community nurses and health care assistants. The teams are located with specialist long-term conditions nurses and Macmillan nurses. Before the reprocurement, many different chronic disease matrons each looked after certain health conditions, but roles have now been changed (and staff trained) so that patients have a case manager or complex case manager who looks across all of their needs and liaises with colleagues with condition-specific expertise if required.

Unusually for a community health services provider, CHCP runs five GP practices. They hold Alternative Provider Medical Services (APMS) contracts and have a support contract agreement and memorandum of understanding for a federated approach with an associated company (City Health Practice Ltd), which holds

General Medical Services (GMS) contracts. CHCP has several subsidiary companies, including community pharmacies and a care home company.

How are community health services commissioned?

CHCP's services are commissioned by a number of organisations, including:

* Hull and East Riding CCGs (some services are commissioned by both CCGs and some are commissioned for one area but not the other)

* NHS England, which commissions primary care, dental services and prison health care

* Hull City Council, which commissions public health services, sexual health services and children and young people's services.

In 2016/17, Hull CCG spent £51.8 million – around 13 per cent of its budget – on community health services. The CCG holds 28 separate community contracts, ranging from large contracts with CHCP to small contracts with local voluntary sector providers for discrete services. The majority of services are commissioned under block contracts, which incorporate specific service lines and performance-related elements.

Following the reprocurement in 2016, the number of contracts fell significantly as services were brought together under single 'integrated services' contracts. Some services that were previously commissioned directly from voluntary sector providers are now commissioned as part of a larger contract with CHCP, which subcontracts the services out to the voluntary sector providers under a lead provider arrangement.

How do community health services relate to other services?

All referrals for CHCP services go through a single point of access, which is open to professionals, service users and carers. Referrals are processed by trained support workers who triage according to urgency and complexity, decide what assessments are needed, and link them into services as required. There is a separate single point of access for social care services.

Currently, community nursing teams are aligned to geographical localities. Each GP practice has two named district nurses (a case manager and a complex case manager) who they can contact directly, and who can attend practice meetings to discuss complex patients. Some community nursing teams are co-located with GPs in health centres; however, many practices do not have any community health service staff on site.

There is one main acute trust in the area, which has links with CHCP, particularly around hospital discharge. There is proactive in-reach into the hospital through a virtual discharge hub, where NHS community health services staff work with local authority social workers and other community services to facilitate discharge and set up appropriate services in the community. Three geriatricians, employed by the acute trust, have roles that span acute and community services. They provide medical input into CHCP's intermediate care facilities and some support to care homes. Another area where the community and acute trust have been working together is in streamlining therapy services – there are direct therapy-to-therapy referral pathways between the hospital and community occupational therapists and physiotherapists to avoid duplication and support timely access to community-based therapy, and a 'trusted assessor' model has been adopted across hospital and community therapy services.

Links with mental health services are less well developed. Community staff and GPs refer patients to these services, but rarely work with them directly. CHCP provides a psychological wellbeing service, so can internally refer people for low-level mental health support.

Adult social care in Hull is delivered by more than 100 different providers. Each care home has a named community nurse. There are some areas of overlap and duplication between community health and adult social care services, particularly around assessments, where it is still commonplace for people to receive separate 'health assessments' and 'social care assessments' in the community, rather than one assessment looking at the full range of their needs. There is also overlap between the roles and functions of therapists, and both CHCP and the local authority employ community-based occupational therapists and physiotherapists. There is ongoing work to address these areas of duplication, and progress has been made in some areas.

CHCP subcontracts to, or partners with, a number of other local organisations to deliver certain services. This includes working with charities such as the British Red Cross and Hull Churches (a local charity), which deliver home-from-hospital services, and partnering with the Humberside Fire and Rescue Service and Yorkshire Ambulance Service to provide a rapid-response falls service in partnership with the CHCP's integrated urgent care services.

How are services changing?

As described above, NHS community health services in Hull have already undergone some significant changes following reprocurement. The services are described as being 'on a journey', with work still ongoing to achieve closer integration and co-ordination with primary care, social care and acute care. Some particular areas of focus are to better integrate children's services across the CCG and local authority; to bring in a single point of access and trusted assessor model that operates across health and social care; and to align models of service delivery across the neighbouring Hull and East Riding CCG areas.

In 2018, the Hull Integrated Care Centre will open. This is a new facility designed to support integrated out-of-hospital care across health, social care, social housing, voluntary sector and other organisations. The hub will initially focus on supporting frail individuals identified through screening in primary care.

The primary care landscape is also undergoing significant change. Hull has many small general practices and has not had much in the way of networked working. But over the past 12 to 18 months, GPs in the city have come together into five groupings and are considering how they could work at scale. There is a hope that these changes will facilitate more integrated working between primary care and community health services, as multidisciplinary community teams could be aligned with networks of general practices. However, community health teams are currently aligned to geographical localities, which is important in terms of having efficient travel times to home visits, whereas GPs are networking according to relationships and common aims. This means that neatly aligning the two may not be straightforward.

Site 3: South Warwickshire

Who provides community health services?

Most NHS community health services in the South Warwickshire CCG area are provided by South Warwickshire NHS Foundation Trust (SWFT), a combined acute and community trust. SWFT delivers community services to more than half a million people across the whole of Warwickshire (covering three CCG areas), from more than 20 locations, as well as in people's homes. More than 750,000 patient contacts took place in 2016/17. The trust employs more than 4,300 members of staff (across acute and community services) and has an annual income of around £267 million. The trust is organised into five divisions: elective care, emergency care, out-of-hospital care collaborative, women's and children's, and support services.

SWFT's community services range from general adult services such as district nursing care, to specialist services such as Parkinson's disease and diabetes specialist nursing services, and children's services such as health visiting and school nursing. The trust also provides school nursing services in Coventry and has recently begun providing the 0–19 services in Solihull.

There are also a number of other providers delivering community services in the area. For example, sexual health services are provided by George Eliot Hospital NHS Trust, and health and wellbeing services in schools are provided by a charity called Compass. Independent residential and care home providers are contracted by SWFT and Warwickshire County Council to support discharge from hospital (as part of the Discharge to Assess programme) and palliative care is also provided by several independent hospices across South Warwickshire.

What services are provided and how are they delivered?

SWFT provides around 30 different services in the community for children and adults. Staff are organised into teams based primarily on the kind of services they provide. These include (but are not limited to):

- **community nursing teams**, known as 'integrated health care teams' – these include district nurses, community nurses and health care assistants, and provide general and specialist nursing care for housebound patients

- **therapy services** – including occupational therapy, physiotherapy and speech and language therapy

- **specialist services** – for example, a continence service, dietetics, and specialist nursing services for diabetes, Parkinson's disease, palliative care, heart failure and tissue viability

- **services to prevent hospital admission or enable early discharge** – the intermediate care and community emergency response teams (which include occupational therapists, physiotherapists, nurses and health care assistants) offer rapid response and focus on rehabilitation

- **children's services** – including community nursing, therapies, safeguarding, health visiting and school nursing

- **other services** – including wheelchair services and podiatry.

Teams cover different geographical areas depending on the services being delivered. Some, such as podiatry, have a single team covering the whole of the county, while others, such as the integrated health care teams (which deliver district nursing) have multiple teams, each covering a different locality area. Each team can refer patients to other community teams within SWFT. They typically have their own assessment processes and eligibility criteria, as well as their own set of patient notes and metrics to be captured and recorded.

How are community health services commissioned?

According to the most recent annual accounts, South Warwickshire CCG spent slightly more than 10 per cent of its total expenditure in 2016/17 on community and palliative care. It commissions the majority of community services under a block contract with SWFT. Within this, there are specified service lines and Commissioning for Quality and Innovation (CQUIN) payments. There is a separate block contract with SWFT for discharge-to-assess services, which is then transferred to Warwickshire County Council, which works with residential and care home providers and commissions the relevant support. The county council commissions sexual health, drug and alcohol services, 0–19 services (including school nursing and health visiting) and school health and wellbeing services. Some of these are delivered by providers other than SWFT (*see* above).

How do community health services relate to other services?

GPs and other health and care staff refer patients to community teams through a single point of access. SWFT community staff are not co-located with general practice or other types of community services, but some attend practice meetings to discuss care and support for particular groups of patients (such as for palliative care). The trust has worked closely with general practice in developing a proposal for a new model of out-of-hospital services (described below).

SWFT has recently entered into a partnership arrangement with Coventry and Warwickshire Partnership Trust to submit a proposal to deliver all out-of-hospital services (*see* below) and it is intended that this arrangement will improve joint working. Joint working between community services and mental health is primarily based on referrals between the two. There is no shared medical record between community services, GPs, mental health, social care and other services outside hospitals.

Within SWFT itself, community services operate as a separate division to acute medical services. Teams of community staff have been created to help avoid admissions to hospital and improve the flow of patients through hospital. For example, community emergency response teams provide rehabilitation support to help avoid hospital admissions and allow people to return home after an admission, and an accelerated transfer team helps support early discharge for people who have had a hip or knee replacement. There is a current strategy to bring together Warwickshire County Council's reablement services with SWFT's community emergency response teams – creating a joint health and social care service called HomeFirst to support people to remain living at home or return home from hospital.

How are services changing?

NHS organisations in South Warwickshire are working together to develop a new approach to commissioning and delivering out-of-hospital services in the area. The intention is that the contracts will support a new clinical model for out-of-hospital services, address issues around the fragmentation and duplication of services and deliver better value for money. The current proposal is for SWFT and Coventry and Warwickshire Partnership Trust to work in collaboration to deliver this, with SWFT as the lead provider for Warwickshire and the partnership trust the lead provider for Coventry.

The aim is to create place-based teams that manage care for geographically defined populations of 30,000 to 50,000 people. Professionals from different parts of the system will work together in multidisciplinary teams, based around GP practices.

Following extensive local engagement, a new outcomes framework has been developed to define the overarching goals of the new model of care for different population groups. A new contract is being developed that will define the scope of services and related incentives, with payments to providers tied to the delivery of agreed outcomes. Over time, the aim is to develop a single model of community-based health and social care services in Warwickshire. Warwickshire County Council is also working with the three CCGs to develop a single approach to commissioning children's services in the county.

SWFT is procuring an electronic patient record for community services, and it is hoped that this will facilitate greater integration and information sharing across services.

What does this tell us about the key issues in community health services?

Drawing on these three case studies, our review of national data, and wider interviews and stakeholder conversations, we now consider the key issues in the current organisation and delivery of community health services.

Although the case studies are just three examples of local NHS community health services provision, they highlight both variation and complexity in how services are provided, who provides them and how they are paid for. This is also reflected in the national picture described in section 2 of this report. There is a mixed economy of provider types covering a range of organisational forms and structures. While one provider will usually dominate provision in an area, there are often multiple other providers delivering discrete services. Even within a single provider, there is often a wide-ranging list of separate services and teams, which may operate in relative isolation from each other. This varied and complex picture has arisen, to a large extent, by circumstance rather than design.

> *I don't get the sense that the services are particularly well linked up to each other... some of them are co-located, some of them are not... there's lots of different routes of access, and it's not always clear when you can self-refer and when you can't.*
> (Healthwatch organisation)

Part of it is legacy if I'm honest – I don't think there's any science behind it.
(Community services provider)

The commissioning of services is equally complicated. There are multiple commissioners (CCGs, local authorities and NHS England), and although services are often commissioned under block contracts, these often contain many separate service lines, activity and process measures and key performance indicators. Commissioners also frequently manage numerous smaller contracts for specific services.

At the moment the commissioning between the local authority and CCG [for intermediate care] is a mish-mash.
(Community services provider)

It's commissioned as lots of different, separate services… and the relationship still seems very transactional.
(Healthwatch organisation)

The way we commissioned community health services left commissioners counting all the contacts district nurses made and dealing with reams and reams of performance reports that weren't telling them much about the quality of the service or the outcomes for patients… What we should be saying is – you've got the money, you know what outcomes we're looking for, how you organise yourselves to do that is up to you and we don't interfere in that.
(Commissioner)

Our analysis of the national landscape paints a clear picture of a sector that is more plural, more fragmented and more open to competitive procurement (whether commissioned by the NHS or local government) than any other part of the NHS. It has more providers, more commissioners and more contracts, and services are retendered on a regular basis. This results in complexity on a number of levels:

- for patients and carers, seeking to access and navigate labyrinthine and seemingly unconnected services

- for health and social care professionals, seeking to refer patients into different services or obtain advice and information in the absence of clear lines of communication, pathways or information sharing

- for providers, looking to build connections and improve working relationships on many different fronts

- for commissioners, who may be making decisions on services in the absence of comprehensive data and managing numerous contracts for closely related services, some of which contain relatively little detail and allow only limited oversight, while others are highly prescriptive

- for national bodies and commentators, seeking to make sense of this in the absence of robust data.

Community services aren't well understood. It's a long old list. I struggle to understand it and I'm working in this job, so how is someone else supposed to? Hospitals and GPs are the bits people can grasp, community services are much harder to understand.
(Healthwatch organisation)

Community services are – by their very nature – highly networked, and interface closely with all parts of the health system. This includes interfaces with hospital services, and with other community services including primary care, social care, community mental health and other services. But the complex, dispersed and sometimes fragmented nature of community services makes more integrated working difficult to achieve and information sharing is often poor. Where interfaces are strong, community services can play a critical role in delivering co-ordinated care across boundaries. However, where these interfaces do not function effectively, there is a risk of duplication, fragmentation and gaps in provision.

Different services offer different things. That extensive range, for example when you've got multiple GPs doing different things, makes it hard for community services to work out where the gaps are and plug them.
(Community services provider)

There appears to be a particularly weak interface between NHS community health services and community adult mental health services, and there is much less evidence of joint working across this boundary than there is across the boundary with social care, acute hospital services and primary care. This is in keeping with findings from previous research that integrated care initiatives have often paid

insufficient attention to the relationship between physical and mental health, despite the close connection between the two (**Naylor** *et al* **2016**).

> *The mental health trust and the community trust have an adversarial relationship. It's not like they are working together.*
> (Healthwatch organisation)

The level of joint working between community services and other parts of the system is highly context-specific. For example, working closely with an acute trust may be much easier for an integrated acute/community provider, and working closely with mental health services may be easier for a community/mental health trust. Working with GP practices may be easier in areas where practices are organised in networks or federations that community service providers can easily engage with, or where local estates infrastructure allows the co-location of community and primary care staff in health centres.

> *Where the district nurses are located in the practice, you can just go upstairs and talk to them, but when they aren't you have to contact them via the single point of access and wait for a call back.*
> (GP)

It is clear that the issues facing local community services, and the solutions required to overcome them, are varied. This is in keeping with findings from our previous work, which highlighted that local context has more influence on the success of community services models than it does for hospital services (**Edwards 2014**).

Our analysis in this report and previous reports (*see* **Robertson** *et al* **2017** and **Maybin** *et al* **2016**) also points to significant financial and workforce pressures in community services, which risk affecting the availability and quality of services as well as putting pressure on staff. Budgets are hard to track but are reported to often be static or reducing despite rising demand, and staff numbers in key workforce groups such as district nurses continue on a steep downward trend.

Pressures are compounded by the knock-on impact of pressures in other parts of the health and social care system – notably in other services that support people at home such as general practice and social care.

Community services are picking up quite a few of the gaps in social care provision at the moment, because social care can't mobilise as quickly as health around crisis points like admission avoidance and discharge.
(GP/commissioner)

The combined effect of these pressures risks compromising the availability and quality of care and leading to growing levels of unmet need. This has serious consequences for individuals and for informal carers who are increasingly left to fill gaps in statutory services.

Financial pressures are often having the greatest impact on services focused on prevention and early intervention, suggesting that the health service may be moving further away from ambitions to prioritise prevention and improve population health.

We could do better on community work on prevention and early intervention. But we are not putting enough investment into it – the spend is still at [the] acute end. Where we are having to cut budgets, it is always the prevention activity that gets reduced. We need to be brave enough to move resources from acute services to managing demand.
(Local authority)

The care at the moment is definitely very reactive, it's absolutely reactive.
(Healthwatch organisation)

Despite the complexities described, and the well-documented pressures that the sector is facing, community services are not standing still. All the areas we looked at were making changes to delivery models with the aim of overcoming some of the issues described and changes are often focused on working more closely with other parts of the system. Across England there has been a wealth of innovation in community services stretching back over many years. But the potential to bring together the full range of community assets to improve population health is not being realised.

In previous research into the development of sustainability and transformation plans, we observed that the involvement of NHS community and mental health

service providers had been highly variable. In many areas, community providers were not fully engaged in the development of the plans, despite strengthening community services being a key aim of almost all of the plans. The involvement of local authorities has also been variable and frequently lacking, and the engagement of primary care has often been poor (**Ham *et al* 2017**; **Alderwick *et al* 2016**). Again, this points to the full potential of these services not being properly explored, and calls into question the feasibility of current plans to deliver more services in the community.

In the following section, we consider how community services need to change to meet the needs of the population in the future, outlining design principles to guide new models of community-based care.

4 Design principles to guide future models of community-based care

In this section, we move beyond a focus on the narrow definition of NHS community health services, and think much more broadly about the full spectrum of support that can be brought together to build a community-based approach to care. We look beyond public sector services to recognise voluntary and community sector organisations and others as key parts of the community sector.

We highlight 10 design principles to guide future models of care. These were developed through a review of existing literature and examples, and workshops with frontline staff, representatives from provider organisations and CCGs, patient and carer organisations, voluntary sector organisations and national bodies. Given the critical importance of local context, these principles will need to be applied differently in different areas.

We also highlight examples of health systems that have made some progress towards the vision of building a community-based approach to care. Examples were sourced through a national call for evidence that was sent to key stakeholders. Although none of these examples provide a full picture of how to transform care on their own, they illustrate how health systems are going about improving community-based care in practice and the impact this has had. Emerging evaluation data from many of these examples, particularly from the national new care models programme, indicates that it may be possible to improve patient experience and in some cases to moderate demand for hospital care by strengthening services in the community (NHS England 2017d).

There is a vast amount of innovative work going on across the NHS and beyond to improve community-based care, and the examples described here are only a small selection of many that we could have used to illustrate the design principles listed below.

10 design principles to guide future models of community-based care

- Organise and co-ordinate care around people's needs

- Understand and respond to people's physical health, mental health and social needs in the round

- Make the best use of all the community's assets to deliver care to meet local needs

- Enable professionals to work together across boundaries

- Build in access to specialist advice and support

- Focus on improving population health and wellbeing

- Empower people to take control of their own health and care

- Design delivery models to support and strengthen relational aspects of care

- Involve families, carers and communities in planning and delivering care

- Make community-based care the central focus of the system.

Organise and co-ordinate care around people's needs

There is evidence that better care co-ordination can improve the experience and outcomes of care, and increase efficiency by avoiding duplication (Gridley *et al* 2014; National Voices 2013; Curry and Ham 2010). This is particularly important for people using community services as they often require support from multiple services. As we have noted previously, '[r]unning community services in their traditional silos is no longer appropriate; they need to be closely connected to all other parts of the health and social care system if they are to be a major driving force in improving community health' (Edwards 2014, p 19).

Many areas are trying to improve co-ordination through introducing 'single points of access' or 'trusted assessor' arrangements to reduce duplication in referral and assessment processes. Some areas are bringing in new roles with a specific care co-ordination function (care navigators or care co-ordinators). These roles are intended to act as a workaround to help people navigate complex and unco-ordinated services. However, a better solution would be to make services less fragmented, so that this additional layer of complexity is not needed.

Many places are seeking to better co-ordinate care by bringing professionals together in integrated community teams. Neighbourhood or locality-based integrated care teams are a core element of MCP and PACS models, and are also the basis of the primary care home model (*see* below). These multidisciplinary teams typically cover populations of 30,000 to 50,000 people, and bring together a range of community health and social care professionals working alongside groups of GPs. Many integrated care teams focus primarily on older people or other groups with relatively high health and care needs (**Naylor *et al* 2017**). Teams are usually locality-based and include a range of professionals, such as district nurses, community matrons, social workers, mental health professionals, therapists, GPs and voluntary sector workers. The core teams can link into a wide network of local services to meet the full range of people's needs. By working together in one team, staff across different disciplines can communicate regularly, share knowledge and expertise and co-ordinate care planning and delivery.

The evidence for the effectiveness of community case management and care co-ordination is mixed, particularly in terms of the impact on secondary care utilisation and costs. However, some studies – particularly those evaluating models involving a functional multidisciplinary team and a strong focus on case management – have found that they lead to reduced hospital use and improved patient experience (**Imison *et al* 2017**).

The Encompass MCP, Kent

The Encompass MCP vanguard, led by a partnership of 13 general practices, is working to improve care for the local population of 170,000 people. Five community hub operating centres have been developed. The hubs bring together multidisciplinary teams of professionals spanning health and social care. Teams include GPs, community nurses, social care workers, mental health professionals, geriatricians, pharmacists, social prescribers (explained in more detail under the next design principle) and health and social care co-ordinators. They support people identified as being at high risk of hospital admission. As of October 2017, the five community multidisciplinary teams were managing a caseload of 350 patients, equivalent to an annual capacity of 4,600 patients.

Other initiatives include a database of voluntary and community services, a social prescribing service and drop-in dementia clinics provided through a partnership with Age UK. A smartphone app – Waitless – has been introduced to help people decide which urgent care centre to attend for treatment for minor injuries.

Five community networks have been established to co-design the care model. Members include frontline staff from local health and care services and voluntary organisations, patients and service users.

Emerging data on the impact of the changes suggests that they are having an impact on the use of services, including a year-on-year reduction in emergency hospital admissions. There are plans to expand the model to cover a population of 700,000 people across East Kent.

Source: **Encompass 2017**

The primary care home model

The primary care home model is based on four defining characteristics:

- provision of care to a defined, registered population of between 30,000 and 50,000 people

- an integrated workforce, with a strong focus on partnerships spanning primary, community, mental health, secondary and social care

- a combined focus on the personalisation of care and improvements in population health outcomes

- aligned clinical and financial drivers through a whole-population budget and shared risks and rewards.

The model is developed, implemented and led by providers, and is intended to encourage collaboration throughout the system. There is an emphasis on understanding the needs of the local population, and each primary care home site has implemented the model differently to address local needs.

Early evaluation has shown positive results. For example, an initial assessment of the impact of the model in three rapid test sites found decreases in the rates of A&E attendances and emergency admissions, reductions in prescribing costs, shorter GP waiting times and improved staff satisfaction and retention.

Source: **National Association of Primary Care 2017**

Effective information sharing is critical. This depends on shared records and interoperable systems. Collecting and bringing together data in real time can also support population health management. The potential impact is evident in some international health systems: shared electronic records have been key to improvements in Canterbury in New Zealand; and a single electronic record has supported population health management in the Clalit system in Israel (both are described later in this section). Although progress is being made in some areas, information sharing remains limited at present.

Organising care around people's needs also requires changes to how services are accessed. In many areas, single points of access have been introduced to streamline referrals and reduce duplication and delay, and some have introduced more flexible access routes. In West Wakefield, patients can be seen directly by a physiotherapist (**NHS England 2017c**); in Derbyshire, there is a new nurse-led acute home visiting service (**Wellbeing Erewash 2017**); and paramedics and pharmacists are increasingly working in primary care to improve same-day access (**Primary Care Workforce Commission 2015**).

Other ways of improving care co-ordination include:

- developing shared processes – for example, shared assessments or care planning that can be used by any professional who is contributing to a person's care

- taking a different approach to the workforce – for example, having more flexible or generalist roles, rather than having many separate inputs from different professionals.

Understand and respond to people's physical health, mental health and social needs in the round

Our second design principle is that future models of community-based care should take a 'whole-person' approach, addressing people's physical health, mental health and social needs together. These factors are often closely related and interact to influence health and wellbeing. The first step in doing this is to understand the full range of a person's needs, and how these impact on their health and wellbeing. Helping people to access appropriate support to address these needs can be achieved through partnership working between different services in the community, and new workforce models to support this.

One way to do this is through social prescribing and related approaches that allow health professionals to refer people to non-clinical services to improve their health and wellbeing. Social prescribing is being increasingly used to connect people with local community resources, and although there is currently limited

evidence to demonstrate its effectiveness and costs (**Bickerdike** *et al* **2017**),
promising results are emerging from some schemes (**Imison** *et al* **2017**; Gottlieb
et al 2016; **Dayson** *et al* **2013**; **Kimberlee 2013**). Many of the vanguard sites have
introduced social prescribing, for example through the Making Connections
programme in the North East Hampshire and Farnham PACS, employing social
prescribers in the Encompass MCP in Kent, and introducing nine local area
co-ordinators on the Isle of Wight to connect people with local community
resources (**Encompass 2017**; **Naylor** *et al* **2017**). A forthcoming report from
The King's Fund highlights the role of volunteers in many social prescribing
schemes – this might involve volunteers supporting connections with other
services or providing direct support (Gilburt *et al* forthcoming).

**The Bromley by Bow Centre – addressing the wider determinants of
health in Tower Hamlets, East London**

The Bromley by Bow Centre, founded in 1984, supports the wellbeing of the local
population in Tower Hamlets – one of the most deprived and diverse areas of England.

The centre brings together primary and community health services with other types
of community support, including a children's centre, employment and housing advice,
adult education, debt and benefits advice, healthy lifestyle and weight management
courses, a community gym and gardening and art therapy.

The centre was an early pioneer of social prescribing. GPs can connect people to
more than 1,100 voluntary sector organisations via the social prescribing team.
People referred to the team spend around an hour with a social prescribing
co-ordinator, who undertakes a detailed assessment and directs them to appropriate
programmes or services. Patients can also self-refer to services at the centre.

Sources: **Bromley by Bow Centre 2017**; **The King's Fund 2013**

There is a well-established link between physical and mental health: mental
health problems are very common among people with long-term physical health
conditions, and there is evidence that when these needs are not adequately
addressed, people experience poorer health outcomes and higher costs of care.
People with severe mental illnesses often have worse health outcomes than
the wider population (**Naylor** *et al* **2012**). It is not only diagnosable mental health

conditions that impact on the outcomes and costs of care – the presence of lower-level psychological issues or distress has a similar effect (Brown Levey *et al* 2012). It is therefore essential to address people's physical and mental health needs in a joined-up way (**Naylor** *et al* **2017**, **2016**). Some areas are making progress in embedding mental health expertise into integrated care teams (for example in the North East Hampshire and Farnham PACS described in the box below), and others are integrating mental health into specific pathways.

Addressing mental health and wellbeing in the North East Hampshire and Farnham PACS

In North East Hampshire and Farnham, mental health professionals are embedded within five locality-based multidisciplinary integrated care teams. Their main role is to work with adults with co-morbid physical and mental health conditions, particularly when this is affecting their engagement with services or their ability to self-manage. A social prescribing programme, Making Connections, has been developed to connect people with local resources and voluntary sector services.

A Recovery College offers educational support and workshops for people living with, or recovering from, chronic mental or physical health conditions. It is run in partnership by the mental health trust, voluntary sector and local authority, and courses are delivered in community locations such as libraries and community centres. The model and courses have been co-designed with service users, carers and staff.

Safe Havens offer out-of-hours crisis support as an alternative to A&E. Each is staffed by a qualified mental health practitioner and trained staff from third sector providers, and peer support is available. The Safe Havens work closely with the local A&E, police and ambulance services to identify and connect with people who would benefit from this support.

Early data from the Recovery College indicates that the model is leading to reductions in users' contact with other services, including with A&E, primary care and home treatment teams. An early evaluation of the Safe Havens found excellent service user feedback, a reduction in admissions to acute psychiatric care and a plateau in A&E attendances for mental health issues.

Source: **Naylor** *et al* **2017**

Make the best use of all the community's assets to deliver care to meet local needs

Our third principle is that future models of community-based care should make the best use of all the community's assets to meet local needs. Community assets are the positive capabilities within communities that can be used to promote health – they include the full range of statutory services, voluntary and community sector organisations, private sector organisations, support groups, social networks, individuals, buildings and community spaces. Asset-based community development focuses on the skills, capabilities and assets of citizens rather than on needs (Social Care Institute for Excellence 2017; South 2015; Bisognano and Schummers 2014).

Developing asset-based models involves health and care services working with a wide range of partners, such as local voluntary sector organisations, community groups, wider community health and care services – such as pharmacies, hospices and ambulance services – and other statutory organisations – such as schools, housing and fire and rescue services. This approach requires a number of steps:

- understanding the needs of the population, using tools and information to undertake risk stratification and population segmentation (categorising key groups of the population according to their needs)

- understanding the community's assets through 'asset mapping' – guidance suggests that this should be community-led and dynamic as assets are constantly changing (Greater Manchester Public Health Network 2016)

- working in partnership to design models of care that draw on available community assets to address the needs of the population.

There has been a strong focus on asset-based community development in Wigan, described on page 74, and also in many of the social prescribing initiatives described elsewhere in this section.

Developing community wellbeing in Erewash, Derbyshire

A key area of development for the Wellbeing Erewash MCP vanguard has been 'community resilience' – 'making sure support is available and easy to find in the local community, and encouraging people in the community to support each other'.

This has led to the development of:

- **an online community directory** of local voluntary and community groups
- **a community development forum** for leaders of voluntary sector groups, supporting them to learn more about each other, avoid duplication, identify how they can work together and take collective action
- **community connectors** – volunteers or people working within services who can link people with groups or assets in the community
- **a time bank** where people can offer their time and skills – such as DIY and garden maintenance – and receive time back from people with different skills in return.

Source: **Wellbeing Erewash 2017**

Fire and rescue services' 'safe and well visits'

Many fire and rescue services carry out 'safe and well visits' to support vulnerable people in the community. They have partnered with organisations including Age UK and the Alzheimer's Society and NHS services. Support might involve:

- visiting vulnerable people who are not engaging with health or social care services
- addressing safety hazards in people's homes
- informing people about available services
- making referrals to relevant agencies.

An example of partnership working between fire and rescue services and community health services is the Hull Falls Intervention Response Safety Team (Hull FIRST). It is delivered as a partnership between the local CCG, fire and rescue service, ambulance service, community trust and acute trust. Non-emergency cases (triaged via 999 or NHS 111) are referred to the team. The team can help people to get up safely, provide an initial assessment and medical care and put in place equipment or other preventive measures to minimise the chance of a repeat fall. The team works closely with the community falls prevention team, who can offer ongoing support.

Sources: **Chief Fire Officers Association 2016**, **2015**; **Hull Clinical Commissioning Group 2016**

Enable professionals to work together across boundaries

Many of the examples given above centre on professionals working together across organisational and service boundaries. Through multidisciplinary working, services can draw on the skills and expertise of a range of professionals from different disciplines and providers to improve the understanding and management of people's needs and offer co-ordinated care. This is particularly important for people with multiple or complex needs.

In some instances, professionals may work together through fully integrated teams that share caseloads – for example in the integrated community teams and primary care home models described above. In other instances, the structures bringing professionals together are less formal, but can still support collaborative working – for example through regular communication, multidisciplinary meetings, shared notes and care plans.

Working in this way can help to bridge traditional boundaries between community services and primary care, secondary care, mental health care and social care. Collaborative working can also extend beyond the confines of the health service; professionals from health and social care services should be able to collaborate with wider services that contribute to people's health and wellbeing – such as housing, schools and emergency services – to co-ordinate care around people's needs.

Community in-reach to acute wards in Nottinghamshire

The Principia MCP vanguard in Nottinghamshire has introduced a community in-reach service to older people's acute wards, helping to improve the interface between the hospital and community, and facilitate timely and co-ordinated discharge.

A community team (including a full-time community matron and four local GPs offering three sessions a week) work within the hospital to support clinical decision-making and care planning. They have access to GP and community health service records. As part of the pilot, GPs and consultants have shadowed each other to improve their understanding of how they work and how they deal with clinical risk and decision-making.

Data from the pilot shows that readmissions of patients aged over 65 fell by 8.7 per cent in one year, and readmission rates are lower than for surrounding CCGs.

Source: NHS Rushcliffe Clinical Commissioning Group 2017

Improving child health in Southwark and Lambeth

The Children and Young People's Health Partnership (previously known as the Evelina London Child Health Programme) focuses on improving the health and wellbeing of children and young people in Southwark and Lambeth.

It focuses on improving cross-system working, for example through children and young people's health teams, which include GPs, paediatricians, psychiatrists and mental health workers. Partners include local CCGs, local authorities, the children's hospital, local acute providers, third sector organisations and children, young people and families. Local schools are closely involved, for example through a programme teaching mental health resilience to children, teachers and school nurses.

Sources: **Children and Young People's Health Partnership 2017**; **Healthy London Partnership 2016**; **Kossarova** *et al* **2016**

Co-locating emergency and unscheduled care services on the Isle of Wight

On the Isle of Wight, an integrated care hub brings together all parts of the island's emergency and unscheduled care system, including GP and community nursing out-of-hours services, the ambulance service and other crisis response services.

Professionals from different services are co-located within the hub. There are 999 emergency call operators, NHS 111 call handlers, paramedic clinical advisers, GP out-of-hours services, a crisis response team, district nurses, social workers, mental health workers, occupational therapists, pharmacists, Wightcare (a private pendant alarm company) and Age UK. Co-location supports constant communication and all team members can access patient records.

The objective is to enable people in crisis to be supported at home rather than being admitted to hospital, and this has led to significant estimated cost savings.

Source: **NHS England 2016b**

Build in access to specialist advice and support

Teams in the community need to be able to draw on specialist medical input when required, as they often manage high levels of clinical complexity, acuity and risk. But specialist medical expertise has traditionally been concentrated in hospitals, with complex and indirect referral pathways standing between community-based professionals and the specialist advice they need. Our fifth design principle is that future models of community-based care should build in this type of support to be readily available.

Building closer links between specialists and community professionals might be achieved through community-based specialist roles (including consultants, specialist nurses and GPs with special interests), outreach clinics, education sessions or consultant-led email and telephone advice lines (**Robertson *et al* 2014**). Previous work by The King's Fund highlights that successful models have gone beyond a 'drag and drop' approach of relocating outpatient clinics into community settings, and have fundamentally changed their approach to specialist care by redesigning pathways, the roles of professionals, or both, and putting education at the core of the model. This has important implications for the role of specialists; in future, they may take a greater role in advising and supporting community-based professionals to diagnose and treat patients (**Robertson *et al* 2014**).

By bringing specialist expertise into the community, some conditions that would otherwise require treatment or monitoring in inpatient settings can be managed in or near people's homes. This can help to avoid undesirable and costly hospital admissions, as demonstrated in the example of Bradford's virtual ward (described below) and the long-running Hospital in the Home programme in Victoria, Australia (Montalto 2009).

Some areas are using technology to bring specialist expertise into community settings – for example, in Sheffield, telehealth is being used to support community nurses to provide advanced palliative care with remote supervision from specialists at a local hospice (**Park and Kyeremateng 2016**; **NIHR CLAHRC Yorkshire and Humber 2014**), and in Airedale, telehealth is being used to support care home staff with access to specialist consultant and nursing expertise (**NHS England 2017b**; **Naylor *et al* 2015**).

There is evidence that better community access to specialist expertise can lead to improved patient outcomes, higher levels of patient and staff satisfaction, shorter hospital stays and fewer emergency readmissions (**Shape of Training 2013**). A recent review found that there is good evidence that interventions giving GPs access to specialist opinions to help them manage patients in the community can reduce hospital activity and whole-system costs (**Imison** *et al* **2017**).

Consultants working in community settings

A previous report from The King's Fund explored services where consultants were delivering or facilitating the delivery of care outside hospitals. Two of these services are described below.

Imperial child health general practice hubs

Child health general practice hubs in West London were introduced to support GPs to manage children's health needs in the community. The hubs are made up of groups of two or three practices, which work with paediatric consultants. In each hub, paediatric consultants run outreach clinics with GPs, attend multidisciplinary team meetings in GP practices and run an email/telephone hotline. A service evaluation of the first 12 months of the scheme found that in the largest and most well-developed hub there was a significant reduction in secondary care usage (Montgomery-Taylor *et al* 2016).

Whittington respiratory service

The Whittington integrated community respiratory team was developed to support patients with chronic obstructive pulmonary disease and other diseases causing breathlessness in their homes following discharge from hospital or referral from a GP. Regular community multidisciplinary team meetings were led by an integrated respiratory consultant. The team included integrated respiratory consultants, specialist respiratory nurses, physiotherapists, clinical psychologists, a respiratory pharmacist, a dietician and a specialist stop-smoking adviser.

Source: **Robertson** *et al* **2014**

Developing a virtual ward in Bradford

The Bradford virtual ward was first developed in 2012 as a discharge-to-assess model and has since been extended to better support frail older people in the community. The virtual ward multidisciplinary team involves therapists, nurses, advanced nurse practitioners, rehabilitation support workers, social workers and consultant geriatricians. Shared care pathways were also agreed between GPs, consultants and community teams.

An integrated hub has been introduced to take direct referrals from community matrons, GPs and local ambulance services. It acts as a single point of access for intermediate care, and can escalate community support within hours, initiate rehabilitation at home or directly admit people to community hospital rehabilitation or a nursing home bed.

Positive outcomes include high rates of patient satisfaction and improvements in quality of life scores. There has been a significant reduction in length of stay, with no increase in readmission rates. It has been estimated that a total of 4,612 bed days have been saved, equivalent to a cost saving of £1.85 million.

Source: **HSJ solutions 2017**

Focus on improving population health and wellbeing

Our next principle for future models of community-based care is that they should be designed to improve population health and wellbeing. In previous reports, we have argued for the need to develop radically new models of care, with the aim of improving population health and wellbeing. This requires collective action across different sectors and organisations to act on the wider social, economic and environmental determinants of health (**Alderwick** *et al* **2015**; **Ham and Alderwick 2015**). The Wanless report (Wanless 2003, p 1) highlighted that there are 'potentially large gains to be made by refocusing the health service towards the promotion of good health and the prevention of illness' and, more recently, the Forward View called for a 'radical upgrade in prevention and public health' (**NHS England** *et al* **2014**, p 3). However, public health budgets have seen significant cuts in recent years (**Buck 2017**).

Health care is only one factor alongside many wider factors that contribute to health and wellbeing, including individual behaviours, the environment, poverty, education and other social factors (**Siegel** *et al* **2016**). Improving health therefore requires action to address these wider social and economic determinants. Action may be through national government policies or through interventions at a population level – for example through joint planning and resource allocation to address population needs and tackle issues such as poor housing and employment levels – or at an individual level – for example through social prescribing (described above). To have the maximum impact on health, health and care services need to work with partners from other sectors and local communities who have expertise in these wider determinants. This can be supported by aligned incentives and outcome measures that incentivise joint working on population health (**Alderwick** *et al* **2015**).

There is also a role for population health management, where information and tools are used to undertake risk stratification and population segmentation to target interventions. This requires shared information systems that bring together comprehensive, real-time population data. For example, Kaiser Permanente (a not-for-profit health insurer and provider in the United States) uses data from system-wide electronic health records to understand the health needs and outcomes of its members and target interventions and support (**Alderwick** *et al* **2015**; **Bibby 2015**; **Curry and Ham 2010**). There are many examples of similar approaches being used by the NHS and its partners. For example, the Healthy Wirral PACS vanguard has developed a shared care record that brings together hospital, community, mental health and primary care records with social care information and is using this to identify patients at risk of deterioration. Meanwhile, the South Somerset Symphony primary and acute care system vanguard is using population data to identify the most complex 4 per cent of patients and provide them with intensive support through complex care hubs.

Most NHS community health services focus on a relatively small proportion of the population with a relatively high level of need, but there are some notable exceptions to this in universal services such as health visiting, school nursing and vaccination programmes. Community health services are well placed to take a greater role in improving population health because they are based within communities; have access to data and information to understand the needs of the

community; are already highly networked with a range of sectors and services; and offer services throughout the life course. There is great potential to capitalise on these assets more effectively and for community health services to take a leading role in improving population health.

Improving population health in Wigan

In Wigan, there is a strong focus on improving population health, reducing inequalities and tackling preventable causes of ill health. This includes a focus on the lifestyle determinants of ill health (such as smoking and obesity) and other wider determinants (such as housing, employment, domestic abuse and social isolation).

Working in partnership with organisations from across the borough, Wigan Council has developed an asset-based approach known as The Deal. A wide range of programmes have been implemented, including:

- The Heart of Wigan – this aims to reduce cardiovascular disease by identifying and bringing together strategies that support cardiovascular disease risk reduction, for example by linking local transport and public health strategies, introducing programmes to encourage physical activity and offering cardiopulmonary resuscitation training

- the Confident Futures programme – this provides opportunities for disadvantaged young people to access employment through a pre-apprenticeship training programme with Wigan Council that involves an employability course and work placement

- the complex dependency live well team – this team works with single adults facing issues such as homelessness, debt, illiteracy, bereavement, unemployment or domestic violence

- campaigns to address the lifestyle determinants of poor health, such as smoking and inactivity

- The Deal in Action – a week of action across the borough to engage communities and showcase engagement in activities ranging from cardiopulmonary resuscitation training to litter picks and bulb planting

- development of community capacity through investment in voluntary and community sector organisations.

These initiatives are being built on and expanded through the Wigan locality plan under the overarching Greater Manchester devolution agenda.

Sources: **Wigan Borough Clinical Commissioning Group 2016**; **Wigan Council 2016**

Promoting child health in West Wakefield

The Schools App Challenge is an annual competition where children create health apps to encourage other children to make good physical, mental health and wellbeing choices. It was introduced by a local GP federation in January 2015 and has since spread to primary schools across West Wakefield. The competition involves a wide array of partners, including GPs, local schools, the CCG, the council, oral health teams, the local child and adolescent mental health service and children's centres. A winning app is chosen each year to be professionally developed. More than 1,000 children have taken part, and two apps – a mental health and bullying app and a healthy lifestyle app to address childhood obesity and oral health – have been launched.

An independent evaluation of the first year of the competition found that 70 per cent of the children involved reported positive health behaviour change as a result of taking part. There are plans to roll the scheme out nationally.

Sources: **Castle-Clarke** *et al* **2016**; **NHS Confederation** *et al* **2016**; **West Wakefield Health & Wellbeing 2016**

Empower people to take control of their own health and care

Future models of community-based care should be designed to empower people to take control of their own health and care as far as possible. This might involve encouraging people to lead healthier lifestyles, or improving people's understanding of their health and supporting them to manage their long-term conditions.

Supporting people in this way relies on partnership working between professionals and patients. Professionals working in the community are ideally placed to do this as they are working with people in their own homes and communities, which often leads to a high level of trust (**Maybin** *et al* **2016**). By seeing people in their own environment, they also have a good insight into people's capabilities to self-care and the types of support (such as family and informal carers) that are available to help them do so. A recent review by the Nuffield Trust found good evidence that community initiatives designed to support self-care can reduce hospital activity and whole-system costs (**Imison** *et al* **2017**).

One way of supporting people to take control of their own health and care is through 'patient activation' approaches, which seek to understand people's

capabilities to manage their own health and then select interventions to improve them – ranging from simple signposting of information to more intensive coaching and support (**Hibbard and Gilburt 2014**). The evidence for the effectiveness of health coaches and health trainers is mixed but evaluations of some schemes are showing positive results (*see* the examples below). Programmes that aim to change behaviours are more likely to have a lasting positive impact than those that simply provide information. Digital technologies can be a useful tool to engage people and support them to adopt more healthy behaviours, but there is evidence that these initiatives are more successful when they are supported by professionals (**Imison** *et al* **2017**).

A number of approaches – including peer support, self-management education, health coaching and group activities to promote health and wellbeing – were explored through the Realising the Value programme. Resources produced by the programme explore how these approaches can be implemented and their potential value (**Finnis** *et al* **2016**).

Health trainers in Bolton

The Bolton Health Trainer Service started in January 2007. Eighteen full-time equivalent health trainers support people to change their behaviours using an evidence-based motivational interviewing technique. The health trainers support people from certain high-risk groups to assess their health and wellbeing risks, promote behaviour change, and collaborate with patients to set health goals and action plans to achieve these goals. They also encourage patients to access support from their local community.

Health trainers are co-located within GP practices and are fully integrated into primary care teams. They are trained to conduct basic clinical procedures such as checking blood pressure and taking blood.

An evaluation of nearly 9,000 participants over a five-year period found that the programme led to improvements on a wide range of health measures, including significant improvements in body mass index, smoking levels, alcohol consumption, exercise levels, diabetes control and overall wellbeing scores.

Source: **Nelson** *et al* **2013**

Health coaches in Salford

The Being Well Salford project uses a team of trained health coaches to support people to make positive changes to their health behaviours. They work with individuals for up to 12 months on a one-to-one or group basis to make changes in any of the following areas: weight, smoking, alcohol intake, activity levels and mood. Evaluation of the programme showed that after 12 months of the programme, nearly half of smokers had quit and a fifth of participants had reduced their weight by more than 5 per cent.

Sources: **Being Well Salford 2017**; **People and Communities Board 2016**

A forthcoming report highlights promising evidence that local councils' integrated health and wellbeing services are responding to the complex issue of clustering of unhealthy behaviours by supporting multiple risk factor changes and tackling underlying factors such as debt and housing problems (Evans and Buck forthcoming).

The Integrated Personal Commissioning programme is testing out ways of giving people greater choice and control over their care, including through personal budgets (**NHS England and Local Government Association 2016**). These shift the control of resources for health and care services to people or their carers and families, allowing them to choose from a wider range of care and support options tailored to their individual needs and preferences. Personal budgets can include health, social care and education funding, offering the opportunity to integrate funding sources around the individual. Integrated personal commissioning is targeted towards:

- children and young people with complex needs

- people with long-term conditions

- people with learning disabilities and high support needs

- people with significant mental health needs.

It has been estimated that it could be the main model of funding and organising community-based care for around 5 per cent of the population (for more information, *see* **NHS England and Local Government Association 2017**, **2016**).

It is also critically important to involve people using services in planning, designing and delivering services, ensuring regular engagement and co-production wherever possible. This approach shaped many of the changes in the Canterbury health system in New Zealand and the Nuka system of care in Alaska (described below). Similar approaches are being used in England, for example through a Big Health and Social Care Conversation in Salford (**Salford Together 2017**) and a Health and Wellbeing Inquiry in Blackpool (**Shared Future 2017**).

Design delivery models to support and strengthen relational aspects of care

Relational aspects of care are often the elements most closely correlated with good patient experience (**National Voices 2013**). Part of this is about people feeling that professionals are treating them as a 'whole person' rather than focusing on care tasks.

Relationship continuity, which describes a continuous relationship between a patient and professional over time, can be an important part of this. It is highly valued by patients, carers and families, and consistently features as a key priority in their care preferences (**Maybin** *et al* **2016**; **National Voices 2013**; **Ellins** *et al* **2012**; **Freeman and Hughes 2010**). Evidence suggests that continuity can lead to better outcomes, including improved disease control, reduced A&E attendance and a lower risk of elective and emergency hospital admission. Continuity tends to be a higher priority for older people and those experiencing complex health or social issues (**Deeny** *et al* **2017**; **Freeman and Hughes 2010**; Nutting *et al* 2003).

This may be particularly important in community services, where patients are often in contact with services over a prolonged period, and often have multiple or complex needs. Future models of community-based care should therefore be designed to support these relational aspects of care. It is important that models such as integrated community teams are designed to support continuity, rather than dispersing relationships across more team members. The Buurtzorg model of nursing in the Netherlands and the team-based approach to primary care in the

Nuka system of care in Alaska (both described below) offer useful lessons in how this can be done.

Using robust measures of patient experience and feedback – as well as involving people using services in designing and planning services – can help to ensure that future delivery models support the aspects of care that matter most to the people receiving it.

Buurtzorg: holistic nursing care from self-managing nursing teams in the Netherlands

The Dutch home care provider, Buurtzorg, has developed an innovative district nursing and home care model. Teams of no more than 12 nurses are responsible for providing all home care to local populations of 10,000 to 20,000 people, with caseloads of around 40 to 60 clients. Each nurse delivers the full range of care, including personal care, nursing care and complex interventions such as intravenous therapy. They also act as health coaches and support clients and families to develop their own capabilities and support networks.

The nursing teams are responsible for organising care, including caseloads, rotas, budgets and recruitment. Central functions exist to support the teams rather than to manage them; there are fewer than 50 administrative staff.

The model has been found to result in improved patient outcomes, higher patient and staff satisfaction, reductions in unplanned hospital admissions and reduced length of stay. The average cost per person has been reported as being lower than for other home care agencies.

Sources: **Royal College of Nursing 2016**; Bisognano and Schummers 2014; Nandram and Koster 2014; **The King's Fund 2013**

Involve families, carers and communities in planning and delivering care

A significant amount of care and support in community settings does not come from statutory health and care services, but from informal support networks of family, friends and communities. They are therefore critical partners for community services. Our next principle is that future models should seek to involve families, carers and communities in the design, planning and delivery of community-based care.

As well as involving carers and families in planning and delivering care, community-based services have an important role in supporting them. Caring often comes at a high personal cost, with many carers experiencing social isolation, financial difficulties and adverse consequences for their own health and wellbeing. They may require support from a variety of sources – including the NHS, social care services, employers and the social security system (**Carers UK 2017**; **Royal College of General Practitioners 2014**). The example in the box below describes how organisations in Leeds have brought together and co-ordinated different types of community support available to carers in the area.

Bringing together support for carers in Leeds

Support for carers was previously commissioned under separate contracts from five voluntary organisations and one NHS provider. In 2014, Carers Leeds (a local charity) worked with local commissioners to bring services together. They are now commissioned under one contract. Carers Leeds is the lead organisation and runs a single point of access into all services.

Carers Leeds has strong links with the statutory sector and delivers some services within health care settings. It runs carers clinics in five GP practices, works with 38 practices to offer dementia support and offers a service to carers of people with dementia in two hospitals.

A recent independent evaluation indicated a positive impact on carers' health and wellbeing, including reduced social isolation, improved mental wellbeing and improvements in diet and physical activity.

Sources: **Bunyan *et al* 2017**; **The King's Fund 2017a**

In keeping with the theme of engagement and asset-based approaches, the wider local community can also make a valuable contribution to designing future models of community-based care, in both identifying local needs and developing and implementing potential solutions – as in the examples of Salford and Blackpool described above. This was also a key recommendation from the Realising the Value programme, which recommended that the health and care system should develop deeper engagement with citizens – including through tested models of co-production (**Finnis *et al* 2016**).

Community engagement in Millom, Cumbria

There has been close engagement with the local community in Millom (a geographically isolated town in West Cumbria) to improve and redesign services.

The community is an equal partner in the Millom Alliance – a partnership between GPs, the community trust, the acute trust, the ambulance trust, social care and the community. Representatives from the local community group attend operations and steering group meetings and run communications for the alliance. The community group has organised health initiatives, including:

- creating an online video campaign to encourage GP recruitment

- promoting a pharmacy minor illness scheme

- producing a regular local newspaper and posters promoting public health messages

- running support groups.

In the first 12 months of the partnership, the number of emergency bed days that people from Millom spent in the acute hospital fell by 29 per cent.

Source: **Better Care Together 2016**

Make community-based care the central focus of the system

Hospitals will always be a critical part of the health and care system, and there will always be instances where a hospital is the most appropriate, or indeed the only viable, option for delivering some types of health care. However, the current focus of resources and attention on hospitals is not suited to the health needs of the population and often comes at the expense of investment in other forms of provision. Our final design principle is that there needs to be a shift in focus across the health and care system as a whole, from health systems centred around hospitals, to health systems focused around communities and community services as defined in their broadest sense.

Previous efforts to move care out of hospital have often focused on individual interventions or schemes, but the change we are describing cannot be achieved by NHS community health services alone. Making community-based care the central focus of the health system requires a whole-systems approach to change, spanning hospital services, community services, primary care and social care. This echoes our work on 'place-based systems of care' (Ham and Alderwick 2015), where we recommended that services and organisations across an area should work together to manage the resources available to them and improve health and care for the populations they serve.

International systems that have shifted the focus of care in this way (*see* the examples in the box below) have taken a whole-systems approach to achieve this. Rather than attempting to make one big-bang change, they have made many simultaneous changes that have collectively altered the focus of care. They have focused on new delivery models and clinical integration, rather than changes to structure or organisational form. They have also invested in community services and shifted the balance of resources over time. Similar lessons can be learnt from the transformation of mental health services in England (*see* Gilburt *et al* 2014).

International examples of systems that have shifted the focus of care

The Canterbury health system, New Zealand

The Canterbury District Health Board in New Zealand has significantly changed health and care delivery over the past decade. An overarching strategic vision – to keep people well and healthy in their homes and communities – was developed through extensive community engagement.

The changes have integrated care across organisational boundaries, increased investment in community-based services and strengthened primary care. Interventions include:

- HealthPathways – primary care management and referral pathways developed in partnership between GPs and hospital doctors

- the acute demand management system – people with acute health needs receive urgent care in the community from GPs, supported by community nurses, specialist advice and rapid diagnostic tests

- the electronic shared care record – a secure online summary care record, combining an individual's GP records, hospital records, community pharmacy records and laboratory and imaging results.

The health system is now supporting more people in the community and has moderated demand for hospital care.

Sources: Charles 2017; Timmins and Ham 2013

The Southcentral Foundation, Alaska

The Southcentral Foundation is a not-for-profit health care organisation in Alaska. When it took over services in the late 1990s, it redesigned primary and community care services and developed the Nuka system of care. It put resources into developing a generalist model, closing specialist clinics and bringing specialists into primary care.

There are six primary care clinics, each of which is home to six primary care teams. Each primary care team is responsible for around 1,400 people and typically consists of a GP, a nurse case manager, a case management support worker and a medical

International examples of systems that have shifted the focus of care *continued*

assistant. For each clinic there is an integrated care team, which includes an integrated care team manager, a pharmacist, two behavioural health consultants, a midwife and a dietician.

The role of the community has fundamentally changed from being 'service users' to 'customer-owners', who are actively involved in designing and managing the care. The system involves its customer-owners in a variety of ways, including through participation in advisory groups and involvement in the governance structure and strategic planning.

Benefits include strong relationships with individuals and families and better co-ordination. The changes have led to substantial reductions in A&E attendances and hospital admissions, and health outcomes are among the best in the United States.

Source: **Collins 2015**

Clalit Health Services, Israel

Clalit Health Services is the largest of Israel's four not-for-profit health maintenance organisations. It provides and funds health services for a population of around 3.8 million people, and receives its funding from the government on a capitated basis.

Over more than two decades, Clalit has gradually shifted the balance of funding from hospital care to community-based care. Additional resources have been directed to community and primary care services, leading to a reduction in the proportion of total health expenditure that is spent on hospital care, and an increase in the proportion that is spent on community care.

Clalit has a single electronic patient record across all parts of the system, meaning that data is available in real time across all care settings. This has improved communication and integration across the system, and has enabled risk profiling and targeted preventive interventions, for example to prevent hospital readmissions and recognise and treat early-stage kidney disease.

Sources: **Balicer 2017**; Shadmi *et al* 2015

While the vision of a community-focused health and care system echoes the ambitions of the Forward View (**NHS England** *et al* **2014**), STPs and many other local and national strategy documents, it stands in contrast to the reality of the current system. Over recent months, the direction of focus and funding seems to have shifted even further towards hospital services as the system grapples to improve financial and operational performance in acute trusts.

Summary

The 10 design principles, and the examples of health systems that have made progress towards them, highlight the great potential that community services have to enhance the health and wellbeing of local populations. The assets available to improve population health in communities are extensive, and there is enormous potential to draw on these in a more systematic and co-ordinated way. There are many examples, both within the NHS and beyond, of systems that have addressed some of the issues described earlier in this report through innovative delivery models. Emerging evaluation data from some of these examples suggests that it may be possible to improve patient experience and outcomes and in some cases to moderate or even reduce demand for hospital care by strengthening services in the community.

These examples highlight the importance of working across organisational and service boundaries to improve models of community-based care. None of the improvements described above have been achieved by NHS community health services working in isolation – they have required hospitals, general practice, social care and others to work differently too. All of these services, and the wider range of community assets described throughout this report, need to be planned and delivered in a much more co-ordinated way, with general practice working at scale at their core. This should be underpinned by a shared, system-wide objective to improve population health in communities.

The effective use of data and technology is a critical underpinning feature of the design principles described here, reflected in many of the examples described. This includes the development of shared care records, the intelligent use of data to understand populations and target support, and the innovative use of digital technologies to support the delivery of care in community settings – for example through telehealth and mobile working.

It is common for efforts to deliver more or better care in community settings to focus on individual schemes or interventions. However, the cumulative impact of the design principles will be much greater than any one taken in isolation. The examples described in this section also highlight the benefits of focusing on delivery models rather than structural or organisational levers to bring about change. This contrasts with the approach to community services reform taken in recent decades, which (as described in section 1) has involved repeated structural reorganisation.

Despite the improvements being made in specific areas, progress is far from uniform, and the fragmentation and complexity of services described in sections 2 and 3 of this report still prevail in most systems. In addition, financial pressures in community health services, cuts in spending on social care and public health services and shortages of key staff groups are making it more difficult to provide the care that is needed. In the final section, we consider the challenges standing in the way of progress, and steps that may help to overcome them.

5 Making it happen

The examples given in section 4 illustrate that services in the community are changing but mainly through innovative projects rather than system- or community-wide transformations in care delivery. If these services are to meet the needs of a growing and ageing population, much more concerted action is needed to raise their profile and to realise the ambitions set out in the Forward View (**NHS England et al 2014**) and in sustainability and transformation plans. This calls for leadership at all levels aligned around a common aim of supporting people to live independently in their own homes and communities and reducing reliance on care in hospitals and care homes where appropriate.

There is relevant learning on how to do this from, for example, the Canterbury District Health Board in New Zealand and the Nuka system of care in Alaska, which have begun this journey, as well as from experience in different parts of the NHS in the new care models vanguards programme. There are also lessons to be learnt from the transformation of mental health services that has occurred in the NHS over the past 30 years or more, which has been analysed in previous work by The King's Fund (**Gilburt et al 2014**). Acknowledging the very real challenges in bringing about this transformation and continuing concerns about a lack of investment in mental health services, we now draw on these lessons to explore what needs to be done to strengthen and develop services in the community.

We also draw on lessons from the experience of other NHS change programmes, and particularly the challenge of moving beyond innovative projects to implement change across organisations and larger systems of care in shifting care from hospital to the community (Ham *et al* 2008). This is precisely the challenge now facing the NHS as the vanguards programme approaches the end of its three-year life. Scaling up and spreading changes in care delivery calls for a different kind of leadership than putting in place innovative projects and has been made more difficult by the reforms to the NHS incorporated in the Health and Social Care Act 2012, which have left a vacuum in system leadership.

1 2 3 4 **5**

The long list of policy documents reviewed in section 1 demonstrates that there is no shortage of ideas on what needs to change but these ideas will have little impact unless they go hand in hand with a well-thought-out and credible implementation plan. Such a plan needs to reflect the inherent complexity of health care systems while avoiding being paralysed by this complexity. Leaders at all levels have a role in managing change, adopting a 'constancy of purpose' (to borrow from Deming 1986) that is often lacking in health policy.

Developing a compelling narrative and vision

Bringing about change in public services is never easy and is made more difficult in the absence of a compelling narrative on why change is necessary and the benefits it will deliver. Elements of such a narrative can be found in the Forward View (**NHS England** *et al* **2014**) and in many of the sustainability and transformation plans developed within the NHS as well as being reflected in the 2006 White Paper *Our health, our care, our say* (**Department of Health 2006**). These elements now need to be brought together, communicated consistently at all levels and developed further through widespread stakeholder engagement, as in the international examples of the Nuka system of care and the Canterbury District Health Board. A vision that explains what a better future will look like needs to be at the heart of the narrative, with an emphasis on how people and communities will benefit from improvements in care.

Combining national leadership and local action

Transformation of services in the community must happen at a local level. However, these efforts need to be supported by national and regional leadership, or progress will continue to occur in pockets and will not achieve the widespread change that is required. NHS England and NHS Improvement are the main national bodies able to provide this leadership, both in identifying these services as a priority and in providing the policy guidance and resources needed to translate plans into practice. The most important resources are funding and the workforce, the latter being the more significant given the staff-intensive nature of services in the community and growing concerns about shortages of some key groups of workers. National leadership should not be overly prescriptive to allow flexibility in how new care models are implemented and adapted to avoid innovation at regional and local levels being stifled.

Leading change in a complex system

The transformation of mental health services was enabled by the leadership of regional health authorities. The Health and Social Care Act 2012 abolished the strategic health authorities that were the successors to regional health authorities and has left a vacuum in system leadership. Sustainability and transformation partnerships and the accountable care systems that are emerging from some of these partnerships have the potential to fill this vacuum and there is also a role for partnerships at a more local level. In some areas, health and wellbeing boards are beginning to perform this role while in others, accountable care organisations and partnerships are being established. There are also lessons to be learnt from the implementation of major changes to stroke services in the NHS, which were brought about through a combination of top-down system leadership and bottom-up distributed leadership (**Turner** *et al* **2016**).

Building alliances and partnerships

One of the lessons from the history of reforming NHS community health services is the folly of relying on structural solutions. A more promising alternative is to work towards integration by building alliances within the NHS and with partners in local government and elsewhere. Voluntary and community sector organisations are a key partner and play a central role in many of the examples in the previous section of this report. Building alliances and partnerships with the third sector should therefore be a priority. In building alliances and shared objectives, NHS organisations and their partners can learn from the experience of system leadership in the Canterbury District Health Board in New Zealand and its vision of 'one system, one budget'.

Investing in and changing the workforce

Transforming services in the community is first and foremost about transforming how staff work with each other and with patients and service users. This includes greater flexibility in how different skills and tasks are shared across professional and organisational boundaries, for example through more generalist roles, advanced clinical practice and agreed common skills and competencies. The example of Buurtzorg in the Netherlands is a good illustration, involving community nurses working differently to deliver better outcomes. Other examples include specialists who deliver care in community settings as well as hospitals,

and GPs who have redesigned their work to provide more accessible services in collaboration with other members of the primary care team. Workforce changes need to extend to staff working in related areas of care to make a reality of the broader conceptualisation of community services adopted in this report. This is particularly important for people working in the care sector who are predominantly in low-skilled and low-paid jobs. Urgent attention is also needed to reverse the decline in key workforce groups. The draft NHS workforce strategy contains welcome recognition of this issue (Health Education England 2017) but lacks detail on how it will be addressed. This ambition should now be accompanied by action similar to efforts to increase GP numbers.

Working differently in primary care

The registered list of patients held by general practices is a valuable source of information that has the potential to be the key building block of a new approach to population health management. In previous work, we have argued that practices need to collaborate with each other to deliver care to a growing and ageing population and to be at the heart of efforts to integrate the full range of services provided in the community (Addicott and Ham 2014). This is already happening in many areas through the development of GP federations and networks and the creation of larger partnerships of GPs. The aim should be to build on the very real strengths of practices working individually and collectively, extend the work going on in the vanguards programme and the primary care home projects, and work to a future in which community-oriented primary care becomes a reality.

Engaging clinicians in leading change

Clinical leadership matters because changes in how services are delivered rest on the willingness of the staff providing care to work differently. In professional service organisations, this cannot be mandated by others. More positively, as the recent experience of the new care model vanguards set up following the Forward View has shown, clinicians themselves are often the most important source of innovations. The vanguards programme illustrates how partnerships between clinicians and managers have already begun to transform care in the direction advocated in this report. Releasing the time of clinicians to work in this way and providing them with training and support to redesign care must be at the heart of the implementation plan.

Engaging people and communities

With few exceptions, change programmes in the NHS and other public services have seen people and communities as an afterthought when it comes to planning these services. Not only does this fail to draw on the experience of people and communities in designing new services, it also risks these services conforming to providers' definitions of what people need instead of what service users themselves want. It goes without saying that people and communities need to be involved meaningfully and consistently in work to transform services in the community to avoid the mistakes of the past being repeated. Community engagement has been central to many examples in this report, such as the work in Wigan. Local authorities have greater experience of engaging communities than NHS organisations and their involvement in transforming services in the community is essential.

Putting in place financial models to facilitate change

The vanguards programme was facilitated by funding to support change. The sums involved were not large but they helped to pay for the time that clinicians and managers committed to the development of new care models – for example, by paying for their work to be back-filled – and in some cases to fund the additional staff needed to implement the models. The transformation of mental health services similarly benefited from funding for upfront investment in new services (capital and revenue) in advance of resources being released from the services they eventually replaced. It is not realistic to expect reductions in acute hospital capacity to pay for extra spending on services in the community at a time when hospitals are working under intense pressure, which is why new and earmarked resources will be needed to invest in these services.

Commissioning and contracting differently

Commissioners of care can facilitate large-scale changes in care delivery through the use of alliance contracts, as in the work of Canterbury District Health Board, going well beyond the complex and fragmented approach to the commissioning of NHS community health services described in sections 2 and 3 of this report. Alliance contracts need to include incentives to reward providers for delivering high-quality care instead of relying on crude block contracts, as is typically the case

in the NHS today, and to encompass social care, public health and other services that contribute to population health. Commissioners should give priority to the development of longer-term (5 to 10 years) outcomes-based contracts and the development of new payment systems, such as capitated budgets, that are aligned with these contracts.

Exploiting innovations in technology

The vanguards programme has begun to demonstrate the opportunities offered by innovations in information and communications technologies. This is evident in work under way in Airedale, Morecambe Bay, Sheffield and other areas and is also illustrated in those parts of the NHS that have made progress in working towards shared electronic care records, which are a fundamental building block of the integrated care systems needed in the future. Technology can also play a part in the delivery of new care models, for example by exploiting digital innovations to support staff and patients in providing care more effectively and efficiently.

Developing quality improvement skills

Improving performance in health services and transforming care on a sustainable basis depends in part on building capabilities for quality improvement among the staff delivering care. This has been demonstrated in the experience of high-performing NHS trusts and in national change programmes going back over a decade (**Ham** *et al* **2016**). Much of the expertise in quality improvement currently sits in NHS trusts that have identified improvement work as a priority and in agencies such as the Advancing Quality Alliance in the north west of England. A concerted effort is now needed to build on and extend these initiatives to community services as part of a national and local commitment to reforming and improving the NHS from within (**Ham 2014**).

Getting the basics right

A previous study of NHS efforts to shift care from hospitals to the community found that initiatives that had dedicated and experienced project managers in place and staff who were released from other commitments to focus on these efforts were more effective than initiatives that did not (Ham *et al* 2008). More successful initiatives also demonstrated superior capacity to engage with stakeholders and

to measure and monitor progress for the work they were engaged in. Drawing on these and other characteristics, the study highlighted the need to get the basics right in change programmes and converting visions into action.

Evaluating and learning about change

Major change programmes in complex systems are never linear. Not only do new demands arise during implementation, but unexpected challenges also occur. For these reasons, there needs to be flexibility in bringing about change and a willingness to evaluate what is happening and adapt in the light of experience. Of particular importance are practical evaluations carried out in real time that feed back directly to the leaders of change programmes on what is working and how improvements might be made. These evaluations, conceived and designed as a form of action research, can also support leaders in learning from each other as they implement changes through 'communities of practice' and other means.

Allowing time for change to become embedded

The transformation of mental health services in the NHS happened gradually over a period of 30 years, while the system-wide changes in Canterbury District Health Board in New Zealand have been under way for a decade or more. There needs to be realism about the time needed to transform services in the community and to achieve greater alignment with related services such as general practice, mental health, acute services and social care. This underscores the importance of the 'constancy of purpose' among those leading change and a willingness to stay the course even in the face of setbacks and disappointments. Had this happened in the years that have elapsed since the publication of *Our health, our care, our say* in 2006 (**Department of Health 2006**), a White Paper that reads as well today as when it was written, the transformation of community services might have progressed much further than has been the case.

Working with complexity

Different areas of the NHS are starting from different places, both in their readiness to transform services and in the leadership available to do so. The actions outlined here therefore need to be used and adapted to reflect different contexts and starting points. Leading large-scale change requires exceptional leadership able to embrace complexity and to avoid change management being seen as a cookbook exercise. Change will often be emergent rather than planned and will require leaders to cope with ambiguity and uncertainty most of the time (Timmins 2015). Not only is large-scale change in health care organisations inherently difficult and often takes longer than expected (Ham *et al* 2003; McNulty and Ferlie 2002), but also it is the interaction of several factors over time that explains the outcome of change programmes (Walston and Kimberley 1997).

Next steps

Transforming services in the community will require a commitment over many years, but where to start?

The balance of funding between hospital and community services should be tilted towards community services in the medium term.

The pressures facing acute hospitals mean that it is not credible to plan to release resources from hospitals to invest in services in the community. Priority should therefore be given to favouring community services in the allocation of additional funding for the NHS. Over time, this will increase the share of the budget spent on community services while not destabilising services provided in hospitals, along the lines achieved in Clalit Health Services in Israel. The immediate challenge is how to do so when NHS funding will be constrained for the foreseeable future.

The most promising possibilities in the short term are through sustainability and transformation partnerships, accountable care systems, and accountable care organisations and partnerships, where plans have already been developed to strengthen community services and improve population health.

STPs got off to a difficult start because of limited engagement with stakeholders and a lack of transparency in how plans were produced. Despite this, the emphasis

on collaboration and working in partnership that lies behind STPs and ACSs offers the best hope for the NHS and its partners to transform services. The rapidly growing interest in accountable care organisations and partnerships throughout England is an indication that system working is being taken seriously and the priority should be to go with the grain of these developments.

Sustainability and transformation partnerships should revisit their plans to ensure that they are credible and will bring about the improvements in care needed in the future.

Our analysis of STPs showed that they were often strong on aspirations but lacked detail on how these aspirations would be delivered. Some plans also made unrealistic assumptions about the potential to reduce hospital use in order to invest in services in the community. More work is now needed to ensure that all STPs offer a credible basis for improving care for their populations and strengthening services in the community, drawing on the 10 design principles set out in this report.

Every sustainability and transformation partnership or accountable care system should identify leaders to take forward their plans for services in the community and identify dedicated management support drawn from partner organisations.

Innovations developed in the new care models programme and the primary care home projects offer a glimpse of the future. Leadership of these innovations has come from different sources, including general practice, NHS managers and local government. It is vital that progress is sustained beyond the end of the pilot phase and that learning is extended to other areas and scaled up. Clinical leaders need to work with the support of experienced managers and in collaboration with community leaders in this endeavour.

Whole-system transformation must be underpinned by the deep engagement of staff and communities to harness their commitment to change.

Learning from experience in other systems, leaders need to give priority to engaging staff and communities in transforming services. This is a strong message from both the Canterbury District Health Board in New Zealand and the Nuka

system of care in Alaska, where leaders adopted an inclusive approach that involved many hundreds of people in different roles and created a social movement for change. The Big Health and Social Care Conversation that has started in Salford is an example of how similar approaches are being used in England.

National bodies should publish a plan for the future of services in the community, akin to the *General practice forward view* (NHS England 2016a), setting out a compelling vision for the future and the resources that will be provided to make a reality of this vision.

The plan should adopt the broader definition of community services used in this report and acknowledge the contribution of different sectors and assets in transforming services. It should outline a compelling vision and narrative that can be used and adapted throughout England. There should be an honest assessment of what funding and staffing are needed as budgets are likely to be constrained for the foreseeable future.

The national plan should capture and codify the different models of care that have emerged across England and establish a team to support implementation.

The aim should not be to put in place a single model everywhere but to provide information, advice and support about the menu of options available. A team of experienced leaders should be appointed to oversee the implementation of the plan at a national level, drawn from different sectors and including people from the third sector and from organisations representing carers and families. The team should be agents and ambassadors of improvement and provide the national leadership that is currently lacking.

Core elements of care should be defined, standardised and delivered consistently.

Where there is evidence to support particular care processes – for example what services people should have access to, how they access the services, how quickly they should expect to receive them and how information is shared – then these elements should be standardised and delivered consistently in all areas. This includes standardisation around transitions of care, for example from hospital to the community, drawing on current best practice.

National bodies should work with local leaders to align the regulation, commissioning and funding of health and social care with the changes that are needed.

This includes building on work by the Care Quality Commission to develop a place-based approach to assessing the quality of care and by NHS England and NHS Improvement to bring their work together. It also means accelerating the development of joint commissioning between the NHS and local authorities, the use of innovative, longer-term contracts that support ambitions to improve population health, and new payment systems such as capitated budgets.

Work to join up information systems should be given priority in view of the importance of shared electronic care records in enabling more care to be delivered in the community.

Much more needs to be done to extend information sharing throughout England, building on areas where this is already happening. More work is also needed to collect and make use of data about community services, akin to how data is used for some other services.

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The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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                    health care

Growing financial and workforce pressures are having an impact on the
ability of community service providers to meet the needs of the population
and to make a reality of the vision set out in the *NHS five year forward view*.

Reimagining community services: making the most of our assets explains the
current situation of community health services and explores how the health
and care system needs to change to meet the needs of the populations
now and in the future.

The report proposes 10 design principles to inform future planning and
provision of care.

- Organise and co-ordinate care around people's needs
- Understand and respond to people's physical health, mental health and
  social needs in the round
- Make the best use of all the community's assets to deliver care to meet
  local needs
- Enable professionals to work together across boundaries
- Build in access to specialist advice and support
- Focus on improving population health and wellbeing
- Empower people to take control of their own health and care
- Design delivery models to support and strengthen relational aspects
  of care
- Involve families, carers and communities in planning and delivering care
- Make community-based care the central focus of the system

There is a vast amount of innovative work going on across the NHS and
beyond to improve community-based care. But this is mainly happening
through innovative projects rather than system-wide transformations in
care delivery.

A radical transformation of community services is needed, making use of
all the assets in each local community wherever these are to be found,
and breaking down silos between services and reducing fragmentation in
service delivery.