Comprehensive Spending Review 2020: Submission from the Community Network

The Community Network is the national voice for NHS community services. Hosted by the NHS Confederation and NHS Providers, the network brings together and represents the NHS and not-for-profit organisations providing NHS community health services. The network uses its voice to promote and support the pivotal role of community services in delivering the NHS Long Term Plan and integrated care.

We welcome the engagement we have had both with the Department of Health and Social Care and HM Treasury as they prepared for the Comprehensive Spending Review (CSR) in recent months. This submission sets out the case for investment in community health services and complements the submissions from NHS Providers and the NHS Confederation, which set out their overarching case for investment in the NHS on behalf of trusts and the wider health and care sector respectively.

Key points

1. Community health services play a key role in local health and care systems. They deliver specialist care to keep people with long term conditions well at home, and provide public health services that play an important role in prevention and population health. Demand on community health services has grown in recent years due to demographic changes particularly in relation to an ageing population.
2. The period covered by the CSR will be incredibly challenging for the health and social care sector, and its staff who have worked tirelessly during the COVID-19 pandemic. Community providers are striving to restore services to pre-pandemic levels while grappling with reduced capacity, winter preparations and a potential second COVID-19 peak. They are also delivering increased asks above and beyond NHS Long Term Plan (LTP) commitments, including the discharge to assess model leading to increased demands on community services.
3. These pressures build on a sustained period of challenge for the health and care system, which already faced increased demand and sustainability issues prior to the pandemic. While we recognise that the government faces a significant post-COVID fiscal challenge, the CSR must address the additional operational and financial pressures on our health and care system.
4. The LTP set out worthy aspirations which were in our view always ambitious within the financial envelope available. The funding for delivering the LTP is now tied to a financial and operational recovery task that predates the pandemic and additional manifesto commitments made by the government. The outcome of the CSR will therefore be central in determining a realistic and re-prioritised 'ask' of the NHS over the next three years. Community services should be prioritised within any reprofiling of the 2018 funding settlement.
5. Community health services also need additional investment beyond the 2018 funding settlement to meet COVID and non-COVID increases in demand, as well as LTP trajectories and targets.

Strengthening community health services is more imperative than ever as more care delivered in the community means lower bed occupancy levels, fewer delayed discharges and proactive management of long-term conditions. This will help restore services, tackle the backlog of elective care, and reduce demand on acute services, which will lead to cost efficiencies.

6. In this context, the Community Network has five key messages for the CSR:
    i. Invest in expanding capacity in the community across all pathways, including but not confined to community beds, to: support ongoing COVID-19 rehabilitation needs; prevent avoidable admissions and pressure on the acute sector; avoid unnecessarily long stays in hospital which are detrimental to patients and financially costly; and deliver more care within or as close to home as possible.
    ii. Given the changed context due to COVID-19, expedite existing LTP investment commitment in rapid response and anticipatory care services.
    iii. Implement a national investment standard for community health services, which will help improve quality and track levels of investment in community services by specifying minimum levels of spending in targeted areas such as rapid response, discharge to assess and 'home first' (including rehabilitation and reablement).
    iv. Provide capital to increase community bed capacity in the areas that need it and drive forward digital transformation across the full range of community providers.
    v. Resolve the local authority funding gap to protect the public health grant, fully fund Agenda for Change pay uplifts and increase social care provision.
7. In our view, if the government is serious about 'bolstering' community capacity, as set out in the LTP and the COVID-19 recovery plan, now is the time to make rhetoric reality. Otherwise it will take the NHS longer to tackle the backlog of elective care, pressure over winter will be higher, and – most importantly – patients will not get the right care, at the right time and in the right setting.

What do community health services offer and why are they important?

8. Community health services deliver a significant proportion of NHS care in England, totalling 100 million contacts every year (The Health Foundation, April 2017) and spending £10bn of the total NHS budget (King's Fund, January 2019). Trusts, social enterprises and independent providers deliver a wide range of community health services that are commissioned by both Clinical Commissioning Groups (CCGs) and local authorities. NHS England also commissions certain community health services nationally, including immunisation programmes. Community health services are delivered in people's homes, community centres, schools and clinics. They include:
    I. Adult community health services (e.g. district nursing, intermediate care, end of life care)
    II. Specialist long term condition management (e.g. heart failure, diabetes, cancer)
    III. Planned community health services (e.g. podiatry, speech and language therapy, physiotherapy)
    IV. Child health services (e.g. health visitors and school nursing)

V. Health and wellbeing services (e.g. sexual health, smoking cessation, weight management)
VI. Inpatient community health services (e.g. community rehabilitation beds).

9. Community health services play an essential role in keeping people well at home or as close to home as possible. Community staff often support people with complex needs and long-term conditions to live independently by providing specialist care. They also deliver public health services that support health inequalities, prevention and population health and wellbeing.

10. Community health services play a key role in the integration between primary care, secondary care, social care and the voluntary sector. They are often described as the "glue" which enables joined up care in the community (NHS Providers, May 2018). The current policy focus on Integrated Care Systems (ICSs) provides a further strategic driver for investing in community services, as they play a key role in bridging the three historic divides as set out in the LTP: primary and specialist care, physical and mental health services, and health and social care.

11. Community health services were stretched prior to the pandemic due to rising demand, workforce shortages and increasingly complex patient needs. Despite the transformation of community services and extraordinary efforts of community staff, additional COVID-19 pressures have exacerbated this situation in recent months.

12. Community service providers carried out vital work in preparation for the first peak of the COVID-19 outbreak. The expansion and transformation of community services' capacity in response to the first wave of COVID-19 proved critical in protecting the NHS from becoming overwhelmed during the initial peak. Community health services:
    - Worked with local partners to safely discharge thousands of medically fit patients from hospital to free up beds before the initial peak, with most patients going back to their own home with support from community and social care where needed.
    - Set up discharge to assess processes within days and expanded rapid response teams to support admission avoidance.
    - Rapidly prioritised services and redeployed staff to care for COVID-19 and non-COVID-19 patients with complex needs in the community.
    - Improved both efficiency and effectiveness by using digital technology to support continued service delivery.

13. The main focus of the community sector's response to COVID-19 is now (as set out in NHSE/I's letter on 31 July) to "restore activity to usual levels where clinically appropriate" and "reach out proactively to clinically vulnerable patients and those whose care may have been delayed". Community providers are also providing ongoing rehabilitation for the long tail of people who

were most seriously ill from the virus, which necessitates a focus on supportive discharge, integrated care planning and rehabilitative care in the community. Providers' capacity is further impacted by increased demand from elective care restarting, undertaking activities such as vaccination programmes that were not running during the initial COVID-19 peak, supporting care homes and delivering prevention programmes to support those most at risk of poor health outcomes (e.g. long-term condition management, obesity reduction) to help tackle health inequalities.

14. The phase three targets to resume activity are very stretching given the clinical imperative to provide high-quality care for patients. While community providers will do their utmost to achieve them, many will likely struggle to meet them due to infection prevention and control procedures reducing capacity by 15-30%. In a recent survey, 93 per cent of trusts providing community services report an increased backlog of people waiting for care, with a knock-on effect on their ability to return to a normal level of service provision (NHS Providers, June 2020).

The strategic context for community services

15. Several recent national policy documents set out an ambition to transfer the volume of care undertaken in acute settings into the community. The Five year forward view (2014), Next steps (2017) and NHS LTP (2019) all made "boosting 'out-of-hospital' care" a key commitment. The ambition is to keep people safe and well at home to improve clinical outcomes and ensure the financial sustainability of the health and care system. Community providers support this ambition and want to expand and transform their capacity to deliver more care to patients at home, or as close to home as possible. Their vision is enhanced by integration and digital technology, embedded in population health management, and supported by new, innovative workforce supply routes.

16. The achievements of community health services and their staff during the pandemic demonstrate that with the right long-term funding, workforce and support, COVID-19 can be the catalyst for that much-needed reconceptualisation of NHS healthcare provision. In May 2020, the government's COVID-19 recovery plan committed once again to 'bolster[ing]' capacity in the community to embed the transformation in service delivery, manage winter pressures and maintain flexibility in case COVID-19 spikes again, but did not set out what this meant in practice or how it would be resourced. The CSR must support the delivery of these priorities by providing adequate funding.

17. While the 2018 funding settlement was a welcome improvement on previous settlements, it was less than the 5% required to recover and transform services (Institute for Fiscal Studies and the Health Foundation, May 2018). We have always been clear that the LTP targets and trajectories were highly ambitious given the resource available. The additional financial and operational

pressures created by the pandemic must prompt a conversation with the sector about what can realistically be delivered by when, particularly if additional investment cannot be made available. It is therefore necessary to explore how the required response to COVID-19 has prompted an expansion of community services that now necessitates reprioritising LTP deliverables and revisiting funding allocations.

Revenue settlement: Expanding capacity in the community through the NHSE/I ringfenced budget

18. With all parts of the health and care system under immense strain, the effectiveness of the NHS's recovery from COVID-19 is dependent on the community sector receiving additional resources (funding and workforce) to manage the impacts of COVID-19, meet competing demands and achieve the strategic vision set out in the LTP. We have engaged with the chairs, chief executives and directors of community providers to identify the following policy priorities for the CSR:

i. **Investment across all community health pathways – including but not confined to community beds – to expand capacity in the community in response to additional COVID-19 pressures.**

Community service providers report an increase in demand for community services, as well as an increase in the complexity and acuity of patients' needs. This is partly driven by the complex ongoing rehabilitation needs of people discharged from hospital after being seriously ill with COVID-19[1], as well as people living longer with complex conditions. For example, some of these patients have severe respiratory conditions that require ongoing community rehabilitation from 'hospital at home' services. Overall, the discharge to assess process will lead to more complex care needs being managed in the community. There needs to be increased investment in this kind of complex pathway so that acute medical care can be undertaken outside of hospitals. These services have a positive impact on patient experience and outcomes, prevent avoidable admissions and reduce demand on acute services leading to cost efficiencies.

Strengthening community health services in this way is more imperative than ever as more care delivered in the community means lower acute bed occupancy levels, fewer delayed discharges and proactive management of long-term conditions. Enhanced community provision will free up hospital capacity to help restore services and tackle the backlog of elective care. This backlog means that it would not be appropriate to transfer investment from the acute to community sector at this stage, so there will be some double running costs to cover the expansion of community services and restoration of elective care. In some instances, immediate financial savings will not always be evident, but community providers have proven system-wide improvements and cost efficiencies through local investment (Annexes 1-5).

[1] There is a growing body of evidence to suggest that COVID-19 has long-term health effects (Public Health England, September 2020), as reported in various media outlets including the BBC.

The discharge to assess process adopted during the pandemic has shown that when community services are fully funded and supported to free up hospital capacity they can do so. Community providers, and their acute and social care colleagues, welcomed the continuation of discharge to assess funding for the remainder of this financial year and would advocate funding this on a permanent basis. Failure to do so risks reintroducing frictions (due to bureaucratic and financial negotiations associated with NHS Continuing Healthcare assessments), delayed transfers and bed blocking. The limiting factor will be workforce capacity in community services and domiciliary care, particularly when managing winter pressures.

Local systems must have the flexibility to spend additional investment on community-based pathways that meet local needs. Below are some examples of where different health and care systems need to invest in community services:

- Increase community nursing as many patients who previously attended clinics are now housebound and require support in their own homes.
- Provide seven-day services to match acute care provision.
- Increase supply of home-based rehabilitation services and admission avoidance.
- Expand digital pathways and invest in data systems.
- Increase resources for community teams providing end of life care, as in some areas the number of people choosing to die at home has doubled and is likely to grow as the hospice sector faces sustainability issues due to the pandemic.

ii. Expedite LTP funding for rapid response and anticipatory care services.

The LTP committed to developing 'fully integrated community-based health care' through multidisciplinary teams that would deliver two new national standards (two-hour community crisis response and two-day reablement care) to provide rapid support to people in their own homes as an alternative to hospitalisation. Funding for these two standards must be brought forward to enable community providers to continue managing demand on the acute sector and therefore provide a cost-effective health service. Reablement services can reduce demand on acute/residential settings through step-down care that enables shorter length of stay in hospital and reduced delayed transfers of care.

Community rapid response services provide crisis care to people in their own home or care setting to prevent conveyances to A&E and reduce hospital admissions and transfers to residential care. This realises financial benefits based on future cost avoidance to secondary care services, frees up bed capacity in hospitals, and improves patient experience and clinical outcomes. Anticipatory care services aim to embed high quality care planning within multidisciplinary teams across primary and community teams. These services aim to provide proactive, integrated care to patients who might be at risk of hospital admission. This means patients are provided with the right support at the right time

before they reach crisis point, thereby improving health outcomes and preventing costs on the wider health and care system.

Some community providers have provided evidence of the benefits that enhanced rapid response services bring (please see further detail in the Annexes):

- South Warwickshire NHS Foundation Trust demonstrated significant benefits relating to their enhanced medical care at home service, including reduced length of stay, admission avoidance (538 A&E attendances and 105 emergency admissions per year in one Primary Care Network) and positive impact on patient experience.
- Tameside and Glossop Integrated Care NHS Foundation Trust worked with the CCG and local authority to deliver new models of out of hospital integrated care services, which was funded by £23.2m of non-recurrent transformation funding from Greater Manchester Health and Social Care partnership in 2016. They reduced hospital attendance and admissions, and ensured people were well supported to live healthy and independent lives. Activity benefits include reductions in DTOCs, average length of stay and non-elective A&E attendances and hospital admissions.
- During the COVID-19 response, the Sussex ICS reduced average length of stay in community beds from 25 to 16 days by redeploying staff into rapid response services. This has freed up an estimated 230 acute beds during the pandemic.

While the COVID-19 pandemic has increased the provision of rapid response services, some community providers have struggled without additional resources (funding and workforce). Even in those areas where services exist, resourcing constraints mean meeting the two-hour target is challenging. For all areas to meet the ambition in the 2020/21 planning guidance to provide "as a minimum an agreed number of guaranteed two-hour home response appointments to be made available to ambulance and other agreed local services for 1 November 2020 to 31 March 2021", bringing forward LTP investment is vital. While the focus on enhancing community rapid response services in the phase three letter was welcome, we are concerned that the expectation on providers to deliver more within the existing funding settlement will curb their ability to meet the ambitious targets and divert investment from other schemes or postpone other priorities.

iii. **Implement a national investment standard for community health services, which specifies a minimum level of spending in targeted areas such as rapid response, discharge to assess and 'home first' services (including rehabilitation and reablement)**

In the LTP, NHSE/I committed to primary and community services funding being at least £4.5bn higher by 2023/24. While this commitment was welcome, combining community care investment with primary care was unhelpful as it allows local discretion around spending when specificity is required.

If the sum total of investment in primary and community care reaches the LTP target, but flows into primary care rather than community care, it will not support community services to prevent avoidable

admissions, provide rapid response services or deliver discharge to assess processes. This is a real risk as the focus on the PCN DES contract has monopolised conversations about investment in primary care and other community-based care. As a recent Community Network long-read blog shows, community service providers have reservations about the way this contract was brought forward; they want to see community care supported by the right funding and contractual mechanisms, rather than a default to the PCN delivery model. This combined approach has also led to delays in funding being released due to additional complexity.

In light of these issues, there needs to be a national investment standard for community health services to ensure that the planned increases in funding flow appropriately. This should be modelled on the mental health investment standard, which has secured sustained and ongoing investment in mental health services. A community health national investment standard should set minimum levels of spending in three targeted areas to hold systems to account and demonstrate return on investment. These priorities should include rapid response, discharge to assess and 'home first' services which include rehabilitation and reablement. The outcome of this policy would be that funding for community services would be spent where it is needed in way that makes most sense to local areas.

The deliverability of these priorities will depend on having sufficient workforce capacity, not only in community health services but also in domiciliary and social care. The investment standard needs to be accompanied by a national programme developing innovative routes into the community workforce.

Capital allocation: community providers must not be overlooked

19. Community services are too often overlooked and neglected in NHS capital funding allocations, such as the health infrastructure plan (September 2019) and recent announcement of £1.5bn capital investment for the NHS in 2020/21 (June 2020). Capital allocation processes remain focused on acute hospitals and while the recent drive to eradicate mental health dormitories is welcome, the same sector specific prioritisation needs to be offered to community services so that they can achieve the transformational aspirations in the LTP. The CSR represents a pivotal opportunity to rectify under-investment in community capital budgets and set aside proportionate capital funding specifically for community providers.

iv. Increasing the community bed base where that meets the needs of the local health and care system.

Community providers are clear that investment in community capacity must take place across all pathways and not just bedded care. However, in some areas, the number of community beds is insufficient to meet rehabilitation needs. These areas coped during the COVID-19 response as acute bed capacity was lower due to the drop in A&E attendances and elective care, so acute hospitals absorbed some of the demand for community beds. These areas will now need to increase their community bed base going into winter, as COVID-19 will be circulating with seasonal flu and

transmission may increase, leading to higher bed occupancy levels. There may be a case for investment in the Seacole centre model in some areas. In other areas where community beds have low occupancy levels, funding needs to be redirected into non-bedded pathways rather than shoring up financial gaps in acute services.

v. Investing in digital transformation to deliver more efficient community care

The future sustainability of the NHS requires a transformation of service delivery that focuses on integrated, proactive and personalised care. This shift can only take place if it is supported by an ambitious programme of digital transformation. Providers need access to both revenue and capital funding to properly invest in digital, as IT suppliers are increasingly moving to "software as service" models.

The CSR must provide targeted capital investment in community providers to ensure a standardised level of core digital infrastructure and maturity across the community sector. This is necessary to support new remote and flexible working, prevent a postcode lottery and ensure interoperability of systems. It is important to note that Community Interest Companies did not have access to central funding for digital transformation during the pandemic, even though they deliver the community health contracts for the NHS. This inequity must be rectified.

Revenue settlement: Appropriate, multi-year budgets for local authorities, including public health and social care

vi. **Local authorities must receive sufficient, sustainable funding so that they do not need to cut vital health services and can fully fund the Agenda for Change pay uplift.**

Local authority budgets were under severe strain before the pandemic, which has exacerbated financial pressures on social care and public health services. Local authorities face a £9.2bn income shortfall for 2020/21, which the £3.2bn emergency COVID-19 funding allocated by the government falls short of covering[2]. As local authorities have a legal requirement to balance their books, they are already having to identify in-year savings. Community providers that deliver NHS contracts commissioned by local authorities are reporting that in-year cuts are being made to contracts and signals made to begin retendering processes. These services have already been retendered, reduced and restructured over several years to meet a much smaller financial envelope, which will impact population health and wellbeing in time. In June, the Community Network wrote to the Secretaries of State for Health and Social Care, and Housing, Communities and Local Government, stating that competitive tendering is a damaging distraction in the middle of a pandemic.

In addition, community service providers are still waiting for a national commitment to fully fund the Agenda for Change pay uplift and pension costs for staff employed on NHS contracts through health

[2] Local Government Association analysis, 1 July 2020. https://www.local.gov.uk/lga-analysis-covid-19-council-funding-gap-widens-ps74-billion

services now commissioned by local authorities. Previous uplifts to public health grants were welcome but do not meet the uplift required on many community health services contracts which are multi-year, fixed price and not open for renegotiation. Some local authorities and CCGs have even held back the Agenda for Change uplift as there is no requirement to ringfence this funding. Some community providers are considering withdrawing from NHS contracts they consider to be unsustainable because of these problems. We are aware that the remaining phase three funding envelopes issued to systems on 15 September make reference to local authorities being funded to cover Agenda for Change uplifts on NHS contracts to the end of this financial year. Even if this is the case, the issue remains for future years, and requires a longer term solution in order to stabilise key NHS services and protect the employment of essential staff.

In short, the deliverability of LTP commitments for community services is dependent on a multi-year settlement for local authorities, which protects public health and social care.

Protecting public health spending

Public health spending has been cut by 25% in real terms since 2015/16 (The Health Foundation, June 2019). The gradual erosion of the public health grant has had a negative impact both on the country's preparedness for a public health crisis such as the recent pandemic, and in terms of our ability to address the wider determinants of health.

Reductions in funding have squeezed community service contracts commissioned by local authorities and frequent re-tendering has created too much variation and challenges around workforce development. The impacts are already evident in the fact that life expectancy has stopped improving and inequalities are widening[3]. The CSR must provide a long-term sustainable funding settlement to local authorities so that they can invest properly in public health services which both protect the public and help control the spread of infectious disease, and tackle the wider determinants of health.

The dissolution of Public Health England scheduled for 2021/22 has compounded questions around local authority commissioned NHS services. There is a reasonable case for the more medical end of the spectrum of public health services moving back into NHS commissioning structures e.g. health visitors and school nurses. However, local authorities also play an important role in addressing the wider determinants of health and making links to other key public services such as housing and criminal justice.

Social care funding and reform

The government must place the social care system on a sustainable footing immediately to enhance its resilience ahead of a challenging winter and prevent avoidable pressures on community health services. Unmet or under met social care need results in deterioration, social isolation, falls and

[3] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/healthstatelifeexpectanciesbyindexofmultipledeprivationimd/2015to2017

greater reliance on more costly community health services as preventative opportunities are not realised and admissions not avoided. Community providers are particularly concerned that shortages of social care staff will undermine investment in discharge to assess.

A long-term financial settlement, accompanied by wider reform, must also be urgently agreed with cross-party consensus to address issues including access and unmet need. If this does not happen, avoidable pressures on NHS services will continue to grow and any investment in the NHS will be devalued. If no long-term revenue settlement for social care is forthcoming, alternative approaches in the community must be explored. Community providers can be funded to purchase additional care packages and employ healthcare assistants to bridge this gap.

The amount of funding required will depend on the reform proposals and funding mechanism (The Health Foundation, May 2018). The Nuffield Trust has set out the different policy options and funding required. In a recent evidence session to the Health and Social Care Select Committee (8 September 2020), the Local Government Association stated that social care funding needed to rise by £3.9bn a year by 2024/25 just to meet inflation and demographic pressures alone, with more required to institute further reforms and address unmet need, and the Association of Directors of Adult Social Services estimated that increasing pay for the workforce would add £2.2bn to these figures. We need a national vision for the future health and care system, which has a focus on both older people and working age adults with care needs, in line with the principles developed by the Health for Care coalition (which comprises 15 organisations representing the NHS) which any settlement for adult social care should meet.

Conclusion

20. The CSR presents a key opportunity to invest sufficiently in care in the community, reconceptualising the way healthcare is delivered and building the foundations of the 'NHS at home' of the future. This has benefits for patient care and outcomes, not least because patients are at less risk of COVID-19 infection at home, but because unnecessarily long stays in hospital can be debilitating for patients physically and mentally. It also has benefits for improving efficiency and value for money including by alleviating pressures on the acute sector. Failure to invest in expanding community services' capacity now will only add to cost pressures on other services and prevent the NHS from delivering care more efficiently, during the pandemic and beyond.