COMMUNITY SERVICES BULLETIN

We are working with patients, carers, the wider population, health and social care professionals and partner agencies to design a blueprint for the future delivery of community based services that will meet the needs of the population both now and in the future. This bulletin provides an update for stakeholders about our approach and progress towards **transforming community services**.

Our Vision

The overall vision and direction statement for community services in the East Riding over the next five years is:

*A truly Integrated Health and Social Care Economy that delivers consistent, systematic, good quality community care by the right person, in the right place, at the right time whilst ensuring the long-term sustainability of the NHS in the East Riding.*

What services are we talking about?

We are focussing on community based services for older people and adults with identified needs which impact on their health and wellbeing. A number of discussions have taken place, in partnership, to determine exactly what services will be in scope (i.e. included in any new contract from April 2017) and those which are out of scope for this particular work (but are linked in some way).

The range of services includes:

- Community beds
- Community therapy (e.g. occupational, physiotherapy, speech and language, etc)
- GP out of hours
- Intermediate care
- Minor injury services
- Neighbourhood care services (eg district nursing, specialist community nursing, McMillan nursing, etc)
- Palliative care
- Older peoples’ community mental health (for a future phase)

The services that we have deemed to be ‘out of scope’ - such as children’s services and musculoskeletal services - will be reviewed separately in the future.
Why are we doing this?

We are exploring opportunities for the future model of community services which may result in a change of provider from 1 April 2017. Community based services are currently delivered by a number of providers; Humber NHS Foundation Trust, GP practices, voluntary sector providers; and some of the contracts we hold with these providers are due to expire in March 2017.

The commissioning and contractual process is complex. In order for us to be in a strong position and ready for implementation of the new arrangements, we have already started discussions with existing and potential providers about future ways of working.

This is a normal part of the commissioning process, and allows us to focus on improving community services in the area. It is not a reflection on any staff currently providing these services who we know work extremely hard in the interests of local people. Nor does it mean we want to cut services. We want to focus conversations on how we can better deliver outcomes for local patients and ensure services are fit for the future.

What are we trying to achieve?

We have considered outcomes from the engagement we have already carried out, gained the perspective of local GPs and other clinicians and have looked at best practice. This has led us to being able to identify four things that we want our services to deliver in the future:

- Community services to work better together across health and social care (seamless handover between staff and providers).
- Care to be provided in a community setting that is closer to, or at, peoples’ own homes.
- Reduce the need for admission to hospital, or speed up the discharge process for those who do require a hospital stay.
- People to be more informed to help them better manage their own condition and avoid going into crisis.

Our plan is to provide community ‘hubs’ where some services can be co-located and integrated so that patients can receive a ‘one-stop shop’ approach to their care, staff can provide joined up care across traditional health and care boundaries, and links can also be made with voluntary sector and community groups.
Governance Arrangements

To ensure we effectively deliver the changes that we need, a Community Services Programme Board has been established, chaired by **Alex Seale**, Director of Commissioning and Transformation, and including clinical and lay member representation.

**Dr Ben White**, GP partner working in Holme on Spalding Moor, is our Clinical Lead for Community Services Strategy, ensuring clinical views are at the heart of shaping our new community services model of care.

A number of workstreams have been established to take the work forward:

- **Clinical Quality and Workforce** – led by Ben White, Clinical Lead for Community Services Strategy
- **Financial and Contracting** – led by Richard Dodson, Chief Finance Officer
- **Transport, Technology and Infrastructure** – led by Will Uglow, Assistant Director of Localities
- **Communications and Engagement** – led by Quintina Davies, Head of Communications and Engagement

Each workstream has agreed Terms of Reference, objectives and broad membership. Further information is available through workstream leads or through Chris Spark, overall Programme Lead - c.spark@nhs.net

Workshops and Feedback

Work has been ongoing through the workstreams and our Governing Body to shape the scope of the service model. In June 2015, as part of the Protected Time for Learning sessions, we also asked our Locality Commissioning Forums for their views on our plans and their thoughts on how we can bring services together to deliver better outcomes.

- In summary, **all five localities** generally **support** the direction of travel for future community services.
- The top three strongest themes overall were:
  - **17%** Better integration
  - **17%** Support new ways of working
  - **16%** Whole system co-ordination
- These themes made up **half** of the total comments received.
- **80%** of responses focused on better communication and integration (45%) and getting the workforce set up right (35%) in response to ideas for ensuring services are brought together to deliver better outcomes.

Plans are in place to continue this valuable engagement and discussion.
Primary Care Transformation Pathfinder

A key element of our community strategy is to shift resource from where it is currently spent to better support delivery of care in the primary and community setting, where it can make the biggest impact on patient care and outcomes and deliver our vision for more seamless care.

We have already been testing a number of different ways of working (such as Rapid Response in Goole, Howdenshire and West Wolds) and are evaluating these to understand what will work best.

However, to help further with this, we have allocated £600,000 of funding this year to support transformational change, with the aim of testing local solutions for primary care transformation. We have invited all our GP practices to submit one or more pathfinder proposal for consideration by 30 September 2015. Further information is available from John Brennan, Project Manager, john.brennan5@nhs.net.

What happens next?

We are currently firming up the outcomes our patients want across the range of community services. Rather than focus on individual services, as we have often done in the past, we are focusing on four overarching service model areas and will be developing outcome based specifications for the new service.

The service model is focussed on delivering services across:

- **Planned care** – rehabilitation & reablement, intermediate care, specialist nursing, therapies, woundcare, end of life, care home support, chronic disease management.

- **Proactive care (prevention)** – wellbeing & self care, avoiding hospital admission, support with system navigation, falls, nutritional support, clinical input 24/7, risk stratification, medicines optimisation, carers assessment and support.

- **Unplanned care** – clinical input 24/7, hospital in-reach / discharge to assess, rapid response, GP out of hours, community beds, minor injury services.

- **Enablers** – ERY wide co-ordination of services (including voluntary sector), telehealth & virtual consultations, skilled & flexible workforce, personalised care planning & shared records, care co-ordination, multi-disciplinary teams, social care, local system leadership, single point of contact, etc

We are working with stakeholders (i.e. GPs, clinical staff, partner organisations, voluntary and community sector, patients and the public) to inform development of these specifications. Then we need to decide on how best to secure the services into the future. This means that we will need to make a decision on the route to market, which could be a procurement process or an alternative approach to ensure that appropriate ‘due diligence’ is undertaken.
**Route to Market**

To help us decide on our route to market, we will consider:

- Do we actually need a new service or is it provided elsewhere to the quality we want?
- Can we work with an existing provider(s) to develop their existing service to the service we want?
- Are there other providers available to deliver the service we want when we want it?
- Are there new ways of contracting across a number of organisations to get the service we want?
- Do we want to go out to wider providers to get the service we want?

Before making a final decision on our approach later in the year, we will carefully consider all our options.

**Contract Approaches**

The current contracting model that we have inherited is typically a series of arrangements with individual providers. Each contract will have been developed in isolation with limited interaction between providers and commissioners in different sectors, for example, health and social care. Going forwards, we have a real opportunity to enhance integration through a potentially new, multi-agency, approach that is seamless for the patient.

Across the NHS there are three key contractual models that are emerging to help govern new ways of working. These contracting models are:

- **Prime provider contracts** – where one provider is contracted to provide a care pathway and sub contracts with other providers for part of that pathway.
- **Alliance contracts** – where the commissioner holds one contract with a group of providers who work in partnership to deliver a co-ordinated service.
- **Integrator contracts** – where a commissioner holds one contract with a provider whose role is to integrate service delivery, holding sub contracts with a range of providers.

We are reviewing the risks and benefits of each model in discussion with a range of stakeholders to help us understand our preferred contract approach at an ERY wide or locality level.

**Timeline**

We will need to make some key decisions by the end of December 2015. Further details will be provided in the next issue of this bulletin.

**Glossary of terms**

We have developed a glossary of terms to help people better understand our terminology. This is available on our website at: [http://www.eastridingofyorkshireccg.nhs.uk/publications/glossary-of-terms/](http://www.eastridingofyorkshireccg.nhs.uk/publications/glossary-of-terms/)
How to find out more

More information is available from Chris Spark, overall Programme Lead - c.spark@nhs.net