**Annex B – NHS Provider Blog**

There have been three important reports published over the past few months from the Kings Fund, NHS Providers and NHS Improvement focusing on NHS community health services. In the eleven years of being a NHS leader, never have I read so much sensible analysis of the problems and consensus on how to move forward, all backed up with clear recommendations. However, never have I been so pessimistic that anything will change as a result of these reports and as an eternal optimist, sitting in this slough of despond, is suitably uncomfortable.

The reasons for my misgivings revolve around two inter-related issues. Firstly, the actions and decisions of NHS England lead me to conclude that it is organisationally blinkered to the issues affecting community health provision. Secondly reinventing the flawed strategy of trying to create integrated care by focusing solely on organisational form issues, rather than how health and social care professionals work together wrapped around local residents, irrespective of their employer, is fool hardy.

*Our collective energy has to be focused on health and social care integrated approaches for local residents that are adaptable to cater for the very differing needs of local people.*

This was highlighted by Lord Carter in his comments to the HSJ the day before his new report was published last week. His "general sense" that integrated acute and community systems produced better outcomes for patients was clearly stated. This infuriated many leaders of community health provision, as testing the most effective organisational form to deliver community services was not even part of the analysis in his report!

I would argue, however, that we would waste a lot of time and energy analysing which type of organisational form results in the best outcomes for local residents. Our collective energy has to be focused on health and social care integrated approaches for local residents that are adaptable to cater for the very differing needs of local people. A multi-professional approach for older people who are frail with multiple health conditions, will not be the same integrated model for supporting all children to thrive in the first five years of life.

*Integration is not all about structure or organisational form – it's about professional relationships; sharing responsibility; common interests; shared premises, user records and much more.*

Integration is not all about structure or organisational form – it's about professional relationships; sharing responsibility; common interests; shared premises, user records and much more. We run a huge risk of repeating the mistakes of the policy 10 years ago, thinking that integration is solved just by fiddling with organisational form options.

Even with the pressing need to ensure all health and care is provided in an integrated way, we must face up to the fact that community health care data, effectiveness measures and clinical models run behind all of the other health sectors in the UK. The sector has not been prioritised, nor resourced to deliver this capability and this must change. Getting the sector up to speed with modern working practices and becoming data rich is not about "reinforcing the current community services standalone fragmentation" as NHS England argued in their comment in the HSJ last week. It is about fixing the infrastructure and understanding of 10% of NHS spend, so that we can all make intelligent decisions when creating new models of

integrated care. Without this detailed underpinning work with all providers of community health, we run the risk of putting a new roof (called integrated care) in local systems, only to find we have no foundations (community data etc) to support the new structure.

*Even with the pressing need to ensure all health and care is provided in an integrated way, we must face up to the fact that community health care data, effectiveness measures and clinical models run behind all of the other health sectors in the UK.*

Therefore it is vital that NHS Improvement and NHS England tackle the gaps in community health infrastructure when they create their new joint national and regional leadership teams. I would hope that this infrastructure is only needed short term to provide the vision, leadership and impetuous to create change and can then be swept away. Additionally I would argue that the following need to happen:

1. Provide the national leadership and infrastructure to support all providers of community health to deliver on the 16 recommendations detailed in the Carter report, as well as those in the recent NHS Providers report - otherwise the ambitions will just sit on the digital bookshelf.
2. Create a shared infrastructure and leadership across NHS Improvement and NHS England that supports at scale the creation of integrated care solutions in all STP/ICS areas, based on the evidence of how integrated care is actually created
3. Start to define standardised national outcomes for local residents living at home and use this to judge the effectiveness of local systems (as not all professional interactions in patients homes contribute directly to meeting the 4 hour A&E target).

It is high time the community health sector was brought in from the cold and used as a willing flexible partner to re-design care for urgent and long care needs of our local populations.

Matthew Winn is chief executive of Cambridgeshire Community services NHS Trust and a member of the Community Network, set up by NHS Providers and the NHS Confederation. This blog was published in the HSJ.

## About the author:

Matthew Winn
Chief Executive
@WinnMatthew