



The art of the possible

What role for community health services in reshaping care?

Introduction

This discussion paper is for commissioners and providers developing new care models in response to NHS England's Five Year Forward View. It offers early thinking on how community health services can add value to emerging new models, aiming to stimulate further debate about their role at the heart of integrated, community-based care.

Key points

- The vision for better and more sustainable care by 2020 rests on community-based models that are coordinated around people's needs. Making the most of community health services will be critical for success.
- Community services' focus on whole-person care makes them ideally placed to help lead and deliver new care models.
- Community health and primary care are natural partners. Deepening this relationship can combine the strengths of both in a community-based offer that increasingly looks like a single service to the people who use it. Practical support from community health services could enable primary care to work at much larger scale more quickly.
- Community services are well placed to enable better ways for specialists and generalists to work together, support self-management, and develop the community and voluntary sector partnerships crucial for prevention and wellbeing.
- Care models need to use innovations found across community health services – including smaller social enterprise, private and voluntary sector providers.
- Evidence of local population needs, and insights from staff and patients, must drive new care models, instead of starting with organisational structures.
- A strategic approach to maximising the value of community health services is needed, locally and nationally. Policy barriers must be resolved as soon as possible if we are to see a step change in community-based care.

Background

People's health needs and personal preferences have changed vastly in recent decades, and there is compelling evidence that the NHS must adapt to these changes if it is to remain sustainable.¹

The next few years will be about developing models of care that are well suited to our population, which includes increasing millions of people with (usually multiple) long-term conditions. These new models need to dissolve the boundaries between primary care, community services, mental health and hospitals, as well as the boundaries between professions and between the 'traditional' NHS and voluntary, independent and community organisations – as highlighted in NHS England's Five Year Forward View. They will need to support healthy lifestyles, enable people to play more active roles in managing their own conditions, restore health and independence when conditions worsen, and respond better to people's needs and wishes towards the end of life. All of these play to the key strengths of community health services: person-centred, coordinated, increasingly complex care delivered by a range of professionals in, and near to, people's homes.

It is therefore no surprise that health secretary Jeremy Hunt recently said his "biggest priority now is to transform care outside hospitals".²

Community health services leaders want to make visible the ways in which the expertise and resources of community services can add value to and increase the potential of new care models. This discussion paper sets out emerging thinking on their role and contribution – in partnership with other services – within new care models. We would welcome further debate.

What do we mean by community providers?

In this paper, the phrase "community providers" refers to all types of provider delivering NHS-funded community health services. This includes:

- standalone community trusts
- merged mental health and community – and acute and community – trusts
- social enterprises
- independent sector.

Community health services provide a wide range of care in and close to people's homes. This includes coordinated care for people with long-term conditions, working with professions including GPs and social care, as well as preventative and health improvement services.

Join the discussion

Please see page 13 to see how you can join the discussion.

Joining up community and primary care

People have increasingly complex and multifaceted care needs, so there is now renewed emphasis on collaborative working between community health and primary care. The two share many key features, including providing person-centred (holistic), lifetime care; coordinating and integrating care; working in partnership with patients and informal caregivers, in the context of family and community; providing a first point of contact; collaborating with a range of professionals and services; and supporting population health. This represents a good basis for closer working.

Community services leaders describe community health and primary care as natural partners. Equally, some primary care leaders (including the National Association of Primary Care) argue we should think of primary care and community health as one service.

New arrangements are emerging that combine a wide range of primary and community care professionals, generalists and specialists, aiming to play to the strengths of each while feeling like a single service from a patient perspective. This collaborative working, based around populations on GPs' registered lists, is at the heart of the emerging multispecialty community provider and primary and acute care system models.

GP practices working alone face extreme difficulty meeting the growing need of local populations for long-term care.³ In response, many primary care leaders⁴ and policy experts⁵ support the concept of collaborations of GP practices. In many areas, federations or networks are already emerging.

Community health services have similarly looked to collaborate more closely with primary care, at scale. In the past, close working and co-location of GPs and community nursing services was common and in some places these professionals are again strengthening collaboration.⁶ Community services leaders recommended in a 2014 King's Fund paper that teams of community staff from a wide range of professions be developed around – and forge close working relationships with – groups of GP practices.⁷ This has already begun. For example,

Bristol Community Healthcare has multidisciplinary teams working with clusters of GP practices and is working to realign these to match emerging new GP federations and then involve a wider range of health and social care services. Other examples include new care models vanguard sites and integration pioneers.

Multispeciality community providers and primary and acute care systems

A strengthened primary and community care offer is at the heart of new population-based models. The strengths of community health services will be valuable.

Community health professionals work in patients' own homes, which means they are well placed to develop a holistic view of people's needs, including their environment, support and anxiety levels as well as their health condition(s), and build trust with them. They are well placed to support greater personalisation:

- Making care planning and care coordination available for more people with complex, long-term needs. Community nurses already lead this in many services. As care planning is rolled out to more people, using community health staff to lead a large proportion of this, instead of requiring GPs to do it all, would allow GPs to focus on the things they do best.
- Self-management and co-production approaches rely on trust and partnership. Community health professionals are in effect visitors in patients' homes, which often leads to more empowered patients and relationships built on trust. Approaches to better equip patients to manage their own care have been led by community services. Examples include the use of telemedicine to reduce hospital admissions led by Airedale Hospital NHS Foundation Trust, a merged acute and community services provider,⁸ and Leeds Community Healthcare leading local implementation of the People Powered Health approach developed by Nesta.⁹ Community services may be able to offer insight and evidence on impact and implementation as more local areas use these approaches.

Community services' experience of working in multidisciplinary, integrated teams across service boundaries could be even more powerful alongside similar knowledge in primary care:

- Strengthening and developing collaboration with social care will be crucial – there are many successful collaborations between community health and social care professionals. A number of community services providers also directly provide some social care. This means community services providers can bring additional practical knowledge of how these cross-boundary collaborations can work well.
- Sustainable urgent and emergency care will rely on responsive community-based care that enables prompt discharge from hospitals and prevents avoidable admissions. This relies on multidisciplinary teams able to meet a relatively high level of care needs and to work flexibly – community services are central to this and community nurses often lead these teams.

GPs increasingly need to work as part of wider, multi-professional teams to meet the challenges of increasing demand, more complex patients and seven-day services. Given the similar skills needed and challenges faced across both 'types' of provision, these teams should be developed in close partnership with community services. (Figure 1 on page 5 is one example of what an extended, multi-professional primary care team might look like.) As partnership working between the community health and primary care workforces grows, it will increasingly make sense to plan and develop both workforces alongside or together with each other.

Some providers of community health services already directly employ GPs. This often reflects new GPs' preference not to take on the burden of partnership in a practice. This could be part of the solution where GP practices have persistent difficulty recruiting.

Solving practical challenges: key issues to tackle

As community health providers work with other providers and commissioners to deliver a step change in community-based care, some practical challenges will need to be solved:

- Given that more money will need to be invested in community-based care, what good practice in demonstrating value and sharing risk has promise for new care models? (Nationally consistent community health services metrics and prices are not yet in place and new approaches to contracting are still developing.)
- How can community services secure the workforce they need for the future? If we worked with primary care on this, what could we achieve?
- How does regulation need to evolve to reflect the realities of multispecialty community provider and primary and acute care system models, including money being pooled and multiple organisations contributing to the quality of a person's care?

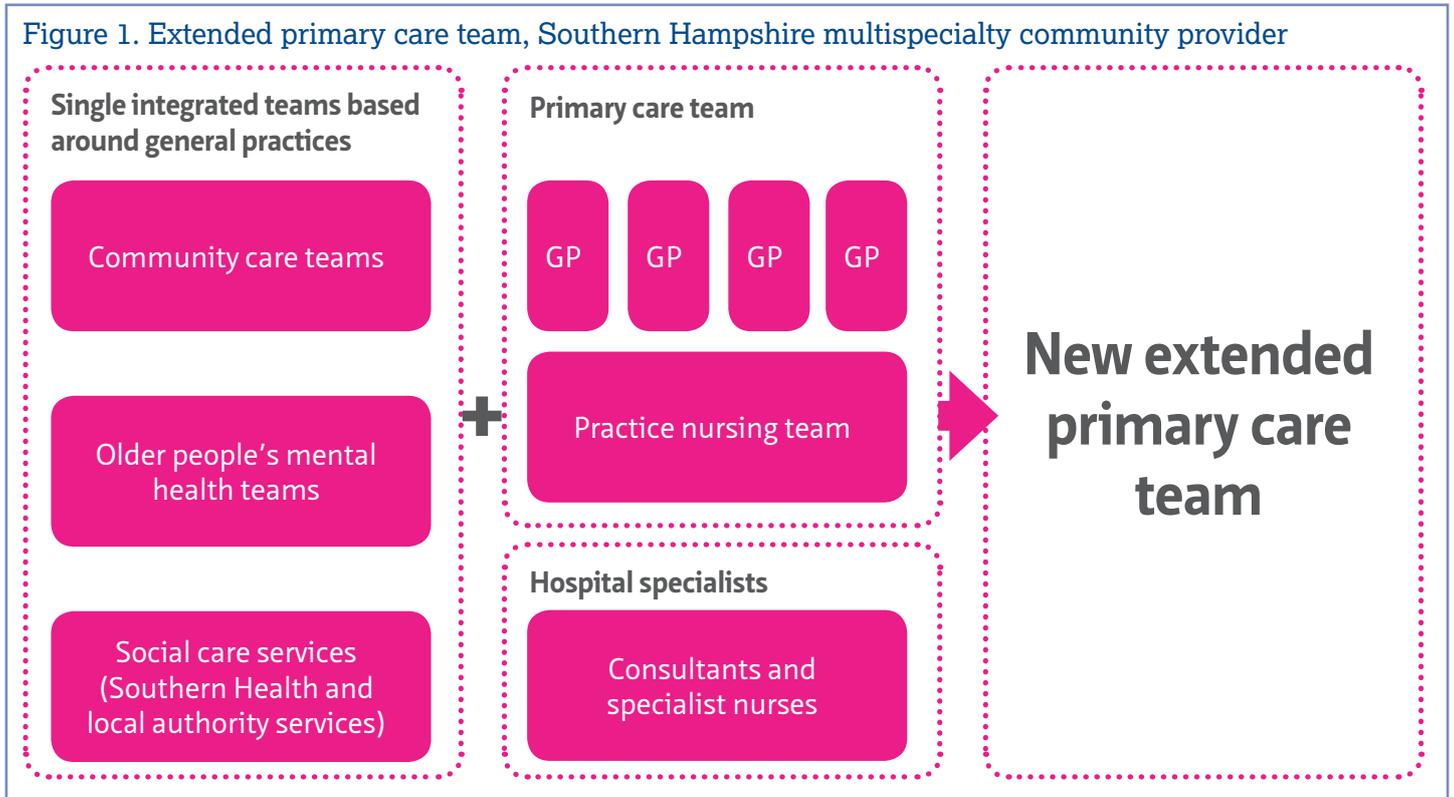
Providers and commissioners need to share learning on what has been tried and the lessons learned – no one has time to reinvent the wheel. The Community Health Services Forum, working with others, will help facilitate this.

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“We need to get away from sectors and siloes – the future is about bringing together professionals and services around local populations.”

Dr Nav Chana, National Association of Primary Care

Figure 1. Extended primary care team, Southern Hampshire multispecialty community provider



Community services could also help develop a different relationship between generalists and specialists in community settings. New thinking about this area involves finding ways to 'de-layer' care so that more can be done in the same appointment and that fewer referrals between different services are required.

Community services could support better functioning of current models for specialists and generalists to work together in community settings:

- Offering direct access to specialist services that are only sustainable across a larger geography (such as a city or county) than GP federations or networks can cover, such as continence services, specialist nursing for particular long-term conditions and falls services.
- Coordinating practical arrangements for a range of hospital-based specialists to work in multiple community settings. The huge potential of hospital-based specialists spending time in community health and primary care locations diagnosing

and treating patients, and educating and training staff, was recognised by the Future Hospitals Commission. These specialists can also gain deeper knowledge of how patients are supported in the services to which they often discharge. King's Fund case studies have shown how these approaches can help patients better manage their chronic conditions and improve patient experience, care coordination, and waiting times.¹⁰

- Developing a contracting arrangement that enables GP practices to refer patients directly to GP specialists in other GP practices within the same federation or network.
- Professionals employed by community health providers, such as extended scope physiotherapists, working in partnership with GPs with a special interest to deliver comprehensive tier 2 services. (Remaining employed by a community provider would help these staff to retain stronger links to more of their professional peers.)

Going further might involve:

- Developing teams of professionals who address both mental and physical health needs, aiming to provide holistic care for the many people who have both physical long-term conditions and mental health needs. This might, for example, mean single health assessments, and the ability to access psychological therapies close to home in GP practices and health centres.
- Using the generalist skills of allied health professionals alongside their specialist skills. For example, a physiotherapist carrying out a falls assessment could at the same appointment undertake other prevention-focused checks commonly requiring a separate appointment at a GP practice, such as blood pressure and weight, with the ability to get advice from or refer to a GP if necessary.
- Developing teams of nurses and therapists with specialist knowledge of conditions that GPs may not encounter regularly enough to have specialist knowledge, such as Crohn's disease. Comparing data across multiple GP practices could reveal the potential need for – and viability of – more such services for the first time.
- Offering access to a wider range of professionals in GP practices and health centres – potentially including gynaecology, paediatrics and geriatrics.

The vast knowledge of local populations and local community, charity and voluntary sector assets held by community services staff and leaders would be even more powerful combined with that in primary care.

Community providers could use their single points of access as hubs to coordinate local access by patients and professionals to what is often a complex web of patchy and specific voluntary capability. Clinics and health centres could also host – and signpost to – services addressing wellbeing challenges such as social isolation and unhealthy lifestyles.

More radical approaches involve community providers and GP practices working together to develop new partnerships with local community and voluntary sector organisations and networks to address a range of health and wellbeing issues. The Healthy Villages model in Birmingham¹¹ is one example. This programme has developed new partnerships and builds on local networks of influence, ranging from horticultural clubs to Islamic madrasas, combining their existing focus on the cleaner, greener, safer agenda with work on childhood obesity, isolation in older adults, cardiovascular disease and physical activity to create a joint agenda. Within this, Birmingham Community Healthcare and Vitality GP Partnership are working together to better join up health, social care, voluntary and community sector resources and make it easier for frail elderly people to reach them. New approaches like these could both improve people's health and wellbeing and help address the social issues that contribute to pressure on services.

One challenge for the organisations developing large-scale, population-based models will be understanding the solutions a wide range of smaller organisations can offer that might represent the best way to improve care for a particular group or pathway. 'Non-traditional' social enterprise, private and voluntary sector providers have developed some important innovations in care. For example, services dedicated to musculoskeletal conditions have recently been set up by GPs and physiotherapists, and can demonstrate significantly improved outcomes and efficiency. Small providers will not have the capacity to engage proactively with every local area and may need to be sought out if patients are to benefit from community health's full potential.

As a commissioner from a vanguard site commented, "We needed to give ourselves permission to stop being constrained and think big – anything is possible."

“We needed to give ourselves permission to stop being constrained and think big – anything is possible.”

Dr Charlotte Keeble, Head of Integrated and Urgent Care, North East Hampshire and Farnham CCG

Figure 2. Community services' value to new models

<p>Holistic view of patient; trusted</p>	<ul style="list-style-type: none"> • Lead care planning and care coordination; GPs focus on what they do best • Lead implementation of co-production and self-management
<p>Multidisciplinary team working</p>	<ul style="list-style-type: none"> • Improve services in crucial areas such as urgent care • Practical knowledge of collaboration with social care
<p>Knowledge of community and voluntary resources</p>	<ul style="list-style-type: none"> • Signpost and coordinate access/referral • Host services • New kinds of partnership, built on existing community networks of influence to improve wellbeing
<p>Practical support for primary care at scale</p>	<ul style="list-style-type: none"> • Policy, processes and accountability for clinical supervision, risk management and CQC compliance • Support larger-scale estate and financial management • HR and OD capacity for a large and varied workforce • Contracting, procurement, IT, data sharing • Communications and engagement
<p>Support new specialist/generalist relationship</p>	<ul style="list-style-type: none"> • Specialist community services • Community health and GPs develop specialist offers • Use generalist allied health professional skills alongside specialism • Direct referral to specialist GPs from other GPs • Support hospital-based specialists to work in multiple community settings and bring more into community
<p>Leadership for consensus and partnership</p>	<ul style="list-style-type: none"> • Build on formal partnerships developed to address challenges of recent years

Transforming care

Community health services are integral to the transformation of care required to address other challenges the NHS faces.

Urgent and emergency care

A sustainable urgent and emergency care system will rely on vastly improving people's access to highly responsive urgent care services outside hospital, as set out in NHS England's urgent and emergency care review. Strong, responsive community services are essential to help avoid A&E attendance and admission, and enable prompt discharge of patients from hospital. Their 'core' offer of nurse-led, multidisciplinary care in and near people's homes is central to both of these objectives. Same-day home visits from the regular community nursing service can help manage demand for care. Some providers are already doing this.

Community health services with a specific focus on urgent care include:

- nurse-led urgent care services offering rapid access to assessments in people's homes – for example, Birmingham Community Healthcare's community-based urgent care service prevented over 1,600 hospital admissions annually¹²
- rapid response teams putting in place multidisciplinary, home-based 'intermediate care' support for people with very complex needs on the day they are discharged
- community health urgent care facilities, such as Abingdon's seven-day emergency medical unit – according to the EMU audit, 65 per cent of patients who are assessed by the unit are able to stay in their own home and only 17 per cent of their patients need acute hospital care.¹³

Care homes

Community services also have an important role to play in improving access to good healthcare in care homes. Care homes sit at a complex interface with primary, acute and community care, mental health and palliative services and a wide range of other statutory and non-statutory services. The ability of community services to work with all of these services simultaneously, and build trusting relationships with patients, means they are well placed to work in partnership with care homes. Examples of community services' contribution to good care for people in care homes include:

- community nurse practitioners working with care homes in Worcestershire to develop clinical management plans for each resident reduced residents' hospital admissions and A&E attendances by around a quarter in their first year¹⁴
- highly qualified nurses, in partnership with GPs, can do regular 'ward rounds' in care homes – the Gateshead vanguard site builds on established ward rounds in care homes, reducing residents' hospital admissions by 45 per cent¹⁵
- nurses and therapists are a vital part of multidisciplinary teams dedicated to specific care homes – as seen in the East and North Hertfordshire vanguard site.

More innovative partnerships might also include community health staff supporting care home staff to improve their health knowledge and skills; joint development of rehabilitation and recovery services; short-term 'intermediate care' within care homes for care home residents suffering acute episodes of illness (enabling people to avoid hospital admission); and joint initiatives between care homes, community services and housing providers to address care, support and housing needs.

Specialised services

Community services are caring for people at increasing levels of acuity. Their role in stroke rehabilitation can now include post-acute inpatient rehabilitation for people severely affected by stroke on small, specialised wards as well as their role in rehabilitation in people's homes. Community services play a similar role in the rehabilitation pathway after neurological injury. The ability of many community services to provide intravenous therapy (such as some chemotherapy regimens and intravenous antibiotics) at home also enables more people to avoid hospital stays.

These changes have reflected the development of clinical best practice. As clinical practice in other areas evolves, there may be other pathways where it becomes possible for more patients to be cared for at, or closer to, home at an earlier stage. This underlines the importance of engaging with community services whenever strategies and care models are developed.

Viable smaller hospitals

Well-functioning community health services are vital for sustainable hospitals. Among other things, their impact on A&E attendance and admission, and on delayed discharges, is crucial for smaller hospitals for whom A&E represents a relatively large proportion of their work.

Some structurally integrated models use community provision to ensure a sustainable system, including smaller hospitals. Examples include the integrated care organisation in Tameside and the Northumbria primary and acute care model, which includes a number of small hospitals and community services and will redesign community and acute services to ensure patient care is delivered increasingly in community settings.

An extended role in securing the sustainability of small hospitals is likely to reflect the ways community services may potentially work with other parts of the system, such as sharing back office functions or supporting the implementation of telehealth and self-care.

Acute and community services are both part of integrated care pathways, and integrated working could now go further:

- Some clinicians already work across acute and community settings, and providers could rotate whole teams between community settings and smaller hospitals, aiding staff retention and development and building geographically orientated teams.
- To maximise utility of hospital estate – some places might want to use part of this for community health facilities such as clinics, community hubs, step up/step down beds and (in partnership with housing providers) extra care homes.

Developing the care model

The needs of the population, and insights of staff and patient leaders, are the best starting point. Community services staff are highly motivated to improve care models and further develop what they can offer.

Bottom-up, clinically led approaches to design are already being used. For example, in the North East Hampshire and Farnham primary and acute care system, community services staff are co-producing a recovery, re-ablement and rehabilitation model, working with their acute, social care and out-of-hours services to co-locate staff and the service in a local community hospital. Similarly, the primary and acute care system in Morecambe Bay “has worked from a stance of letting clinicians design the model that they would like to see and that they think will work, and have done it in an organisationally agnostic way”.¹⁶

Bottom-up approaches should help new behaviours and thinking to emerge, as well as a new model. It is also more likely to allow sufficient flexibility where collaboration between GPs is developing at varying speeds. Local communities also need to be engaged, so that the solutions developed reflect their priorities.

Those collaborating to develop new models will need to ensure they understand the detailed evidence of the needs and priorities of the population they cover. Data provided through Public Health England,¹⁷ local Healthwatch, and the relevant local joint strategic needs assessment and joint health and wellbeing strategy are all sources of evidence alongside the data and insight providers already have. Local directors of public health could have a particularly important role in helping those developing new

models understand how the available evidence relates to the specific population they will cover. There are a number of possible options for formalising collaboration between providers within multispecialty community provider and primary and acute care system models. Different types of health need may also suit different population sizes, payment approaches and contracting mechanisms. This may mean local areas contain multiple care models and multiple formal collaborations. Areas might also want to be able to bring in small providers with leading edge solutions for particular problems or groups. Flexibility will be important as models develop. With vanguard sites in their early stages, it is also not yet clear which approaches to contracting for multispecialty community providers and primary and acute care systems will work better.

There is strong support for collaboration as equal partnerships, rather than one dominant organisation and the others as ‘poor relations’. These include forming joint ventures; becoming partners in alliance contracts delivering care within capitated budgets; or community services becoming partners in GP federations. Leaders stress that the first question must be about what local people need and want, not organisational mergers or takeovers (which may anyway fail to meet their objectives¹⁸) or the size and status of individual providers. New models and new structures are two different things.

Infrastructure and leadership

The infrastructure, leadership and management capacity within community health services could play an important role in developing and implementing a new integrated, community-based care offer. Community services are ideally placed to lead new models as the provider focused on whole-person care.

“Community services staff are highly motivated to improve care models and further develop what they can offer.”

“New models and new structures are two different things.”

Tracy Taylor, Chief Executive, Birmingham Community Healthcare

Both multispecialty community provider and primary and acute care system approaches involve primary care working at a far larger scale than GP practices usually do. Nigel Edwards has suggested that GP federations could cover populations of 50,000–120,000 (30,000+ in rural areas)¹⁹; the population sizes that are covered by new care model vanguard sites appear to vary from 53,000–365,000.²⁰ This may work best around natural communities rather than being organised rigidly around particular pre-conceived population sizes.

Working across these much larger populations presents opportunities and challenges. Challenges include a need for skills in strategic planning, large-scale operational management and standardised internal systems to support change.²¹

Management and support staff in community services already have some understanding of how primary care colleagues work and are used to working with relatively autonomous practitioners operating across multiple sites. Providers of community services that are already working across large populations are therefore well placed to help address some of the practical challenges to operating at scale, such as:

- Managing consistent approaches to clinical supervision, clinical risk management and CQC compliance, so that policies and processes align and accountability is clear across a whole, complex primary and community services collaboration.²² Senior nurses or allied health professionals may be the most appropriate senior accountable professional for particular functions. Looking at clinical governance across a whole community and primary care collaboration should identify these kinds of opportunity.
- Support to manage estates and finances on a larger and more complex scale. (The latter will be particularly important given the complexities and risks of capitated, outcomes-based contracting and pooled budgets.)
- HR and organisational development capacity to manage and develop a varied workforce at a much larger scale than that of the GP practice.

- Additional capacity to develop bids for contracts, undertake data analysis to support data-driven decision-making and measure spend and outcomes, procure equipment and supplies and manage and upgrade IT and data sharing systems.
- Communications and engagement support: communications professionals employed by community services will be valuable to engage local people about change and what it will mean for them as new models develop.

New care models will need to have this kind of infrastructure in place early on, and using the management resources in community services to augment GP practice management could represent an effective, efficient approach.

The success of new care models will rely on collaborative leadership with a common purpose and mature partnerships between organisations. Community health leaders are one source of expertise in building consensus and partnerships. They will already have extensive partnerships with a range of other services locally to deliver joined-up care such as early supported discharge, and often have developed innovative formal partnerships to improve care and address sustainability challenges.²³

Community services are often well placed to flex and adapt their services, making new, unexpected approaches to delivery possible – primarily because they are usually less building-based. Not all of the possible approaches will therefore be visible, and insight from community services will be needed at all stages of care models' development and evolution.

“Community services are ideally placed to lead new models as the provider focused on whole-person care.”

Tracy Allen, Chief Executive, Derbyshire Community Health Services

Confederation viewpoint

The vision for better and more sustainable care by 2020 rests on truly joined-up, community-based models. Making the most of the services, infrastructure and leadership within community health services will be critical for success.

Maximising the value of community health services means building on the strengths of their 'core' offer of multidisciplinary care based on what matters to people with long-term and often complex needs, in and near their homes, as well as the wide range of other services, which will vary locally. Community services can also bring a wealth of local community knowledge and engagement, expertise in developing partnerships between organisations, and management and infrastructure capacity. These will add great value at the heart of new models that no longer have artificial barriers between 'types' of service.

A strategic approach by commissioners will be crucial. Co-commissioning of primary care, and freedoms to use new contracting approaches, are important opportunities to better use existing best practice and maximise future potential in community services to deliver a step change in care.

There are, however, two key risks that may prevent community services' potential from being realised.

Firstly, knowledge and understanding of community health services' potential remains variable among commissioners and providers. It has often lacked prominence in high-profile discussion about the future of healthcare, including the Five Year Forward View. The complexity and variability of

what community services deliver compounds this problem, as does the challenge of developing new models while simultaneously managing unprecedented financial pressures. To address this:

- local community services leaders need to articulate the value their services can add and the changes they can enable, and be at the table as equal partners throughout new models' development
- national leaders need to do more to articulate the value community health services can add within new, integrated models
- clinicians in the community, including community nurses and allied health professionals, need to be more visible and vocal in sharing their insights on how models of care can deliver better value.

Secondly, policy barriers to community services growing and maximising their value have yet to be resolved. These have been rehearsed in detail in previous publications.²⁴ As we develop new models of care, we most urgently need the following:

- Nationally agreed measures of the quality and efficiency of community health services, including outcomes-focused measures. Experts have for years called for this to be addressed.
- Alternatives to block contracts. Freedom to develop capitated budgets and new approaches to contracting is welcome, but the lack of nationally agreed metrics adds to the practical challenges. New payment mechanisms are still urgently needed.

“Knowledge and understanding of community health services' potential remains variable among commissioners and providers. It has often lacked prominence in high-profile discussion about the future of healthcare, including the Five Year Forward View.”

- Investment to enable safe transfer of care to new services.
- Clarity about competition and procurement rules. Some commissioners and providers are concerned that competition and procurement rules represent barriers to new care models; the King's Fund also highlights uncertainty.²⁵ Short contracts often used for community services work against investment in large-scale change that requires a longer-term approach.
- Approaches to regulation of quality and provider finances that look at systems and pathways in the round rather than focusing on individual organisations in isolation.
- A strategy to overcome workforce shortages and workload pressures in community nursing, and recruit and retain an increasingly highly skilled workforce. The professional opportunities associated with leading services and autonomously managing high-acuity patients are often invisible to potential recruits.

These policy barriers are not new. Resolving them soon enough to enable a step change in community-based care is a key test for NHS England and the other national bodies supporting the Five Year Forward View.

For more information on the issues covered in this discussion paper, contact Kate Ravenscroft, head of policy and research, at kate.ravenscroft@nhsconfed.org

“Policy barriers to community services growing and maximising their value have yet to be resolved.”

Join the discussion

This paper offers early thinking on the value community health services can add to emerging new models.

This is an exciting time for anyone interested in the art of the possible in community health. Many local areas are at an early stage of developing the care model and creating the collaborations and practical arrangements to deliver it.

We need to keep sharing new ideas on care models and how the capacity and expertise in community-based services can make the most effective contribution. As well as ideas, it will also be vital to share evidence and learning on what can be delivered and how people have overcome the practical challenges of implementation.

The NHS Confederation's Community Health Services Forum will be exploring these questions through its work programme, including meetings open to all forum members. We will also work in partnership with other organisations such as the National Association of Primary Care.

We hope you will join in the discussion.
www.nhsconfed.org/communityservices

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Community Health Services Forum

The Community Health Services Forum is the only forum that brings together and represents organisations from across the community health sector. Our membership includes:

- community NHS trusts and foundation trusts
- social enterprises
- independent sector providers of community health
- integrated mental health and acute trusts.

We also have a close working relationship with commissioning groups through NHS Clinical Commissioners. The forum is open to all NHS Confederation members with an active interest in community health.

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