PROVIDER VOICES

COMMUNITY SERVICES: OUR TIME

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NHS Providers

A unified voice for NHS community services

The Community Network is the national voice for NHS community services in England. Established by NHS Providers and NHS Confederation, the network brings together and represents NHS and not-for-profit organisations providing NHS community health services.

Community NETWORK

The network is making the case for community services to play a leading role in the development of integrated systems, and for sufficient funding and national emphasis for community services to support the sector to deliver the ambitions of the NHS long term plan. It also promotes the link between community services and the rest of the health and care system, including primary care and social care services.

PROVIDER VOICES

Welcome to the fourth report in our *Provider voices* series, in which we highlight the views of senior leaders on the key issues facing the NHS today. We hope the series will make a valuable contribution to discussions on how health and care services can respond to challenges ahead and how the NHS can implement its new long term plan effectively.

Our topic in this publication is *Community services: Our time*. The NHS long term plan puts community services, along with primary care, at the heart of its ambition to ensure patients receive care closer to home, to place greater emphasis on prevention and to deliver genuinely integrated care. So, the question of whether community services will receive the national focus they deserve has never been more relevant.

We have interviewed 10 leaders from across the health and care sector with representatives from acute, mental health, ambulance and community trusts alongside national commentators, and voices from social care, primary care and integrated care systems to explore the opportunities and risks presented by this transformation.

National NHS leaders have often promised to give greater emphasis to community services, making them more central and allocating greater investment. Will this now happen? As our interviewees set out, there is optimism amongst frontline leaders. However, there are some big challenges to address too: securing the right workforce, adapting to new technologies and ways of working, and changing national perceptions of how patients best access services and are supported closer to home.

We are grateful to the leaders who took the time to contribute to this publication. And we would like to thank Helen Crump for carrying out the interviews.

Chris Hopson

Chris Hopson
Chief Executive, NHS Providers

PROVIDER VOICES

COMMUNITY SERVICES: OUR TIME

For years an under-valued part of the NHS, community services are finally set to have their turn in the spotlight.

The NHS long term plan, published in January of this year, puts the sector at the forefront of the health service's drive to deliver truly integrated care. For the first time, community services, along with primary care, will receive a greater than average funding increase. This comes with the expectation they will lead a reimagining of community-based urgent care, working alongside GPs, with whom they will be forging new working relationships via primary care networks (PCNs).

Raising the profile of the sector

Despite longstanding commitments to community services, the sector has had to develop its profile at a national policy level.

This may in part be due to a lack of data captured at a national level compared to other parts of the NHS. For example, a reliance on block contracting approaches within the community services sector has meant there has been less of an imperative to capture activity data than parts of the NHS where payment by results is in use. This has, in turn, led to a national policy and public focus on services with clear data on which performance against national targets can be measured – essentially, the services that can often grab media headlines.

Unlike the acute and primary care sectors, community services do not tend to have a clear physical presence locally that resonates with the public, like a hospital or an ambulance fleet. Instead, services are usually provided in community hubs and within the homes of patients, by a mobile workforce.

The combination of these issues, and the lack of a national figurehead for community services, means there is less awareness of how community providers operate at the national policy level.

In spite of this, community services have a distinct culture and identity, with flat operating structures and an often forward-thinking approach to focusing care around the needs of the patient. As Andrew Burnell, chief executive of City Health Care Partnership in Hull and a former community nurse, explains, "*you come at it from a different angle. Get rid of hierarchy, get rid of yes sir no sir – it's more about tenacity. Your value is your people – if you forget they're your most important asset, you're doomed*".

Rob Webster is chief executive of South West Yorkshire Partnership NHS Foundation Trust, which provides both community and mental health services. He is also the integrated care system (ICS) lead for the West Yorkshire and Harrogate Health and Care Partnership. Rob highlights the complexity of the community sector patient base – which prefigures the demographic trend across the wider NHS: "*Most of the people we look*

after have got one or more long term conditions, of which they'll never be cured. Being older or having a special educational need or having chronic obstructive pulmonary disease, asthma, diabetes, dementia, means we're going to be a partner in your care for the rest of your life. That means we start with the person and we deliver a team around the person".

A sense of optimism

All of the leaders interviewed for this publication expressed a sense of optimism about the community sector in light of the NHS long term plan's recommendations. As Siobhan Melia, chief executive of Sussex Community NHS Foundation Trust, puts it: "*It feels as though we are at a really exciting juncture for community services and it feels quite motivating to know that services that make a real impact across the systems that they work in are receiving national focus and having some policy and investment decisions specifically targeted at them*".

Alongside this enthusiasm for recognition of the sector in the long term plan, there is a sense that community providers have already built up significant momentum in moving towards the types of approach that the plan sets out. Robert Harrison, chief operating officer of Harrogate and District NHS Foundation Trust says: "*The NHS long term plan backs up the direction we've been heading in ourselves – to work together across primary, social and community care in developing an ethos of prevention being better than cure, and to develop services that promote independence and support people throughout their life, including end of life*".

There is a sense that community providers have already built up significant momentum in moving towards the types of approach that the plan sets out.

Workforce challenges

The widespread workforce challenges evident throughout the NHS are all too familiar to those leading community services.

In recent years, community providers have been forging closer relationships with primary care services in particular via locality-based approaches. These approaches see community services partnering with groups of GPs to offer more closely integrated provision, with community staff such as district nurses working out of GP surgeries.

These interrelationships between community services and primary care will become even more important as new PCNs are rolled out across the country – one of the most significant demands of the NHS long term plan. In order to mitigate the risk that PCNs might duplicate activity already underway via locality teams and existing collaborative models of provision, there is an emerging consensus in both primary and community care that PCNs must be designed and implemented in a joined-up, collaborative way taking account of what is already in place and working well.

Royal College of GPs chair Professor Helen Stokes-Lampard says: "*Primary care networks are a complement to community services. The whole point of this is to help us to work better to provide services for our patients. We could find we're going to focus on particularly frail patients with a wraparound service focusing on a lot of the touch points they have with the service, making sure we're all communicating, and then do more preventative work for them. There are plenty of really good exemplars of how that works. If PCNs end up in competition with community services, that would be a complete waste and a failure of the system*".

The need to ensure that community services and primary care can work in a harmonious way under PCN arrangements is one of the most pressing challenges facing the sector. Twenty thousand new community staff are to be recruited by PCNs under NHS long term plan proposals, and the existing community workforce skews towards older staff. Unless care is taken, there is a risk that community providers and expanded primary care teams could find themselves competing for the same staff, which might destabilise some aspects of provision.

Siobhan Melia points to the need to ensure that workforce decisions are joined up at PCN level: "*While the development of primary care networks is a massive opportunity for the community sector, it's also a risk in that if implementation of the networks is focused on money going directly to GP practices to choose how to expand the workforce, that could cause further fragmentation and some movement of staff from the community sector towards primary care. I would hope we will be able to ensure that we build new integrated workforce models that are resilient and don't encourage a drift of clinical staff one way or another*".

Faced with this workforce challenge, some community providers have adopted creative approaches to expand the pool of staff available to them. Northamptonshire Healthcare NHS Foundation Trust has started to use apprenticeships as a route to attract new people into the sector, as chief executive Angela Hillery explains: "*Apprenticeship can give us an opportunity to encourage people to come into the NHS through community services, to get a foot in the door, to get a taste of what the NHS has to offer, whether through therapy apprenticeships, research apprenticeships, or whatever*".

Driving integration forward

A further characteristic of both locality approaches and the PCN model is the emphasis on working effectively across sectoral boundaries. The community workforce tends to be highly aware of the role of other providers in caring for patients and service users. Often, people accessing community services have multiple conditions and receive social care support. When services are provided in patients' homes, community nurses and therapists can find themselves visiting alongside professionals employed by other organisations both within and outside of the NHS.

Rob Webster explains: "*Community services are increasingly part of an integrated neighbourhood team. That team includes social workers, community nurses, occupational therapists, speech and language therapists, social care staff and GPs, all with a tailored offer which involves the patient and their carers as partners in delivery. That's a very different ethos from what we've had in the past. I think across the whole country people are embracing joined up teams across sectors in the neighbourhood*".

Association of Directors of Adult Social Services president Glen Garrod supports this view, pointing to three "*big gains*" to be had from "*respectful, trusting and coherent*" relationships between health and social care – these are a more coherent service for patients, more effective matching of supply and demand and a more financially efficient service.

However, the potential benefits of a more integrated service offer stretch beyond the relationship between community services and social care. Another major component of the long term plan is a move to expand the scale and coverage of urgent care provision out of hospital. A multidisciplinary clinical assessment service is planned, which will bring together ambulance services, NHS 111 and GP out-of-hours services, but also crucially provide access to community health crisis response services. This will be complemented by quicker access to reablement support in the community.

South Central Ambulance Service chief executive Will Hancock is clear in highlighting the wide variation in the types and nature of community services he sees across his patch, but also recognises the benefit for his own sector in improving access to community-based urgent care: "*We're trying to build a more inclusive offer quickly, which is why our relationship with the community services and out of hospital providers is so important. One of the big areas we're interested in is integrated urgent care and working collaboratively with all out-of-hospital providers to populate a directory of services*".

Policy commentator and former government advisor Paul Corrigan CBE shares this view that the sector's future lies, at least in part, in providing services at the urgent end of the care spectrum, supporting people with significant levels of illness to stay in their own homes. He characterises this as providing a "*place of safety*" in the home for ill patients but warns there is a learning task for community staff to be able to operate in this way: "*The staff that we've got that are doing community services at present are staff that are good at domiciliary care, and are not used to providing a place of safety. Even in residential care, people are being taken to hospital because the staff don't feel they can create a place of safety*".

Looking to the future

As the NHS as a whole begins to grasp the opportunities presented by technology and digital innovation, it is evident that some community providers have been quietly forging ahead in this field. The home-based nature of community provision lends itself to mobile technology and many providers have been adopting technology that enables their staff to view and update records remotely from patients' homes, hot-desk in different office locations, and even begin to provide care using telehealth.

At Andrew Burnell's organisation, which is a social enterprise, staff have embraced an even wider range of technological opportunities. He explains: "*We're all on mobile working and we'll be using logistics management for community nurses very shortly. We're looking at how we develop our own app with others and we've got conversations with other providers around further digitisation of communities. We've just won an award with Amazon and our local university, developing a system to go into care homes around assistive technology using Raspberry Pi and an Alexa. It will probably cost around £50, but it's extremely interesting in terms of what it can and can't do*".

Combining digital innovation with remote working can open up opportunities to achieve greater efficiency by enabling frontline staff to spend more time engaged in clinical activities. Here, community providers can learn from the experience of ambulance services, which are further along in their journey to implement remote working.

Will Hancock describes how in an attempt to optimise the efficiency of the deployment of their staff, ambulance services tested working patterns that had unintended negative consequences for staff: "*We were driving a model which increasingly pushed a relatively unsustainable pattern of rotas into the working life – shorter rotas and then longer rotas and staggered rotas to match the peaks and troughs of demand and iron out underutilisation. Then we'd also asked staff to operate as lone workers as a part of their role. We've spent the last couple of years rowing back from that, because we've seen a huge exodus of staff and a lot of issues in terms of wellbeing, resilience and sickness rates. I think we're in a better place now and a lot of work is going on around trying to improve the lot of ambulance staff*".

As the sector looks to the future, another major challenge which is being addressed is the shortfall of data and evidence for the different approaches used in community services. Through efforts such as the work under the Carter review programme on addressing unwarranted variation in community services, and the creation of new nationally collected community services

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datasets, the range and quality of information about community services is set to improve.

Community Network chair Matthew Winn says over the next decade he wants to see the sector moving to a position where there is absolute clarity around the evidence base and outcome measures in use for the services community providers offer, and that this information should be provided with "*the same rigour, science, intent and specificity as you'd expect in a hip operation, cataract surgery or a surgical intervention for a stroke*".

He goes on to add: "*We need to take out the variability that is unwarranted and shouldn't be there. People have created barriers and mini-empires that need to be changed. We shouldn't have a single provider setting criteria that stops people coming in to community rehabilitation beds, meaning those beds are empty, while hospitals are stacked to the gunnels with people who could really benefit from a rehabilitation bed-based programme. That still happens and is unacceptable*".

Our time

Community services are now benefitting from a level of national policy focus not experienced in the last decade. This includes an emphasis on driving forward technological innovation that plays to the strengths of the sector and a renewed drive to integrate services with community provision at its heart. Alongside this is a sense that gaps in national, comparable performance data that have been tolerated in the past will no longer be accepted either by the sector or by its partners and commissioners.

Taken together, it is clear that the ingredients are in place for a step change in how the community sector both views itself and presents itself to the world. Community providers are tasked with implementing new approaches effectively and at a fast pace while responding to considerable challenges including a serious workforce shortage. Nevertheless, the advent of the NHS long term plan, combined with a renewed dynamism in the sector, means the sector is well placed to deliver on these increased expectations. As Paul Corrigan says: "*We've got a crisis which isn't just a crisis for the NHS – it's a crisis for older people. We have people losing their independence sooner than they should, because the only way in which we deal with this is via hospital*". The NHS long term plan acknowledges the scale of the crisis – the task is now for these forward-looking community services providers to work with their partners to resolve it.

Amber Jabbal
Head of Policy, NHS Providers

With thanks to Helen Crump, Director, Cogency Analysis & Research for additional research and input

THE INTERVIEWS

MATTHEW WINN

Chair
COMMUNITY NETWORK

Matthew Winn is the chief executive of Cambridgeshire Community Services NHS Trust. Previously, he worked in London in roles in acute care, local government and primary care trusts. Nationally, he is chair of the Community Network and a board member of NHS Employers policy board and sits on the National Social Partnership Forum.

It's easy to ignore community services because they are ostensibly delivered in people's homes behind closed doors. The people affected by them are not the most visible, unlike the photographs you see of people sitting in trolleys in an A&E corridor. National leaders have been slow to understand that this is a sector that can be of great benefit in providing solutions to the pressure the NHS is under, but it needs resources.

Providing care with rigour, science and specificity

The long term plan is good news for the sector but still doesn't help develop the model of care delivered at home – whether that's integrated around adults, frail older people or children with complex needs. It doesn't get onto the territory of really driving new models forward, especially around health and care.

What is called community services in one area of the country can differ from other areas because of history and investment. In 10 years' time, I'd like us to be absolutely clear on the evidence base, the data, the outcome measures that we are driving for the 10% and growing proportion of the NHS pot of funding that we have access to. To be able to describe how we help people to age healthily, how we give people a great start in life and help people live with incidents in their lives and with long-term conditions, and that all of that has the same rigour, science, intent and specificity as you'd expect in a hip operation, cataract surgery or a surgical intervention for a stroke.

We need to take out the variability that is unwarranted and shouldn't be there. People have created barriers and mini-empires that need to be changed. We shouldn't have a single provider setting criteria that stops people coming in to community rehabilitation beds, meaning those beds are empty, while hospitals are stacked to the gunnels with people who could really benefit from a rehabilitation bed-based programme. That still happens and is unacceptable. In some areas, they don't have these beds at all and it's all done at home anyway. That variability needs to come out.

While clinical commissioning groups (CCGs) still have a role in saying how money should be spent, there should be a core offer, so that across the country there is one NHS approach and then there are variations according to the needs of local populations. We need identifiable clinical national leaders that will champion this, in the way that some of the progress that started in London on stroke care has now spread across the country.

Using data to improve children's care and address the wider determinants of health

There has to be an improved and more targeted approach for children and early years across health and care. That's children centres, early health work from councils and nursery provision. We need to coordinate our approach around families, especially around healthy eating and diet, to avoid greater obesity and to support school readiness. We've had a siloed set of initiatives around early years support, very much focused around the healthy child programme. It's not enacted in that integrated way that says "let's use all our resources to really drive improvement in a targeted way".

We're beginning to see increasing use of data in older people's care, triangulated across acute primary care and community and sometimes further afield in social care and mental health, but we're not seeing that in children's services at all. We really want to improve – some more predictive modelling of how we support children and family units in getting a better start in life is key.

It's not segmenting people into an approach where you only pursue one set of interventions, but it is about allowing us to know what's going on with local communities. We know the risk of adverse incidents creating problems for mental health later in life is massive. Taking what we know about risk factors, there is a much broader set of data around housing, domestic violence, poverty levels and using universal credit. All of these are potential alarm bells or issues, but if we don't collect them together, we won't get a composite view of how we support families, other than through door knocking.

We need to take out the variability that is unwarranted and shouldn't be there. People have created barriers and mini-empires that need to be changed.

Prevention and wider determinants

There is a need for NHS organisations to take on a greater role in addressing prevention, wider determinants of health and public health, but often the focus is on the role of acute care. This is an area where there is untapped potential for community services.

There is a statutory healthy child programme that requires every child in every part of England to be seen a set amount of times pre-birth and post birth up until age five. My problem with describing it as a public health thing is it immediately pigeonholes it as a fluffy intervention. None of this is fluffy – all of this is really essential in preventing things from happening later on. Councils can't afford to give universal children's provision and a lot of families don't need universal blanket support, but we do need to be targeting those who do need it.

There are five to six key issues that evidence shows are always prevalent when it comes down to safeguarding issues. They are risk factors that every single children's clinician will be looking out for – for example drugs, alcohol and domestic violence. Community health care organisations are front and centre here because they do so much work with councils' children's services to improve children's outcomes and get them ready for school. It's not classic 'prevention' – this is hard edged action to drive improvements and take out some of the health inequalities that we've got. You could quite easily argue that is also true of comorbidity in adulthood and frailty as well.

Process data is probably not the way to go in the community sector. We do need to be talking about impacts on patients and getting into a level of detail about what's appropriate for different groups. What you'd count as appropriate for a child with autism would be vastly different for a child who is just receiving universal children's support and doesn't need any specialist intervention. It is about dicing and slicing according to what's appropriate.

Opportunities for the future

The NHS long term plan described the framework and the strategy for delivering care in vastly different and improved ways and had some investment attached to it. The sector needs to respond to that and say "our role is to make it happen". We need some national leadership, focus and a national approach without being over-prescriptive. Chapter one of the plan, though, absolutely put community healthcare with primary and social care at the forefront of being the strategic change that will help the NHS to be sustainable. As long as we keep the focus on that, spend the money wisely and remember this is the start of an investment cycle, and there can be further rebalancing when the sector proves itself on data, the ground work is there and done.

I hope the Community Network will continue to agitate, to lobby and push for all the things I've been describing. Where there are gaps in national leadership, the strategy, the involvement of the royal colleges, the role of network is to be a single unified voice for sector.

There is a need for NHS organisations to take on a greater role in addressing prevention, wider determinants of health and public health, but often the focus is on the role of acute care.

SIOBHAN MELIA

Chief Executive
SUSSEX COMMUNITY NHS FOUNDATION TRUST

Siobhan has held several clinical leadership roles in the NHS. Before becoming chief executive at Sussex Community NHS Foundation Trust in September 2016, Siobhan held senior management and board positions in another community health provider was the head of the telehealth division in Telefonica UK.

The long term plan is a call to action to deliver more joined up and integrated services, predominantly in conjunction with primary care. That's absolutely the right thing to be doing – in Sussex we've been organising ourselves with a focus on integrated networks of community and primary care services focusing on populations of 30-50,000 for the last three or four years.

It feels as though we are at a really exciting juncture for community services and it feels quite motivating to know that services that make a real impact across the systems that they work in are receiving national focus and having some policy and investment decisions specifically targeted at them.

A need for realism and investment

The aspiration in the plan is around dissolving historic divides in order to join up care. The divides are not there because people have built them, they are from custom and practice. Although the plan represents a call for us to do things differently, to join up care and to be more responsive will require a degree of realism and a degree of investment.

Realism is needed around the timeframe to change some of the service models and investment is necessary to expand capacity and capability in out-of-hospital care models. We've faced growing demand with an ageing population. There will come a point where the capacity is saturated in a workforce that is already pushed to do more for less every year.

The targets in the long term plan don't feel particularly realistic at the moment because of the absence of any clarity about investment. While the sector is focusing on 2019/20 as a transition and rebalancing year around the money, I would welcome some firmer commitments beyond this next year.

The plan talks about several big priority areas. There needs to be either a minimum investment standard in some of these community services, or at least, as alluded to in the plan, a clarified ringfence or an amount of money that is available for the next three years, targeted specifically at two to three headline areas of community service delivery. What needs to happen is first and foremost a commitment to investment in particular areas of community services, clarity over the timeframes and realism that some of this will take a good two-to-three years to sustain and embed because of the workforce challenges.

Tackling unwarranted variation

We've been left with huge degrees of variation based on historical commissioning patterns and, across the sector, service delivery models are very different. The poor standard of data systems and standardisation of data at national level is without doubt a risk. The lack of a national tariff has created gaps in the quality and the accessibility of data and business intelligence in the community sector.

There needs to be a better national narrative about data in the community sector. There's a minimum dataset, and NHS Digital has done some work, but it still doesn't seem clear to me that at national level we can articulate either the value of the community sector or the variance within it.

The targets in the long term plan don't feel particularly realistic at the moment because of the absence of any clarity about investment.

It would be good to have a small handful of national metrics that are counted in the same way and mean the same thing. We all know an A&E target is an A&E target, an 18-week pathway is an 18-week pathway. Similarly, there need to be a handful of high-profile standardised metrics that give us the ability to discuss, compare and improve facets of community services.

Dealing with workforce challenges

The other headline risk is around workforce availability. There is a challenge around the supply of clinical staff into the NHS full stop, but the demographic profile in district nursing and community nursing errs much more towards retirement age, which is a well-documented challenge for us.

I don't think that risk is unsurmountable as long as we get sufficient headroom and a timeline to plan and put actions in train now. If we can promote the breadth and complexity of our services, that should start to attract new graduates into the community as their first or second place of work rather than what was traditionally seen as something you went into later in your career.

We've been able to create some rotational posts for new graduates so they get that breadth of experience quickly. As we're a large organisation, it's not that difficult for us to support someone with some early career rotations so they can get a feel for the breadth and complexity. Within our community-based services, we've been able to support nurses in experiencing older people's care on a ward, urgent care at a minor injuries unit, home-based care through the community nursing team, and responsive services.

While the development of PCNs is a massive opportunity for the community sector, it's also a risk in that if implementation of the networks is focused on money going directly to GP practices to choose how to expand the workforce, that could cause further fragmentation and some movement of staff from the community sector towards primary care. I would hope we will be able to ensure that we build new integrated workforce models that are resilient and don't encourage a drift of clinical staff one way or another.

Challenges and benefits of being a standalone community trust

Being a standalone community provider gives you an absolute focus on the types of governance and quality assurance that you need when a significant percentage of your day-to-day care model is delivered in patients' own homes. That enables us to expand and care for patients with increased levels of complexity and acuity and deliver more care outside hospital. There's a huge degree of clinical, psychological and emotional complexity involved in the care delivery that our teams are undertaking.

Increasingly, the vast majority of the partnership working is interfacing with primary care and the local authority, either with children's social services or adult social care. We work quite extensively in partnership with the local authority at both ends of the age spectrum. We have absolute focus on that partnership agenda, whether it's children's safeguarding or joining-up care packages for older people through adult social care teams, staff in a standalone community trust have to work much more in partnership across organisational boundaries every day. There are very few teams I can think of where who can undertake their clinical day job in isolation – that does bring something very unique around the culture, the understanding of the way of working and the focus on partnerships. As a standalone, all of the standard key performance metrics that we are delivering and that we are monitored on are focused on that community-based service model.

The reality on the ground for us is that primary care partnerships and health and social care partnerships coming together are what matters to join care up for the patients on our caseloads. We've got some good models of community and voluntary sector partnerships and a big volunteer workforce – joining-up care across organisational boundaries is absolutely what's right for patients, but I don't see any evidence that trusts that are integrated are more able to do that. Metrics like 'super-stranded' patients, delayed transfers of care and ambulance handovers would be vastly improved in those organisations if the reality on the ground was one that supported that theory, and I just don't see it.

A sector with diverse models of provision

Variation in the models of community provider is simply a fact of life. I'm not sure there is any value in trying to rectify something that happened a number of years ago in terms of standardisation of the delivery footprint. I would encourage the arm's-length bodies to focus on what makes a difference to patients and not organisational structures. It does feel as though conversations over the last couple of years, and certainly the long term plan, are focused much more towards joining up care for patients in a variety of ways rather than organisational change. I'm not sure that moving the deckchairs around again in terms of organisational form is going to help us help patients or build more resilience in out-of-hospital services.

There's quite a lot that could be done at national level that would improve all aspects of community services, irrespective of whether it's provided by a social enterprise, a standalone or an integrated trust. I don't necessarily think that the organisational infrastructure needs to get in the way of progress. If the national ambition in the plan can be translated into a blueprint for success and commissioned using a system approach, then the organisational type shouldn't really get in the way.

There is a challenge around the supply of clinical staff into the NHS full stop, but the demographic profile in district nursing and community nursing errs much more towards retirement age, which is a well-documented challenge for us.

GLEN GARROD

President
ASSOCIATION OF DIRECTORS OF ADULT SOCIAL SERVICES

Glen became the president of ADASS in April 2018. He has worked in or researched the public sector for 36 years. He joined Lincolnshire County Council in March 2012. His role was expanded to include public health in October 2016 when he became the executive director of Adult Care and Community Wellbeing.

Increasingly, parts of the NHS are recognising the value of integration with local government, driven by a number of factors which were most recently given voice in the NHS long term plan. There is (or should be) a great deal of common purpose between primary and community health services and local government around personalisation, digital, technology and mental health, learning disabilities and helping people out of inpatient facilities. The NHS has got funding to support that, but it's desperately needed in social care. The ambitions in the long term plan run the risk of being undermined by the lack of funding in social care and local government in general.

Maximising the value of closer working

If a group of system leaders in health and social care and a wider council develop a relationship which is respectful, trusting and coherent in terms of what we want to achieve for our populations, then one is far more likely to evolve quicker and more consistently than other areas who don't have that quality of relationship.

There are three big gains to be had. The first is that people in these areas get a more coherent response from public services. This is a better reflection of the kind of people that we are increasingly supporting, who have both health and care needs – a common endeavour that better reflects people's lives, wishes and ambitions and the complexity of their own worlds, rather than the complexity of organisational structures. Related to this, the rejuvenation of personalisation, notably in the NHS but also in social care, has been quite powerful. Personalisation is all about working with the focus on the individual, working around that individual so that they get a single unifying experience of care.

The second gain is that we've all got budget pressures – we've all got a really difficult job in balancing supply with demand and better meeting of expectations. We are more likely to cope with that if we are working well together and supporting each other.

The third element is the likelihood that better collaborative working will make better use of the scarce public pound. It's not about making massive savings through integration – I'm not convinced that's true. There's an increasing recognition that if we want to address the pressure on hospitals, we have to spend some money in the community and GPs, clinical colleagues, community health, primary care, and social services.

The mixed impact of national policy

In social care, the better care fund (BCF) was more significant than the *Five year forward view* and sustainability and transformation plans. The early documentation around sustainability and transformation plans said nothing about health and wellbeing boards or local councils and was

pretty thin on prevention. This was – it seems – more about a fragmented NHS getting its act together. The NHS long term plan is also about the NHS being less fragmented than it currently is. It isn't necessarily as focused upon integration with local government.

Before the BCF came in, we had a few local systems, local government, the NHS, coming together, working well at local system level, making a difference and improving services because they were able to work collaboratively. Then, along came the BCF and at roughly the same time we had the Greater Manchester devolution experiment about place-based practices in health and care, which was terribly exciting. There were a number of influences increasingly giving localities an opportunity to shape how things were working to the benefit of local populations. As we start to increasingly talk about ICSs, it's the language of ICSs that has got more resonance in the context of local government.

Is national policy supporting those local interactions sufficiently well at the moment? I'd have to say no. If we ask the question *"can we have coherent and cogent national policy drivers to effect change in local areas?"* that's not an easy ask of government for a number of reasons.

To meet people's needs better in the future cuts across several government departments. It seems they do not all have the same agendas, despite what the rhetoric may say.

To meet people's needs better in the future cuts across several government departments. It seems they do not all have the same agendas, despite what the rhetoric may say. It's a tall ask of any government to pull all these strands together and achieve something that no previous government has, and I must admit I am not confident that we will get that any time soon.

Local government is in its ninth year of austerity and despite some of the rhetoric that austerity is coming to an end the money just isn't there to support people as they need to be supported. I can understand why austerity had a place in national policy, but the government has taken austerity too far. There is no transformation funding in local government and asking local government to invest in a new way of working with the NHS at a time when a lot of councils are struggling to balance their budgets is not an easy place for many councils to go. Despite that, many are.

The need for holistic models of care

Nearly all systems in the country are pursuing integration at one level or another. Localities are beginning to find common purpose amongst system leaders. There's also been a lot of interest in how other countries are responding to local need, given rising cost and complexity. You can

go to New Zealand, Germany, Scandinavian countries, Canada, all sorts of countries, and there's been lots of interest and exchange of ideas about how to configure public services to better meet local population needs.

Because local population needs are becoming more complicated, they are cutting across more areas of government such as housing, social care, health and benefits. We can't see people in 'bits' any more – where one agency will treat that bit of someone's life, and someone else will deal with another. We can't afford such high levels of fragmentation and it's a pretty poor customer experience.

You only have to look at the way non-elective admission rates to A&E and non-elective rates are going up while delayed transfers of care (DTOC) are coming down. The money and resources to address the DTOC priority is coming from the community services, so one ends up with long waiting lists for assessments in the community, unmet need, carers having to take more of a caring burden and people inappropriately placed in residential settings who could have gone home if we hadn't been pushed to just get people out of hospital. It's just absolutely the wrong thing to pursue and it has been pursued in isolation, which is just such limited thinking.

Care staff working in social care, who are by far and away the biggest number in the whole sector, are not getting the recognition or the career structures that would say to them you're really rather important. Yet if we can't supply good quality care staff, the system will fold.

We can't see people in 'bits' any more – where one agency will treat with that bit of someone's life, and someone else will deal with another. We can't afford such high levels of fragmentation and it's a pretty poor customer experience.

A prescription for joined-up working with community service providers

What would I expect to see in a well-functioning local system? Pooled budgets around populations and system totals within the NHS are one of the measures of success. Then system totals for populations across local government, particularly social care and the NHS, integrated information systems and shared premises for staff, so a group of nurses working in the community work in the same room as their social work colleagues.

Integrated management and shared governance arrangements would bring together the respective statutory bodies, and in local government, of course, politically elected members. Care Quality Commission area reviews also pointed to the importance of a shared narrative, a shared set of indicators as to what good looks like and also a clear set of shared goals and ambitions. Most of the advanced systems have some of those if not all.

Looking ahead, I'm reasonably optimistic that there's a greater sense of drive and ambition. There is a danger that the pace in local government, which has become much more business-like and much more capable of managing the money, can move quicker than the NHS. Plus, local government cannot afford to wait if it's to meet the stringent austerity requirements that mean it can't overspend. It's an issue of how to generate pace, whilst the NHS is so controlled from the centre, at a rate that would encourage partners increasingly to see common purpose. There are very good examples of where that has happened. It is possible to resolve but it requires a certain tenacity and strong sense of purpose.

The ambitions in the long term plan run the risk of being undermined by the lack of funding in social care and local government in general.

ANGELA HILLERY

Chief Executive
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST

Angela is chief executive at NHFT which provides mental health and community services in Northamptonshire. She has worked within the NHS for 31 years. In 2018 Angela was listed 15th in the HSJ top rated chief executives and in 2015 was a finalist for 'Chief Executive of the Year' at the HSJ Awards.

As a combined community and mental health trust, we see our services very much through a community lens. We have inpatient and community-based services in our community and mental health parts of our trust. Our perspective is very much around population – we see mental health very much in that regard and being a combined trust allows us to think about the models of care quite similarly.

Integrating care around a community asset base

We're very much working on a community asset-based model. What we've increasingly tried to do is recognise that people exist in their local area and to make sure we are connecting as a partnership around that, whether that's sexual health services, community nursing, school nursing or crisis care. We want to increasingly use assets like schools and work with local communities. We've got crisis cafes and breastfeeding support services, for example, making sure there are natural community opportunities to access services, not just services being available for people to come to us. We use what's available in the community and dovetail our services to it.

I'd like to think service users engage with us differently as a result. We've tried to listen very much to what people want and have a real golden thread at the trust around co-production, which means that we're trying not to determine or dictate in any way how services look – we're trying to shape them around what people feel is needed to maximise their outcomes.

Everybody is always busy and very much focused on their particular perspective, so we've tried to create ways to exchange information across the trust, for example with intermediate care for older adults and mental health. We still have to work at bringing people together but we're very conscious of it so we do create those opportunities.

Commissioning challenges

You can be commissioned from a very different perspective in mental health and community services and that lends itself to different emphases. While we have our local clinical commissioning groups commissioning both community and mental health services, we also have commissioners that are outside the county and clearly there's sometimes a challenge around how those things fit together. That can mean keeping that localism and understanding its relationship to community assets can be difficult.

Making use of patient and service user feedback

We put a lot of emphasis on engaging with our local communities. We work extremely hard to get feedback and we use that in all of our teams across our community to understand how people feel about all our services, so that teams can be responsive. It can be things like people saying appointment times were not necessarily suitable for young people coming out of school. We've got a service for childhood and adolescent mental health services called CAMHS Live where we developed an online chat facility where service users can talk to a healthcare professional through a forum when they want to. That sort of thing was directly in response to what young people wanted and in a medium that they wanted to use.

In our children's services, we had – as many do – examples where services were very disparate. We looked at that in order to connect all the handoffs between services. We developed a referral management centre that now receives all of our referrals so we can screen, triage, and get a response according to need. This has been very well-received.

Outcomes over structures

Does the organisational model of the community provider matter? It's less the variability of the type of community service provider and more about what they are delivering in terms of outcomes and how they are interfacing in partnership terms. I welcomed the long term plan's focus on community service and mental health. The fact that there's going to be a range of PCNs, that community services will play a pivotal role in creating the primary care workforce of the future in partnership, is very beneficial. Doing that around populations is something that I would support.

Having said that, we need to get that right, because there are services that do need to exist at scale, that do need to be managed at a specialist level, and we do need to make sure that we can deliver localism but also at a scale that is safe and effective.

We are in partnership with a couple of GP federations locally. We deliberately took that step to create a way of transforming community and primary care services together. Within that, we've trialled things like physiotherapy in primary care teams. We've looked at paediatric nursing, we've got some very successful examples, well-supported by primary care, where we've made a real difference to access to paediatric support. Those sorts of things are very much where we want to be.

For me, it's about accepting that transformation is necessary and that actually we should all be receptive to it. This is, in my view, a fantastic

Apprenticeships can give us an opportunity to encourage people to come into the NHS through community services – to get a foot in the door and get a taste of what the NHS has to offer.

opportunity for community service, but it won't be realised if we don't transform – and by transform I mean that we are cognisant of the role of PCNs and want to work in partnership. If we don't genuinely challenge ourselves around productivity and technology, we won't be able to satisfy the requirements of the long term plan. We do need to be able to demonstrate that we are making productivity challenges to ourselves – that we are recognising that there are different ways to do things.

Using apprenticeships to expand the workforce

We've got a really big push here on apprenticeships. I really do believe that community services are natural bedrocks for apprenticeship into the NHS, so we can play a big role in creating a pipeline for a career there. Apprenticeships can give us an opportunity to encourage people to come into the NHS through community services – to get a foot in the door and get a taste of what the NHS has to offer, whether through therapy apprenticeships, research apprenticeships, or others. Community services give us a platform to attract people into that work and then give them routes into the NHS. There are more and more different types of apprenticeships being developed here. We've got a number now who have tried it and gone into other roles – for instance they've decided to become a nurse and do more training.

What we've increasingly tried to do is recognise that people exist in their local area and to make sure we are connecting as a partnership around that.

A future of changing and adapting to local systems

It's hard to crystal ball gaze too far, but as for the future of the sector I think we'll see a journey of forms changing and adapting to local systems around populations. I'd want to be playing a very significant role in these alliances around population, with community being at the centre of any integrated system and, within that, the voluntary sector and local communities very much being at the heart of integrated care systems.

I'd like community and mental health services to be involved in a number of provider alliances that will allow us to adapt and flex capacity according to different needs and outcomes, much more organised around need and population rather than services. That's why we took deliberate steps to take a partnership approach here.

I'm hopeful that commissioning will go on its own journey – in many ways it's essential it does, or we won't get the focus on population health that we need. My vision for that is that commissioners would be much more focused on outcomes, very much linked with public health, local authorities, and adopting a common perspective on outcomes, enabling providers to for the most part work in alliances to deliver them.

ANDREW BURNELL

Chief Executive
CITY HEALTH CARE PARTNERSHIP CIC

Andrew transferred from his role as managing director (designate) of NHS Hull provider services to the chief executive on the 1 June 2010, the date that City Health Care Partnership CIC became an independent, co-owned 'for better profit' company which invests its profits into the services, staff and communities.

It was really nice to see that the importance and value of community services was recognised in the long term plan. The fact that community services, working in partnership with GPs and primary care colleagues with what appeared to be new money attached, was a key element of the delivery of the plan was welcome. However, missing from the plan itself are links with colleagues in social care. The lack of the social care green paper is quite a gap. The Department for Health and Social Care needs to wake up to the fact that a hell of a lot of community service provision is via the local authority. That needs to be funded properly.

Over the last decade or more, community services always seem to have faced the most cutbacks and most disinvestment. We are where we are, but we we need to make the best of that and demonstrate the value and worth of the services we provide. They provide the glue that sticks most of the service together – most people spend the best part of their time at home in the community where they live – not within a ward or sitting in A&E.

The centre has to understand that through the further development of the integrated care system approach in the plan, there will be a different approach in each area. My hope is that we're seeing some fundamental changes in the way in which general practice will be contracted. The notion of the network approach working at populations of 30-50,000 comes with risks for these services but, if you're looking at the fundamental principles, there are opportunities at population health level, looking at how our datasets and evidence base can help facilitate quality improvement. For years we've been trying to get our frontline staff to really engage with their broader role in the wider determinants of health in the communities they are working in. Though we do have capacity and demand issues.

You tend to have a big fanfare that there will be 20,000 new workers in primary care, from pharmacists through all the way to physiotherapists – but where are they going to come from? If you have all these PCNs trying to employ individual members of staff, we'll just be taking those from existing services. My hope is that the more forward-thinking networks and groups of practices will be looking more imaginatively at how that can be commissioned and provided.

Opportunities to work together

There is an opportunity for us to work together to enhance the attractiveness of integrated primary, community and social care, and share people, but also rotate staff much more and give people much broader experiences of the value that working in the community can offer. We've all got a job to do – how can we utilise this new plan and contract in the way that we want to work, with population health? Most community providers are coterminous with either one or two

local authorities. We can then really start to think about integrating provision supported by a different way of commissioning which is seen as a partnership in collaboration. I'm quite happy for us to be part of a system that doesn't get into large amounts of tendering but works together in partnership. We may lose some of our current community service, but if it's a better service then we're all for it.

Commissioning a patient-led NHS really gave rise to our type of organisation (the community interest company) out of necessity. We were born out of policy but we're also forgotten in policy in some respects – it is important to maintain and understand the value and worth that our type of organisation can bring to a local partnership, and to a wider system partnership as well.

All the profit we make, which is only 1-2% on contract value, we put back into the service and into the community. We've got business flexibility, we've got the ability to do what the NHS was set up to do and which it gets distracted from, through being driven by political circumstances beyond its control and a very hierarchical system.

The Department for Health and Social Care needs to wake up to the fact that a hell of a lot of community service provision is via the local authority. That needs to be funded properly.

Value of social enterprise

Our staff themselves are the shareholders of the company. There is a value and a worth there which it would be a pity to lose. I do think that centrally, the value of the social enterprise sector needs to be seen. As an organisation we've driven 3-4% efficiencies for the last 10 years. We've made a profit every year, we have high levels of patient satisfaction and we've grown. There are around four to six of us and there are not many in the red. Nobody seems to look at us and think "how have they done that? What's the difference? What is it about our system that's different?".

I've only got two non-executives (NEDs) and a company secretary. We're a group so we have other companies as part of the board as well but those are run by members of staff. We are set up differently – the two NEDS we have are from business but from the local communities that we serve, and are still active. We don't structure things in the same way as other NHS organisations but we still have robust governance.

Our flexibility has allowed us to make acquisitions, so to say we are a community service provider is a misnomer because we are an integrated care provider. I have a care home business, I have an estates business, we bought out the intermediate care service from the local authority. We have a range of community pharmacies that we link into the business and drive efficiencies through that and we run specialist out-of-hours primary care. It's such a wide range of things, but through that you can drive productivity and efficiency.

Investing in modern tech

We've invested millions in IT. A lot of things in the plan we're already getting on with. We haven't been able to drive 3-4% efficiency sat back twiddling our thumbs. We're all on mobile working and we'll be using logistics management for community nurses very shortly. We're looking at how we develop our own app with others and we've got conversations with other providers around further digitisation of communities. We've just won an award with Amazon and our local university, developing a system to go into a care homes around assistive technology using Raspberry Pi and an Alexa. It will probably cost around £50 but it's extremely interesting in terms of what it can and can't do. We've got our own care coordination centre and 24-7 NHS 111 cover, which we put in ourselves.

Hull and the East Riding is the birthplace of quite a bit of modern tech. Although sometimes people forget it, it's quite a forward-thinking, innovative place. We tend to have partners that are up for helping us. Technology is an enabler but it's not going to solve all the problems of the world. The biggest thing people forget is culture – how do you get people to change – because they can take the technology and walk around with it but if they can't see the benefit, they don't use it.

It's also very important that some of the emotional intelligence stuff doesn't get lost. It can get lost in high-pressure environments and some of those softer skills are really important because community provision is a different type of mindset – you are much closer to people in their own homes. I've been a community nurse in the past and a health visitor – you come at it from a different angle. Get rid of hierarchy, get rid of yes sir, no sir – it's more about tenacity. Your value is your people and if you forget they're your most important asset, you're doomed.

The thing I suppose that I've learned most is that in the community you tend to get nowhere by trying to be bombastic and clever – one has to be far more facilitative, inclusive and extremely global in your view of how to solve problems. The community sector has a character that should be celebrated, not squashed. At the end of the day, it can't be homogenised into a one size fits all – people seem to forget that, but they will forget that at their peril.

There is an opportunity for us to work together to enhance the attractiveness of integrated primary, community and social care, and share people, but also rotate staff much more and give people much broader experiences of the value are that working in the community can offer.

WILL HANCOCK

Chief Executive
SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST

South Central Ambulance Service provides 999, 111 and patient transport service to a population of over four million people across six counties. Will also leads nationally for the ambulance services in England on mental health issues, as well as being a member of the Crisis Care Concordat steering group and the Mind Blue Light Programme steering group. Will also sits on the NHS Providers board and the Community Network board.

My perception of community services is that there's a range of custom and practice in operation, but I see a lot of variation across the community providers we work with. There are those who have done quite a sophisticated job of mapping their resources, capabilities and demand and creating a contact centre, a hub, a single point of access model which is fairly similar to the ambulance service model. Then you get others that are operating completely distributed models, which seem much more based on traditional custom and practice and a lack of data.

When I talk to community providers about our operating model, they see the obvious benefit but there's something holding them back and I can't quite put my finger on it. I think they're rightly a bit nervous about staffing, because the ambulance sector has pushed its staffing model almost to breaking point in the past and adopted operating models which are completely 24/7 in terms of matching rota hours to demand. Becoming one of the most responsive services available to patients increases demand even further.

An operating model built on teams

In terms of efficiency, we were driving a model which increasingly pushed a relatively unsustainable pattern of rotas into the working life – shorter rotas and then longer rotas and staggered rotas to match the peaks and troughs of demand and iron out underutilisation. Then we'd also asked staff to operate as lone workers as a part of their role. We've spent the last couple of years rowing back from that, because we've seen a huge exodus of staff and a lot of issues in terms of wellbeing, resilience and sickness rates. I think we're in a better place now and a lot of work is going on around trying to improve the lot of ambulance staff.

It continues to be a risk that people get disconnected from the organisation and colleagues – every minute of the time they are working they are on their own or with one crewmate, patient-facing in the community, and you've lost that contact with them. You need to be quite careful to build that contact back in. There are operating rules that you need to define – things around meal breaks, end of shift overruns, shift length. We've been looking more recently at fatigue, particularly with the length of some of our shifts and how busy a shift is. We have piloted staff wearing Fitbits, enabling us to measure their levels of alertness when they are at work, particularly during the night shift. There's quite a lot of evidence around fatigue and safety in safety-critical industries and you can design your roster patterns so you can make sure you're within a tolerance level of what's safe. This has helped us to shift the engagement with staff around rota design to find a win-win in terms of patterns.

As far as supporting a disparate workforce, what we have done is create a model built on teams and ensured we encourage those teams to be strong and effective. You don't break the team up – you need to have a line manager who's consistently there and available to support the team in real time and also does the team's feedback and appraisals. We create regular team time to encourage the team to be a supportive unit – it's small but non-negotiable in our operating model. We've got 138 teams in South Central Ambulance Service and they have half a day three times a year of their own team time which they spend self-directed. Team leaders are completely rostered so support is always there.

Integrated urgent care

Although we provide the NHS 111 service we recognise we can't provide the entire 'front door' that patients need or want because a lot of other organisations have the staff and expertise that need to be incorporated into delivering that effectively. Carving a virtual clinical assessment service (CAS) into a separate organisation potentially disconnects the front end from further referral pathways that naturally sit within community, mental health and primary care services. We're trying to build a more inclusive offer quickly, which is why our relationship with the community services and out of hospital providers is so important.

In terms of efficiency, we were driving a model which increasingly pushed a relatively unsustainable pattern of rotas into the working life – shorter rotas and then longer rotas and staggered rotas to match the peaks and troughs of demand and iron out underutilisation.

One of the big areas we're interested in is integrated urgent care and working collaboratively with all out-of-hospital providers to populate a directory of services. That's to do two things really – one is to provide earlier assessment and advice for patients presenting, and secondly, to potentially refer patients to other services once they've undergone an initial assessment so that they can get more bespoke personalised access. Building an integrated front door and behind that a directory of services that we can book and signpost patients into is a significant part of our service strategy – particularly for those ambulance services that are providers of the integrated urgent care 111 service.

Trusted advisors

Levels of conveyance of patients to acute hospitals is a real area of focus for our whole system. It can get quite contentious around whether a patient is inappropriately conveyed – it's a sensitive area because in different settings, with different information and clinical expertise, different decisions might be made, and, in addition to that, organisations (and individuals) have different tolerances to risk. That's why we need to shift the model so we've got trusted advisors and trusted assessors support as early as possible to make decisions. One of the things we're

trying to pursue is to have the ability for any of our staff to be able to access decision support advice from anyone they think they need support from. If, for instance you're with a mental health patient and the ambulance crew could benefit from more information, expertise and experience from someone in a mental health service, you'd be able to access that in real time. I think you'd get quite a different range of outcomes as a consequence of that model.

Traditionally, a lot of ambulance work – particularly the less acute patients – hasn't been clearly differentiated in terms of condition and therefore best practice pathways do not always exist. Things like the stroke pathway, the trauma pathway and the heart attack pathway are extremely well-evidence based. Wherever you go in the country now, these clear pathways will be in place, but that's still quite a small proportion of what ambulance services do. There's a large amount of undifferentiated urgent demand – for instance for patients with long-term conditions, minor injuries, illnesses and infections, or mental health concerns. In our clinical strategy we've got eight or nine groupings in those areas and what we try to do is to work with other providers (the experts) to understand what the best pathway is for those patients – which isn't necessarily to go into hospital.

To try and put the right trusted assessment and advice in place when we find patients fitting into those particular cohorts – that's quite a shift for the ambulance service, which has traditionally been a transport-based service. We now face much more into the community than into the acute sector.

Our primary model of trusted advisor at the moment is through the GP. Where it's clear a patient doesn't immediately need to be conveyed, we will try and access the patients' GP and get trusted advice from them. There may already be a care plan in place for the patient. We do have care plans in place as well – written plans that are loaded into our system for individuals with long term conditions. We also have midwives, mental health nurses, children's services and social workers available in our contact centres.

One of the things we've done to bridge to community and primary care services is to create our own urgent care specialists (paramedics), who deal with minor injuries, long-term conditions and increasingly prescribing. In a way they are reaching into an area that's more traditionally nursing and community district nursing and that's helped us to connect up. We have explored some of that with our community providers because there's a whole resource out there in the community, such as district nurses, that is local, particularly in more rural areas, that could meet the patient's need where otherwise there's no alternative but to send an ambulance. A good example is where we now send appropriately trained volunteers to our non-injury fallers and to silent alarm calls for elderly patients. The model we operate there is one where

the patient can be assessed by a healthcare professional on the telephone with the volunteer on scene and once satisfied we can discharge without sending a registered healthcare professional. We are perfectly happy with clinically authorising that remotely, from a governance perspective.

An art and a science

In terms of planning and organising our 999 service we look at call and incident demand, geographically and by hour of the day. You then start to map your route patterns. It's harder for us to meet demand at certain hours of the day and we would tend to start from a slightly lower base of performance in the morning. It's pretty advanced planning – based on operational and production management – essentially it's an engineering production science. You've got to ally all of that with the human factors as well. Ambulance services have made a real art of it.

In terms of the scope of 999, 111, primary care and community services I wouldn't make a distinction between planned care and unplanned care at all, quite frankly. I think there's just varying degrees of responsiveness in a continuum and it should be planned together and seamlessly integrated. We've been having this debate a little bit recently in terms of integrated urgent care and the scope of services that should be included. The future operating model is one lots of service industries moved to years ago, particularly as we look to exploit technology. They don't make an artificial distinction in terms of what's planned and what's unplanned – it's all about how responsive the service needs to be. Most patient generally have a sense of what responsiveness means and it's relevant to the context of the situation.

One of the things we've done to bridge to community and primary care services is to create our own urgent care specialists (paramedics), who deal with minor injuries, long-term conditions and increasingly prescribing.

ROB WEBSTER

Chief Executive
SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST
and WEST YORKSHIRE AND HARROGATE ICS

Rob joined South West Yorkshire Partnership NHS Foundation Trust as chief executive in May 2016 and is responsible for leading the organisation and its 4,200 staff. He is also lead chief executive for the West Yorkshire and Harrogate Integrated Care System, which sees him bringing together West Yorkshire health and care leaders, organisations and communities to develop local plans for improved health, care and finances over the next five years.

If I look at the long term plan through the lens of the West Yorkshire and Harrogate integrated care system, there are significant opportunities around enhancing community services to ensure that they are the bedrock of future health and care. Most STPs or ICSs have the same ambitions for the future – joining up primary, community, mental health and social care services, with populations of around 50,000. The fact that this is now embedded in the primary care contract is the biggest opportunity and the biggest risk that we face.

Opportunities and risks

Things look different in community services because we start in a different place. Most of the people we look after have got one or more long-term conditions, of which they'll never be cured. Being older or having a special educational need or having chronic obstructive pulmonary disease, asthma, diabetes, dementia, means we're going to be a partner in your care for the rest of your life. That means we start with the person and we deliver a team around the person. This plays out in the way that we structure community services in our neighbourhoods. Community services are increasingly part of an integrated neighbourhood team. That team includes social workers, community nurses, occupational therapists, speech and language therapists, social care staff and GPs – all with a tailored offer which involves the patient and their carers as partners in delivery. That's a very different ethos from what we've had in the past. I think across the whole country people are embracing joined up teams across sectors in the neighbourhood.

Investment in community services has suffered over recent years because of differences between the payment systems in use. Commissioners have had to pay for a tariff-based, activity-based system in the hospital sector. Once they've worked out what that leaves in terms of risk, they've been able to invest very little in real terms in community and primary care services. So the balance of investment and growth hasn't been in favour of community services. Routing guaranteed money through an investment through primary care contracts, and having additional resources within ICSs, means there's an opportunity to invest in the sector. It is a big opportunity to look at the mental, physical and social needs of people. This in turn will help to deliver better outcomes for people and reduce care variation.

However, there are risks for community services though the long term plan. We have been working to exploit one of the biggest potential benefits in our health and care system compared with every other country – that we have list-based general practice. General practice has a relationship with just about every member of the community and great data. What we've been working on for the last couple of years in West

Yorkshire and Harrogate is to use that list base and population of 50,000 to develop integrated neighbourhood teams and services.

The big risk is money going straight to general practices could undermine some of that progress. People could start to look at the practice as a unit, not at that population of about 50,000, and there could be a risk of money not flowing appropriately.

There's also a risk around staffing – we need a future workforce which is going to be sustainable, rather than just poaching staff of each other. Not having a settlement for social care or local government that's workable in our more economically-challenged places will be a problem, with other sectors being under the cosh while the NHS looks a bit more cash rich.

A focus on places, not structures

In West Yorkshire and Harrogate, we've got six different 'places', each of which has a different history, different relationships, different geography and different partner services. The approach we've taken is to always keep the energy in the places. We've got 50 neighbourhoods of 50,000 people with integrated primary and community services. They come together in seven partnerships to deliver the vast majority of care in our places, commissioned by six joint commissioners – councils and the NHS – and supported by an association of acute trusts that works to deliver all the hospital care. There is also a joint committee of mental health providers who deliver all the specialist mental care.

It's a different way of working. We start with the services, and with what service offer we want to build around the population, recognising that one in four people has a long-term condition, the majority of emergency admissions to hospital are for older people and a significant proportion have five or more long-term conditions. We've got to change the model – national solutions will not work – you've got to have a local approach where people decide what's right for them.

Things look different in community services because we start in a different place. Most of the people we look after have got one or more long-term conditions, of which they'll never be cured.

Tackling health inequalities from a community perspective

We know some populations get a bad deal. if you're a man in West Yorkshire and Harrogate and you've been in touch with secondary mental health services, you will die 18.6 years sooner on average. If you have a learning disability, you might die between 14-20 years sooner – a learning disability is not a health condition. If you live in a poorer part of society, you will have a shorter, unhealthier life. We know these things – what we need are models of primary and community services that can work with these populations differently.

In the secondary prevention area, we know poorer people are more likely to smoke, to drink, to have mental health issues and long-term conditions, and are less likely to access services. We're looking at how to change that by having better models that people can access more easily. Secondary prevention work around people who we already know have an issue will reduce health inequalities. Beyond that, there is a primary prevention agenda about community resilience and the dividend we get from having community-based services.

A simplified commissioning approach

My direct experience as a mental health and community trust chief executive is that we've had the most competition and the most tendering to deal with. If you provide services in the community, you have constant tendering and competition. That is energy-sapping, takes up a lot of capacity and leads to fragmentation of services in my view, and that's where we've ended up. What I think will happen, and what's started happening, is that commissioners will simplify a set of arrangements which provide a uniform offer at certain points. This will include intensive home-based treatment and crisis services in mental health, specialist community teams operating as an interface between home and hospital and effective urgent care teams that focus on delivering care at the point of need.

If you provide services in the community, you have constant tendering and competition. That is energy-sapping, takes up a lot of capacity and leads to fragmentation of services in my view, and that's where we've ended up.

This means a simplified offer in community with consistent standards which focus on outcomes and providers working in partnerships of GP federations and the community providers, working together to deliver simpler, better, more effective, joined-up care. That's got to be better than what we've got at the moment. In West Yorkshire and Harrogate, five out of six systems have aligned incentive contracts with their acute trusts which manage risk. We can build on this approach and have a contract with a focus on outcomes, population-based and with some degree of risk in it – a cap and collar, some fixed costs, some variable costs, a quality premium. You can use a lead provider arrangement, an alliance arrangement or a single contractual arrangement, but that will be horses for courses, I think. You work in partnership to deliver outcomes. Ultimately that is about relationships as much as contracts.

PROFESSOR HELEN STOKES-LAMPARD

Chair
ROYAL COLLEGE OF GENERAL PRACTITIONERS

Helen Stokes-Lampard is chair of the Royal College of General Practitioners, the UK's largest medical royal college, representing over 52,000 family doctors across the UK and internationally.

Primary care and community services have always worked collaboratively. We couldn't do our jobs if we didn't communicate well with each other. Perhaps we've been the part of the NHS that has put the patient at the centre more than other areas of the service traditionally have, because we haven't been confined by the structures that secondary and tertiary care are confined by.

Collaboration challenge

Structural changes and financial restrictions in the NHS have made it harder for us to collaborate. I think back to 10 years ago when the district nurses, midwives and health visitors were based in the health centre where I worked. We had corridor consultations about our complex, comorbid frail patients. We all knew who they were – we talked about them. If a health visitor had a concern about a family that was struggling with a young child, we put together a plan. We were efficient in the care we provided. We didn't all turn up on the same day by accident – we staggered what we were doing, we coordinated and talked to each other.

Then we lost that connection and the systems that were put in place to help – bits of paper, writing things down – meant things got lost in translation. When you try and repair it, you end up defaulting to more process, which is well intentioned but actually drives deeper wedges. We're not allowed to send handwritten notes or leave voicemail messages for each other – we have to communicate via electronic forms with 20 mandatory fields – which means people are less likely to even bother and may rely on the patient to pass on an important message to another healthcare professional. You get some real perverse outcomes in the system as an unintended consequence of this evolution.

The obvious benefit of course has been that the system has been more resilient in providing cross cover to understaffed areas. We can all benefit from that, but what we've lost in translation is hard to reclaim. Trust and high-quality communication take a long time to build but minutes to destroy.

Mapping out primary care networks

The aspirations within the long term plan are to move back to better integrated working, using the PCN as the unit of service delivery and as the population health service. If you allow PCNs to be the unitary building block of future, there are a lot of other structures that are going to have to be mapped onto that which don't currently work that way. We're going to have to look at district nursing, midwifery provision, community nursing and dentistry and pharmacy.

The process for forming the PCNs is already set and in train. Setting the networks up has been totally predicated on groups of GPs getting together and saying "we'll work together". It's hard enough to get GP surgeries in some places to work together, but in other areas we've got years of experience of doing this and very effective systems already in place which just need to be mapped across. In areas where this is not the normal way of working, a huge culture shift is having to happen in a short space of time and these wider issues haven't been factored in yet. There's not a cause for panic, but there's probably cause for realism about the timescale in which these new structures are going to be able to realise their ambitions. It's going to be slower than I think people would like it to be, because building trust takes time. If I were a patient, I'd look at the first pages of the long term plan with hope for the future of the NHS so how do we all get behind that?

There's quite a spectrum of views about the plans. There are some people who are perhaps the visionaries – the people with the energy who see this as common sense. They are already working like this very effectively, delivering care. They are already in this space and they don't know what the fuss is about. There are a lot of people who are fearful of taking on change, recognising that it's coming anyway, so what they need is help to overcome their fear. There are lots of people that are cynical about any change because they believe it's all a conspiracy and that's because many people are bruised and damaged by the past decade. Those people are often desperately caring, grass roots clinicians who have had the compassion battered out of them by an unrelenting system. When I talk to them what I feel is anger from them and cynicism. They haven't got any hope left and they are looking to survive and they can't see the light that others can.

I think there's something really important for leaders to be honest in our conversations with people so we don't try to ignore this groundswell, frustration and anger, and we have to reflect it back to the politicians and policymakers in a dignified and professional way.

I think there's something really important for leaders to be honest in our conversations with people so we don't try to ignore this groundswell, frustration and anger, and we have to reflect it back to the politicians and policymakers in a dignified and professional way – in a way that they can understand without descending into ranting and shouting. It is the lived experience of people who are out there, but it is not the universal truth – not everyone feels like that.

Then there are some people who don't think there's a problem and don't want to change – the ostriches. They are an increasingly small minority but there are – often quite small – practices I've visited who don't think there's a problem because they've had an incredibly stable clinician workforce for a long period of time. The financial levers will

be the motivation to get them working in innovative ways, but whether they will be prepared to work at the timescale that others want I'm not sure.

There are workforce shortages right across the board. In the first year, the only additional employees PCNs are looking to take on is more pharmacists and social prescribers. We'd been led to believe that there was an oversupply of pharmacists. For the first time, I'm hearing pushback from people saying we don't have an oversupply and I don't know what the truth is.

Getting to know each other

If we are truly serious about population health management, we've all got to start working in more professional ways in terms of trusting one another, getting the financial incentives aligned to motivate us to trust one another and work together, and starting to recognise that what's right for the population could also be right for our groups. If we get these things right and we are truly working in a population-based way, a lot of these issues will just evaporate.

If you allow primary care networks to be the unitary building block of future, there are a lot of other structures that are going to have to be mapped onto that which don't currently work that way.

The first thing we've got to do is get to know each other – start building relationships and recognise the new unit of functioning is the PCN. These networks are going to be having conversations with local government, education, lots of other places, recognising that other community services providers are one of a range of other people that are going to be working with the networks and we will all need to establish this new relationship.

PCNs are a complement to community services. The whole point of this is to help us to work better to provide services for our patients. We could find we're going to focus on particularly frail patients with a wraparound service focusing on a lot of the touch points they have with the service, making sure we're all communicating, and then do more preventative work for them. There are plenty of really good exemplars of how that works. If PCNs end up in competition with community services that would be a complete waste and a failure of the system.

ROBERT HARRISON

Chief Operating Officer
HARROGATE AND DISTRICT NHS FOUNDATION TRUST

As chief operating officer, Robert is responsible for the daily operational management of the hospital and the achievement of performance targets. Duties also include responsibility for IT, information, estates and facilities. He is the chief operating officer lead for Urgent and Emergency Care and Stroke on behalf of the West Yorkshire Association of Acute Trusts.

The long term plan supports the direction we've been heading in ourselves – working together across primary, social and community care in developing an ethos of prevention being better than cure, and developing services that promote independence and support people throughout their life, including end of life.

The Harrogate and Rural Alliance is made up of the local CCG, the county council, the district council, ourselves as the acute and community provider, the mental health provider and the federation of GPs. It's a coalition across the whole of health and social care but also includes housing and other teams within the two tiers of council services. Our focus is on beginning to align our services to make them as efficient as possible and to ensure we're able to provide the best possible services within the resources we've got as a coalition.

We are working to create a set of core services that will be jointly managed. They will predominantly be the community adult social care teams and community health teams. Then there's a group of aligned services that sit alongside them, including community mental health provision, primary care, GP out-of-hours services and services from the hospital, including consultant geriatricians. These essentially come together to provide a service that works around the concept of the primary care home model. Four localities will have virtual hubs within which those teams will come together and undertake their multi-disciplinary teamwork.

Getting the basics right

We're into the soft launch period at the moment. We've been redesigning our services for the last eight to nine months – the initial changes were around management structures and governance of the teams. We're in the process of appointing an alliance director who will take over joint management of the community teams. The alliance director will be employed either by the foundation trust or the council. To encourage people to apply, we've left it so they can pick either employer, but whichever they choose, they will be managing people who are employed by a different employer.

This programme has required us to work through what localities look like and how we align with GP practices when they've got populations spread across boundaries where different community and social care teams have historically worked. We've had to look at how to align those and make them function differently. We've been working with our teams on how to make sure they've got the IT kit they need to be able to do mobile working. Some of this is just getting the basics right – for instance how can we make sure that staff can enter any of the buildings any of us owns, and hot-desk so they're not restricted to going back to their own base?

We are sharing the case load, understanding who the best individuals are to have the most impact on the patient or service user, and trying to avoid the ping pong scenarios that have happened in the past where a GP on a home visit wants to refer and isn't really sure where to refer to. How can we support keeping people out of hospital, keeping them well in the long term and building on the work the local council had been putting in place around living well practitioners?

The real change has come in the last eight to nine months, when we agreed we'd all put the whole caseload into the work programme. As a result, people don't feel that they have to manage another risk somewhere else. It says "actually, we're all in this together, we recognise we've got a whole case load from every partner that's involved in this, we've also got to do our day job and manage that case load, but now we can start to have a conversation about whether there is a way in which by sharing those resources and sharing the way in which we manage those caseloads we can become more effective".

Some of the bigger challenges are about, when somebody does need acute care, how quickly we can get them back home again. In the last 12 months, we've developed a supportive discharge service which also has a consultant geriatrician as part of the team, whose focus is on getting people back home as soon as possible. If someone's got a package of care in place but can't start it until the Monday, we will bridge that care in the community over the weekend until the package starts, so we can get people out of hospital – that's enabled us to get our long length of stay down. Working with the local authority and the CCG, we've also got delayed transfers of care down to under 3% recurrently at the moment.

The long term plan supports the direction we've been heading in ourselves – working together across primary, social and community care in developing an ethos of prevention being better than cure, and developing services that promote independence and support people throughout their life, including end of life.

Relationships over structures

There is a whole heap of arguments either way as to whether to put community services in with acute care or not. If you've got the relationships right, I don't think it matters much whether you're a combined trust or not. The work we've been doing with the CCG, the local authority and the GP federation in particular demonstrates you can start to align services, integrate the way in which teams work together, regardless of what the corporate body is.

There are up-sides and down-sides to the trust being the provider of acute and community services. In some ways, the community has a different type of focus from acute management. Even so, we've put acute medicine, A&E, out-of-hours GPs and community district nursing teams into the same directorate management team. That gives them an overview and understanding of those services

and how they can impact on each other, but actually the biggest impact on hospital services doesn't come directly from health community teams – it comes from the ways those health community teams work with primary care, with mental health services and particularly with social care.

I don't think you can solve all of this just as an acute and community provider on your own – it gives you a level of understanding of how to manage some of those movements across acute and community, but the broader benefits of working with system partners actually mean that its not critical that community services are managed as part of a combined organisation. We've achieved a lot under our approach, but with the right relationships in acute and community, we could have achieved exactly the same result without being a combined trust.

We are sharing the case load, understanding who the best individuals are to have the most impact on the patient or service user, and trying to avoid the ping pong scenarios that have happened in the past where a GP on a home visit wants to refer and isn't really sure where to refer to.

This is about leadership – about trust between organisations, relationships and doing the right thing. If you've got a focus on the individual who's receiving care or can be prevented from needing care, you can build a coalition of the willing around that. You've just got to make sure you've got the right governance structure in place. This is about leadership not organisation. We're not necessarily saying we've got it all right, we've been on a long journey to get to this place – we've had our ups and downs, as every partnership does. You build the trust – we've got to a place where our senior management teams and middle management teams are now starting to work in a really different way.

Ensuring the right governance

There are some basics you've got to get in place – how do you manage your complaints between you and how do you make sure you've got good consents in place for sharing data? That's about being upfront with people about creating an alliance, and being clear about who's in that alliance. One of the things we're really focused on at the moment is getting the pace right for staff so they feel confident that they are still providing services in a really safe way through the transition, while giving them the opportunity to innovate and experience new ways of working, and backing that up with the right governance structure so that they continue to feel safe in what they do. While we'd all like to just come in on Monday and start doing things completely differently, it's important to recognise that this is a transition and to have a really clear, phased mobilisation.

PAUL CORRIGAN CBE

Policy Commentator
FORMER GOVERNMENT ADVISOR

Paul Corrigan CBE is the former health policy adviser to Tony Blair and former special adviser to Alan Milburn and John Reid. Between 2007 and 2009, Paul was the director of strategy and commissioning at the London Strategic Health Authority.

Emergency care is the crisis for the NHS at the moment. The crisis can be symbolised by the care of an 80-year-old woman – Mrs Jones – who at 5pm on a Friday afternoon loses her breath. The obvious thing about someone being at home and being in a bit of a crisis is that services should deal with her at home. However, for nearly everybody in that situation, the way we've structured the relationship between the NHS and the public is that there is one real place of safety for that older lady and that is a hospital.

We have created in the public eye a single place of safety, and that place of safety is actually one that contains an enormous amount of anxiety – where our 80-year-old patient would love to stay at home but it's almost the last thing on her mind when she's taken ill. The place she'd like to be – the place we'd like her to be – is actually the least likely place she's going to end up.

We've built an NHS system around hospitals as the only place you can feel completely safe and we've done that because the hospital is the place where you can be covered for everything. The emphasis on hospital is partly because of the fact that the diseases of aging have curiously crept up on us – even though they shouldn't have. We've not got a health system that's structured for the diseases of today – we've got one that's structured for the diseases of decades ago.

Places of safety

If we'd got a system for the diseases of today, we'd create a place of safety around Mrs Jones's home. There would not just be the current community service – there would be emergency community services. This is the direction where I think the long term plan is moving, in that it would say "we need this old lady and her daughter to be completely safe with services being provided in her home". At the moment, she wouldn't be – she couldn't trust them to be there to make her feel safe, and that's because we've not constructed community services in that way.

The idea of the long term plan is very much to get community services into a place where they can provide this care 24 hours a day, seven days a week. The staff that we have that are providing community services at present are staff that are good at domiciliary care, and are not used to providing a place of safety. Even in residential care, people are being taken to hospital because the staff don't feel they can create a place of safety.

So the contemporary problem is that we've got to create places of safety, where people feel safe and staff are themselves providing that safety in the home. That's a different job for district nurses from what they've had before. Their job has in a sense been to pick up the pieces from the hospital but not to say "what are we doing here to keep people from going into hospital?".

Acute care in the home

The long term plan in itself achieves nothing – the likelihood of succeeding in the area I'm talking about, which is acute care in the home, is quite high because if it doesn't succeed the NHS will be in a really bad place. Unless the health service can, in the next five to ten years, create thousands of places of safety in people's homes, the hospital system will fall over.

I've spent some time over the last three years working with the multispecialty community providers. Two years ago, in Whitstable, a GP started working with ambulance staff to persuade them they had the competency, with backup from a GP, to provide care at home. If two people in ambulance greens turn up, give Mrs Jones some oxygen and say "provided we can get someone round to sit with you I think you'll be ok", she will feel pretty good about it. We've got around the country bits and pieces of this. What we've not got is a national system which can say to every part of the country "this is what needs to be done".

We've built an NHS system around hospitals as the only place you can feel completely safe and we've done that because the hospital is the place where you can be covered for everything.

Working differently together

Because this is *the* crisis that the NHS is facing, everybody is trying to deal with it, so everybody is trying to do bits and pieces of bringing this together. However, if you're a commissioner and you want to commission a safe, urgent care service that will keep people at home and away from hospital, you put an advert in the papers – but there's no one providing it, it doesn't exist. There will be new forms of community service – new forms of integration with other services. To create that 'safety', you're going to have new forms of integration with ambulance services and local government, but the people who are going to do this are the people who are actually providing integrated care – not talking about it.

The interesting thing is, as the purchaser provider split gets squished, if you're running a hospital that's under a lot of stress, you'll probably be buying this service because you're the one with the crisis. You will need to incentivise people to provide a service which stops people going into your hospital. That's a problem, because you don't know much about community health services – all you know about is hospitals – but more and more hospitals are reaching out to begin to take this on.

If I was running a community health services provider, I would be looking at the emergency care problems in my local hospital. I'd have some idea of the needs of older people in my community and I'd go to the hospital and say "for this sum of money, we can between us identify all the Mrs Joneses – the people with long-term conditions – and I will construct

a service which keeps the younger Mrs Joneses out of your hospital. This is what it will cost". Now, is that the right way of doing it? Should the CCG be doing it? The CCG should be doing it, but they're not going to.

All the people I know who are in this situation in hospital do not trust the capacity of community services to stop people coming into hospital. They've been promised it for the last decade and it's never happened. If you're running an emergency service in an acute hospital and you'd listened to what the NHS had said over the last few years, you'd have been sacking accident and emergency doctors and you'd be in big trouble because you'd have been taking seriously the promises that were made to you. If you'd read any sustainability and transformation plan and you'd taken it seriously, and you were running a hospital, you would have been sacking your staff. So actually, what I'm suggesting is that institutions that feel the pain do this themselves, because they don't trust anyone else to do it – there's a very understandable lack of trust.

You grab the attention of the policy makers by solving their problem. Their problem is too many older people in emergency beds in hospital. Community health services are very well placed to solve this problem. At the moment, no one trusts community health services to do it because no one has done it before. No one has solved that problem and we've gone on having a big increase in the numbers of people going into emergency beds. It seems to me you grab policy makers' attention by doing something that is significant. I think it's entirely feasible to do that at the moment, given that the big crisis for the NHS is pressure on emergency beds.

The long term plan in itself achieves nothing – the likelihood of succeeding in the area I'm talking about, which is acute care in the home, is quite high because if it doesn't succeed the NHS will be in a really bad place.

Existing organisations are going to have to work very differently together. Some community services are already linked up with others. Not many are already linked up with the most crucial services, which are GP services. That is probably one of the biggest problems – community services need to be linked up with GP services and social care services. If you are an 80-year-old woman with three long-term conditions and you've got some social care provision, the number of human beings looking after you is enormous and they are usually coming from very different organisations. It's just chaos and that's the norm. This is the median patient in 2019, so we've constructed a system that is chaotic for the median patient. There is a necessity for all of these organisations to work better together.

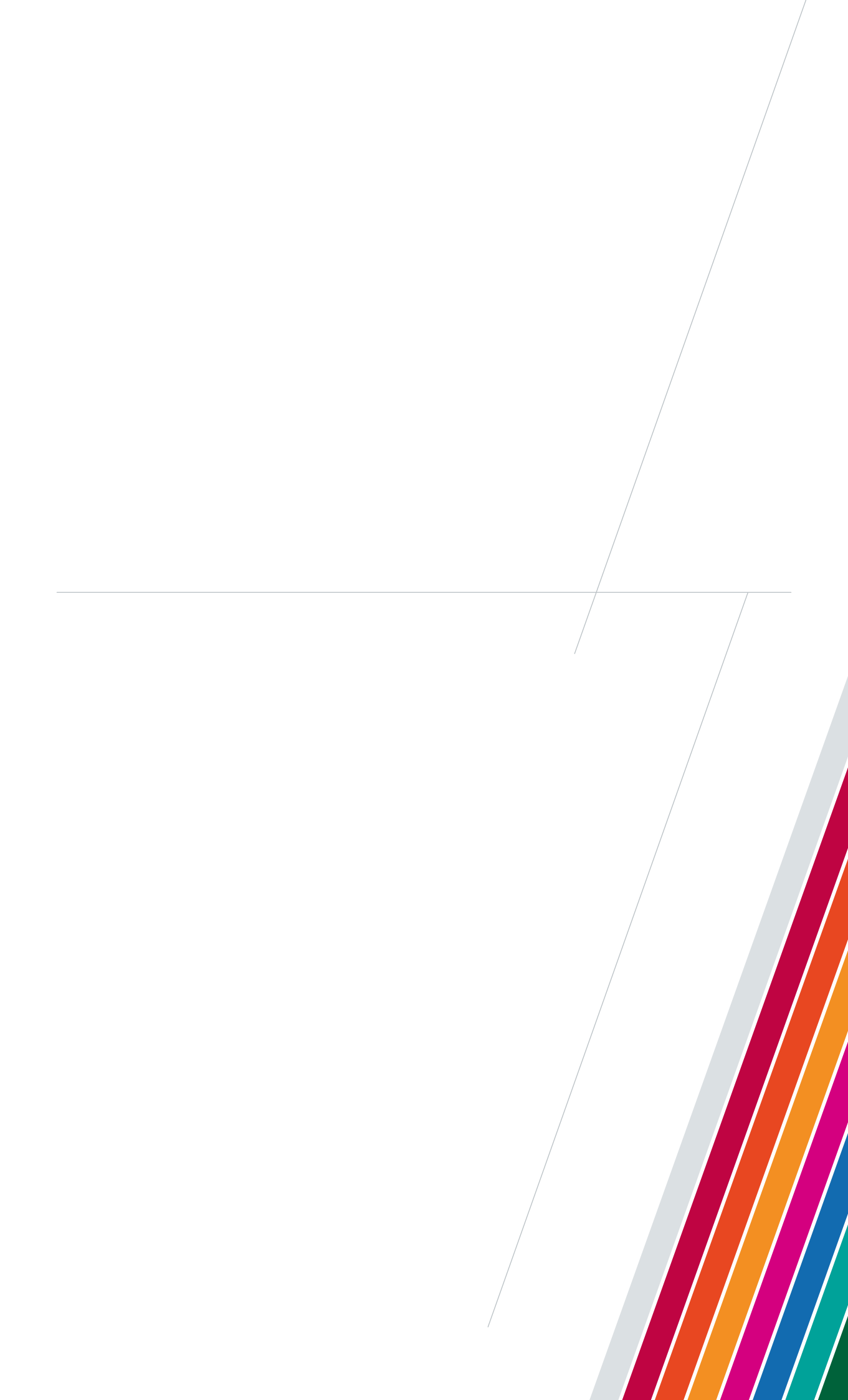
Person-centred care

However, we cut these organisations up – we've got to find much better ways of working together around person-centred care. The problem with hospitals is they've got walls, and the walls define the institution. The walls of the community are loads of people's homes, so community services have a better chance of working with other organisations. We've got a crisis which isn't just a crisis for the NHS – it's a crisis for older people. We have people losing their independence sooner than they should because the only way in which we deal with this is via hospital. The long term plan recognises the scale of the crisis, but it's a crisis that will get worse every year until we do something about it. In 10 years' time, at the end of the long term plan period, if nothing has been done about it, it will become an acute crisis.

To create that 'safety', you're going to have new forms of integration with ambulance services and local government, but the people who are going to do this are the people who are actually providing integrated care – not talking about it.

Five years ago, National Voices did a lot of work on how we talk about integration to the public – the 'I' statements narrative for person-centred care is fantastic. Community health service staff are so much at the core of that process of defining what person-centred coordinated care is, that they could be playing a much bigger role than they are in lots of cases, in constructing integrated care.

If we found a way of empowering community health nurses to be much more active in the process of integration and person-centred care, I think it would be better than the way we're doing it at the moment. This is not about policy – it's about practice. Locally, if you're trying to integrate services, doing that through community services is likely to lead to more success than just doing it without.



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