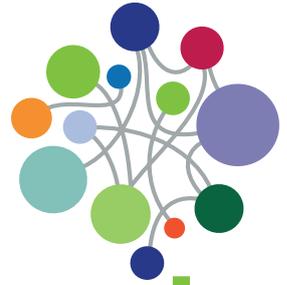


NHS CONFEDERATION



NHS Providers



Community
NETWORK

The impact of COVID-19 on community health services

AUGUST 2020



The impact of COVID-19 on community health services

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Foreword

Over the past few months, community health services have stepped up and shown their value, flexibility and resilience in the face of unprecedented challenges. Our community staff have adapted, transformed and delivered essential services during the most demanding and difficult time of their careers. COVID-19 has shown that with the right long-term funding, workforce and support from the centre, we can reimagine the NHS and deliver more care within and closer to home.

This report highlights the NHS community sector's response to COVID-19, and the critical contribution they made together with hospitals and other local partners to prevent the service from becoming overwhelmed during the first peak of the pandemic. It also explores the challenges presented by COVID-19 pressures and the support required from the government and the NHS national bodies to invest in a sustainable 'new normal' level of community service provision. We hope it showcases the critical role that community health services have played during the pandemic and the central role they must play in our health and care system going forward.

For far too long, community services have lacked due recognition and prioritisation at the national policy level. Yet they are firmly at the heart of every local health and care system. Against the backdrop of the pandemic and looking ahead to the prospect of a testing winter, we stand ready to make the rhetoric of 'bolstering care in the community' a reality. How do we ensure community health services have the resources they need – both workforce and funding – to increase capacity and deliver more care closer to home? How can we embed the transformation and innovation seen during COVID-19, at the same time as dealing with ever-increasing and competing demand on services? This report goes some way into setting out these challenges and a way forward.

We are, of course, grateful to the community provider chairs and chief executives who have contributed their views and case studies to our research. This report would not be possible without them, and we hope it does justice to their incredible efforts throughout the pandemic.

Andrew Ridley
Chief Executive, Central London Community Healthcare NHS Trust
Chair, Community Network

Key points

- **The expansion and transformation of community services' capacity during the pandemic proved critical in supporting the NHS's response** and protecting the service from becoming overwhelmed during the initial peak. Community health services entered the COVID-19 pandemic under considerable pressure due to rising demand, workforce shortages and increasingly complex patient needs.
- **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.** Community health services helped discharge thousands of medically fit patients to free up hospital bed capacity, with most patients going back to their own home with support from community and social care where needed. Community providers also rapidly transformed services and cared for COVID-19 and non-COVID-19 patients with complex needs in the community.
- **As the health and care sector moves to recover and reset after the first peak of the outbreak, community service providers are now embedding innovative practice** and learning from the COVID-19 response. The use of digital technology has radically changed the way that some community health services are delivered, with virtual consultations and remote monitoring proving effective and beneficial for both staff and patients.
- **System partnerships should continue to engage with the community providers within their local area**, building on their expertise to 'lock in' successful innovations and ensuring community capacity remains central to meeting the local population's health and care needs as we move to a new normal.
- **The main focus of the NHS's response to COVID-19 over the next few months will be on providing ongoing rehabilitation for people who were most seriously ill from the virus** and maintaining surge capacity in case there is a second peak. Leaders of community service providers describe this as a 'long tail' of patients who have suffered the effects of COVID-19. This necessitates a real focus on supportive discharge, integrated care planning and rehabilitative care in the community. **The effectiveness of the NHS's recovery from COVID-19 is dependent on the community sector receiving additional resources (funding and workforce) to manage these competing demands.**
- **It will be a real challenge for community providers to sustain COVID-19 services as well as restore other essential services.** Politicians, the national NHS bodies and the public need to be realistic about what a new normal level of community services will look like.
- **Community providers would welcome national support and an enabling system architecture to deliver more COVID-19 and non-COVID-19 care as close to home as possible.** To support community providers in this endeavour the government must do the following:
 - **Invest in public health and place the social care system on a sustainable footing as a priority.** Local authorities have experienced years of funding cuts, exacerbated by the pandemic, and will soon have to identify savings to balance their books in 2020/21. This places intolerable pressure on a fragile social care system and could mean community and public health services face cuts or repeated, disruptive retendering exercises.

- **Agree a pause on the retendering of NHS community health and public health services contracts until the end of 2021/22** in line with the spirit of collaboration promoted by system working and to ensure services and frontline staff are not subjected to undue disruption.
- **Support the reduction of unwanted bureaucracy**, mainstreaming the discharge to assess model and reviewing cumbersome bureaucracy including around NHS Continuing Healthcare.

To support community providers in this endeavour, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement (NHSEI) should do the following:

- **Continue to invest in and develop the required level of policy infrastructure** to work with the full range of stakeholders at the national level, to support the critical contribution made by community services.
- **Support investment in home-based community pathways as well as community rehabilitation beds** to 'bolster' capacity.¹ This is essential as community health services will play a key role in supporting patients who have been seriously ill with COVID-19 for some time to come, at the same time as maintaining surge capacity and phasing back in essential services.
- **Help boost the community workforce** with a national recruitment campaign and increased deployment of returners before winter pressures hit.
- **Commit to fully fund the Agenda for Change pay uplift** for staff employed on NHS contracts through health services now commissioned by local authorities.
- Work with NHSX and the community sector to **create a digital improvement strategy, robust national dataset and national performance standards** to standardise and spread best practice.

Introduction

Like colleagues across the health and care sector, community health services entered the COVID-19 pandemic at a time of significant challenge. Demand for care in the community outstripped capacity largely due to a growing and ageing population and an increasing number of people living longer with complex health needs. This was exacerbated by funding constraints on the NHS and local authorities and workforce pressures, including shortages in several key professions.² In addition, despite being the cornerstone of effective, preventative and rehabilitative care, and central to the vision set out in the [NHS Long Term Plan \(LTP\)](#), the community sector is more vulnerable than other parts of the NHS to the disruption wrought by repeated re-tendering of services.³

Yet despite these significant challenges, community providers have adapted quickly to COVID-19 and effectively prepared their staff and services to best meet people's needs during the pandemic. Their response has been central to the NHS's achievements in avoiding COVID-19 overwhelming services. Community providers and their staff have established 'discharge to assess' procedures; safely discharged thousands of patients into community settings; invested in digital transformation; and provided support for rehabilitation closer to home. Once again, community health services have shown their flexibility and perseverance when under pressure.

This report captures the community sector's response during the pandemic and showcases the achievements of community providers and their staff. It seeks to learn from community providers' experiences of the pandemic to secure much-needed transformation for the longer term and makes a number of recommendations for support from government and the national NHS bodies to enable this.

1 The NHS Long Term Plan and the policy context prior to the pandemic

Community health services play a key role in our health and care system. They keep people well at home, or in community settings as close to home as possible, and support them to live independently. Yet they have historically suffered from a lack of understanding and profile within the NHS national bodies. This has improved recently with the creation of a senior director role at NHSEI to champion community services and ageing well, however there remains a need for NHSEI to invest appropriately in national policy and support infrastructure for these key services.

Successive national NHS policies have stated their intention for community services to play an even more central role in the health and care system, with the aim of delivering more preventative care, reducing demand on acute services and improving population health. This ambition was most recently articulated in the NHS LTP, which explicitly set out to 'boost out-of-hospital care,' (NHSEI, January 2019).

We know that there is a connection between the lack of visibility for community services in national policy making and an absence of clear national performance targets, activity data, quality metrics and information on patient outcomes in the community – many of which are now under development by NHSEI in partnership with the sector. While every community services provider has local targets, quality metrics, and activity and outcomes data, which are often linked to contractual or tendering processes, this variability makes national comparison and standardisation challenging.

The NHS LTP marked a significant step forward in this regard, with commitments to introduce a new national two-hour standard for community health crisis response and two-day standard for reablement care by 2023/24, supported by an annual funding uplift, which were welcome. While COVID-19 has accelerated progress against these standards in some areas, the backloaded funding will need to be brought forward and the feasibility of these commitments reviewed in light of COVID-19 pressures.

Prior to COVID-19, the national policy focus on system working and integrated care therefore formed a clear priority for community health services. As set out in the Community Network's recent [long-read blog](#), multidisciplinary community teams work in partnership with primary and social care colleagues at neighbourhood level through various forms of collaboration, including primary care networks (PCNs) with patient populations of 30,000-50,000. The Community Network has also recently published case studies showing how integrated place- and neighbourhood-level teams are delivering better patient outcomes and experiences.⁴

2 What community health services have achieved during the COVID-19 response

Community service providers carried out vital work in preparation for the first peak of the COVID-19 outbreak, which prevented the NHS as a whole from becoming overwhelmed. Given the challenges that pre-dated the pandemic, the community sector's achievements are even more remarkable.

Preparations for the initial peak of COVID-19

National modelling on a reasonable worst-case scenario suggested that the NHS was at risk of being overwhelmed in April by an initial peak of COVID-19 patients requiring hospitalisation. To prevent this, on 17 March 2020, NHSEI instructed trusts to initiate COVID-19 preparations including discharging all medically fit patients out of acute and community hospital beds. For community providers this meant designing and implementing a discharge to assess service within days (hospital discharge requirements, 19 March), reprioritising services (prioritisation framework, 20 March) and redeploying staff to priority services. This section of the report sets out how community providers and their local partners achieved this rapid transformation.

Discharge to assess

Community service providers coordinated the safe discharge of thousands of medically fit patients to free up much needed hospital beds, with most patients going back home with support from community and social care, where needed. Many acute trusts were running hot at over 90 per cent capacity prior to COVID-19, but community service providers were able to manage this down to 50 to 60 per cent. Without this rapid action in the community, the NHS could not have coped with the initial peak of COVID-19 cases.

NHSEI published the hospital discharge requirements on 19 March, which effectively removed the bureaucratic and financial negotiations around NHS Continuing Healthcare assessments, which are known to contribute to bed blocking and delayed discharges. The national guidance set out four clear pathways for discharging patients, with 'pathway 0' intended to ensure that 50 per cent of people could leave hospital with minimal support as soon as they are medically fit. Community service providers report that, in the best-performing areas, 80 to 90 per cent of patients are now discharged on pathway 0, far exceeding initial national policy expectations.

This has effectively implemented the 'home first' model, which many local systems have aspired to for years. Best practice around hospital discharge shows that a home first model has benefits for the patient, including lowering the risks of hospital-acquired infection (including COVID-19) and deconditioning; as well as for and the health and care system, as bed capacity is used more efficiently and non-elective admissions are reduced. All discharge decisions are led by clinicians who weigh up the full balance of risks to the individual. While community service providers are aware this was not a perfect process, they did everything they could to address issues as they arose and adapt the new service accordingly.

To implement the discharge to assess model, community service providers set up rapid coordination hubs to plan and enable discharge from acute hospitals. These efforts were often supported by rapid response services that managed incoming NHS 111 calls for people with COVID-19 symptoms and helped prevent avoidable admissions. The short case studies below show how community services implemented the hospital discharge requirements, redeployed staff such as community nurses, and managed to successfully reduce bed occupancy.

Surrey Downs Integrated Care Service is comprised of six partners including the county council, GP federations, community care provider and acute trust. It has a multidisciplinary team that supports discharge to assess, rapid community response, A&E front door and community hospital beds. The @home service launched in 2016 supports patients over 65 at home as an alternative to hospital admission and has seen a 6 per cent reduction in admissions over the past three years. Key principles were developed around bed usage, which helped shape pathways including home first, avoiding multiple moves where possible and maximising local capacity. The integrated discharge services, including the @home service, reduced community hospital capacity by 50 per cent in preparation for the surge of COVID-19 cases.

Great Western Hospitals NHS FT worked with local partners, including social care and charities, to bolster care in the community during their COVID-19 response. They created a robust seven day 8am to 8pm service to support patients affected by COVID-19 directly or indirectly. This service reduced acute bed occupancy to 50 per cent at the height of the pandemic's first peak, as well as a sustained reduction in the number of medically fit patients waiting for discharge and over 21-day stranded patients. Most patients have gone home with wraparound support. This was possible as staff and volunteers took on duties beyond their normal scope. For example, podiatrists supporting tissue viability nursing services and therapists undertaking care visits.

Anglian Community Enterprise (ACE) community interest company reorganised its discharge model within days to support the timely discharge of patients from hospital. This involved redeploying staff from community therapy services to manage the discharge to assess process from both acute and community hospitals, with support from social care colleagues on more complex cases. The discharge team has oversight and case management input for all discharges on pathways 1–3, which are all tracked from the initial local setting to the final destination by the ACE discharge tracker. This tracker enabled ACE to develop a sitrep showing a system-wide view of discharge capacity in health and social care settings.

The sitrep provides a real-time tracker for activity and quality metrics and is used to make evidence-based decisions about discharges. This has delivered improvements to the use of home first. ACE is now working with the CCG to use this data for improved population health management and the ICS is looking to roll the sitrep out to other parts of the system. The discharge team enables ACE to be more responsive with earlier input into appropriate care needs, provide more support to hospitals in the discharge process, which should improve the safety of discharges, and support admission avoidance.

This multidisciplinary approach and integrated working is increasing knowledge around issues such as safeguarding and helping to build good relationships. To sustain this innovation, ACE supports a joint commissioned service with associated timescales, funding and key performance indicators. This will help provide clarity around a staffing model, as redeployed staff will soon need to be released back to their substantive roles.

Developing flexible service provision and workforce roles

Trusts and not-for-profit organisations reprioritised their community health services to staff the discharge to assess model, step up COVID-19 care in the community and maintain essential non-COVID-19 services. This process was guided by the [prioritisation framework](#) issued by NHSEI on 20 March, which provided welcome flexibility to pause or partially stand down some services and increase capacity in discharge teams. Where capacity allowed, providers did not stop services altogether but delivered services differently, sometimes by amending clinical prioritisation or using digital technology.

Community services have been transformed to maintain good infection prevention and control (IPC) protocols, including physical distancing and the use of personal protective equipment (PPE). Community providers cohorted patients, teams and premises into hot (COVID-19) and cold (non-COVID-19) groups to avoid cross contamination.

Community providers also worked collaboratively with primary care (including PCNs) and voluntary sector colleagues to support high-risk individuals advised to shield for 12 weeks. While community service providers' experience of [collaboration with primary care during COVID-19](#) has varied, in many areas they have been working closely together. For example, Croydon Health Services NHS Trust worked with the local GP collaborative to extend medical cover to be available 8am to 8pm seven days a week, which was supported by the multidisciplinary community rapid response service. This enabled management of more complex cases in the community, including end-of-life management.

Community service providers also collaborated ever more closely with acute hospitals during COVID-19. In some areas, geriatric teams that are usually based in hospitals are now providing in-reach to community rapid response services. In other areas, acute hospitals are providing clinical support to care homes as part of multidisciplinary teams. One of the strengths of community service providers is the relationships they hold across the spectrum of local health and care organisations (including primary care; social care; local authorities; voluntary, community and social enterprise (VCSE) providers and so on) and their subsequent ability to coordinate integration at place and neighbourhood level.

Liverpool Heart and Chest Hospital NHS Foundation Trust adapted its community respiratory palliative care service in the first six weeks of the COVID-19 pandemic. Senior healthcare professionals became senior decision-makers in initiating end-of-life care (EOLC) in the community, which was previously a multidisciplinary team decision, as GPs were no longer doing face-to-face contacts. Following some cases where lack of access to EOLC drugs in the community led to poor outcomes and patients not dying in their preferred place of care, the team looked at alternative ways of prescribing and secured future provision. Sharing agreements for electronic care records helped immensely when putting in place plans for patients who needed EOLC. These agreements would normally take months to get signed off but were swiftly approved during the pandemic.

Use of digital technology

To minimise the risk of COVID-19 transmission, community service providers moved rapidly to utilise telephone and video consultations, where appropriate. The [standard operating procedure for NHS community health services](#) during the pandemic advised using digital technology 'by default' (NHSEI, 15 April 2020). In a recent survey, 83 per cent of community trusts reported that they have increased their capacity for remote (telephone and video) appointments ([NHS Providers](#), June 2020). For example, Lincolnshire Community Health Services NHS Trust conducted 1,559 e-consultations between March and June, with an average 4.5/5 patient experience rating.

Some providers set up digital pathways and delivered physical and mental health services remotely, such as musculoskeletal services, group physiotherapy and ward consultations. One community interest company (CIC), Accelerate CIC, achieved the virtual transformation of its wound care service, which has facilitated patients to become more independent with the support of a structured self-care programme. Accelerate CIC is clear that patients are assessed based on risk, using clinical judgement, and those who needed urgent or essential face-to-face care during the pandemic continued to do so.*

Tameside and Glossop Integrated Care NHS Foundation Trust expanded their digital health service to support care homes during the COVID-19 pandemic. The digital health service is a team of nurse assessors, clinicians and GPs, who provide support to care homes to help staff make informed decisions about their residents and prevent avoidable hospital admissions. Individuals and their carers, care home residents and staff, and the community rapid response teams, are able to contact the digital health service via Skype. Visits to patients' homes or care homes continued where clinically necessary. The digital health team stepped up their service to offer 24-hour support and provided senior clinical leadership to help care homes with difficult clinical decisions. They did a virtual round every day of all care homes, including gathering information about the prevalence of COVID-19, which was then used to direct support with infection control. The service usually runs between 7am and 10pm seven days a week and provides other services including urgent care GP triage, falls prevention and community response to 999 calls. The existing Safe Steps app was expanded to include COVID-19 monitoring and was used by care homes to help identify patients requiring review and care interventions.

In addition to virtual consultations, many providers also set up remote monitoring services for patients at home or in care settings. These virtual wards helped identify the soft signs of deterioration in care home residents before medicalised symptoms develop and provided oxymeters to patients at home to monitor their oxygen levels. These virtual wards kept patients under the care of secondary care consultants, which avoided over-burdening GPs.

* As presented at the NHSEI COVID-19 webinar for NHS community health services on 5 May 2020.

Bromley Healthcare CIC set up a community COVID-19 monitoring service in two days to manage referrals from NHS 111. A multidisciplinary team of community matrons, respiratory specialists, GPs and consultant paediatricians undertook the clinical assessments, with a target response time of two hours. If patients were assessed to need low support, they were offered advice and a 24/7 hotline in case they had any concerns or queries. If patients were assessed as complex, they received a daily check-in call from the multidisciplinary team and the same 24/7 hotline. The community COVID-19 monitoring service could book directly into the 'hot' clinic (run by the GP federation) or request a home visit from the rapid response team to avoid hospital admission. Oxymeters were distributed to patients to support review. Patients who were anxious were referred to the Bromley Talk Together service (IAPT) for support. Only 7 per cent of referrals were admitted to hospital. Access to operational data has enabled effective management of this new service and ensured that all patients received their daily call.

Community provider boards have adapted well to holding board and committee meetings virtually. This has expanded attendance and encouraged participation. It has also allowed boards to be more effective, strategic and forward looking. Leaders of community providers would welcome national and regional NHSEI teams supporting the continued use of this digital technology, where appropriate, alongside the reduction in contract monitoring and negotiations during COVID-19.

Supporting staff in the community

The impact of COVID-19 on staff in community health services has been significant. Staff were already tired after a difficult winter when COVID-19 hit. They have been working under pressure and in highly stressful environments for months. Community service providers have worked tirelessly to support their staff who are often spread out across hundreds of sites or work remotely, and are very conscious that they will need the opportunity to recover and rest after this extremely challenging period.

Community providers welcomed the 2.8 per cent pay rise for doctors, which was announced on 21 July, but stress the importance of providing central funding to recognise the additional work undertaken by community staff in all roles and professions during the pandemic. Colleagues in social care have also been working under intense strain during the pandemic and must be equally rewarded for their efforts by increased funding to local authorities, as well as a long-term financial settlement. While the recently published [People Plan](#) rightly focuses on a commitment to look after staff, the government must still provide a sufficient multi-year financial settlement to tackle the workforce crisis and deliver a coherent approach across health and social care.

In response to the growing evidence that black and minority ethnic (BME) groups are disproportionately affected by COVID-19, NHSEI instructed providers to risk assess BME staff (29 April 2020). Many community service providers were already working with their staff to address the potential increased risk. They engaged with their BME staff members to find out what support they needed and worked with community and faith leaders to identify potential actions and initiatives to support local BME communities. For example, Derbyshire Community Health Services NHS Trust built its own risk assessment tool following engagement with its BME workforce and provided support including training for line managers.**

** As presented at the NHSEI COVID-19 webinar for NHS community health services on 22 May 2020.

Central and North West London NHS Foundation Trust (CNWL) has set up a COVID-19 First Responder programme. This scheme enables staff to volunteer to join the response to any future spikes in COVID-19 demand. During the first peak of COVID-19, staff were redeployed into key services responding directly to the outbreak including rapid response, palliative care and district nursing. The feedback CNWL received from redeployed staff was positive; they learnt new skills and knowledge quickly, as their COVID-19 roles provided opportunities for professional development. This led CNWL to establish a team of staff who, if there was a second wave, are prepared to be redeployed at short notice. This provides a chance for the trust to have more time to reform its other services and then deploy additional staff. Applicants can express a preference for a service where they might be redeployed at short notice if there was a second spike. They are trained and upskilled, with regular 'touch-base' days to maintain their skillset and familiarity with the team. The scheme has already identified 140 people to support those critical COVID-19 teams. The vision for First Responders is to become a community of colleagues who can share best practice and latest research and developments of managing people with COVID-19.

Community service providers are clear that the next phase of recovery from COVID-19 must not exacerbate existing health inequalities or race inequalities and instead accelerate work in earnest to reduce them. The NHS must act now to protect and improve the treatment of patients from BME groups, as well as tackle racism, deliver race equality and support the resilience of their communities. It was fitting that the People Plan placed emphasis on supporting BME staff and tackling discrimination, which are key priorities for community providers.

Supporting the social care sector

The tragic impact of COVID-19 on care homes manifested in high numbers of excess deaths, with 42 per cent of care homes reporting a confirmed or suspected outbreak in the week commencing 8 June.⁵ The experience of the social care sector, and of care homes specifically, raises a number of critical lessons to be learned from the pandemic. However, it is clear that years of underfunding and undelivered promises to find a sustainable funding and provision model for social care left care homes particularly vulnerable. Recent [survey data](#) from the Association of Directors of Adult Social Services (ADASS) highlights the financial fragility of the provider market and pressures on local authority finances (ADASS, June 2020). Workforce shortages and high turnover rates are also a key challenge in the social care sector, as staff are undervalued and low paid.

Community service providers support care homes on a regular basis, particularly with flu outbreaks and winter pressures. It quickly became apparent that care home residents would be particularly vulnerable to COVID-19, given their age and prevalence of comorbidities. We have heard from many community service providers that increased their regular support to care homes by providing training on IPC, mutual aid of PPE and temporary staffing when vacancies threatened closure or agency use.

Some community service providers set up care home cells to support the clinical management of residents, respond to issues with staffing and resilience, and develop good monitoring and identification of deterioration. Some acute trusts also provided outreach therapy, nursing and medical support, which helped prevent admissions from care homes. For example, the integrated care homes team at Sandwell and West Birmingham NHS Trust proactively called all care homes that registered concerns on the daily updates to the CCG tracker, rather than waiting for care home staff to call the GP who would then refer on to the community services.^{***}

^{***} As presented at the NHSEI COVID-19 webinar for NHS community health services on 29 May 2020.

On 1 May, NHSEI wrote a [letter](#) to primary and community care services to bring forward elements of the enhanced health in care homes service specification from October to May. This included regular clinical check ins by either a GP or multidisciplinary community team (either virtually or face-to-face), personalised care, support plans and medication reviews. However, as our recent [long-read blog](#) shows, community service providers had reservations about the way this package was brought forward. COVID-19 has accelerated different system-wide models of support to care homes, which community providers want to see supported by the right funding and contractual mechanisms, rather than a default to the PCN delivery model. PCNs must build on the different forms of primary and community care collaboration that have flourished before and during COVID-19.

For example, during the COVID-19 outbreak, the care home support team at Hounslow and Richmond Community Healthcare NHS Trust increased their regular contact with the 17 residential and nursing care homes in their patch to daily telephone calls, including out of hours. The team also maintained their clinical visits, working in partnership with primary care colleagues, as they recognised that carers were anxious and facing great challenges to keep the vulnerable residents safe. This included ensuring that homes had sufficient PPE and arranging more mutual aid deliveries if required. The multidisciplinary nature of the care home support team ensured residents had access to expert advice, staff were supported to implement the latest national guidance and avoidable hospital admissions were prevented.

Leicestershire Partnership NHS Trust adapted their new model of integrated adult community health services (launched on 1 December 2019) for COVID-19 patient needs. The discharge hub and home first offer with enhanced step up and step down services supported patient flow throughout the pandemic. In one patient case study, the trust describes how an elderly gentleman was discharged into a care home and supported to recover:

A 71-year-old gentleman, Mr R, was referred to the community therapy service when he was discharged into a care home on a discharge to assess pathway. He had been in hospital due to a fall and fractured hip and would need support to progress his mobility. The initial assessment by the community therapist was completed via telephone consultation with a senior carer. Mr R was able to transfer with staff between the bed and chair and then self-propel around in a wheelchair. He required a walking frame to progress further and the therapist ordered this for delivery. Care home staff were advised about how to adjust the frame to the correct height when it arrived and how to support the patient to carry out his exercise programme. The therapist already had an established working relationship with the care home and was confident in the care staff there. Through the use of regular remote consultations and working closely with the care staff, the therapist was able to support Mr R to regain his mobility and is now working with social care colleagues to plan for Mr R's discharge back home where he lives with his wife. Good working relationships and a foundation of trust between the care team and the community therapist supported the effectiveness of the interventions. Digital technology enabled the therapy team to be responsive while reducing footfall into the care home, and ensured the desired outcome was achieved.

While trusts did everything they could at a local level to support care homes during a national pandemic, we recognise the care sector's view that the government did not focus sufficiently, or soon enough, on social care. Emergency social care funding has been slow to arrive and insufficient in some areas. It is more urgent than ever that the government meaningfully progresses social care reform and a long-term funding settlement. While some care homes have reported feeling pressured into admitting residents on discharge from hospital in late March, we need to learn the right lessons from COVID-19 and avoid a blame game between the NHS and social care.

3 The next phase of NHS recovery and the new normal

The NHS is now firmly past the initial peak of the COVID-19 outbreak, thanks to the efforts of the community sector and partners across the health and care system. As the number of COVID-19 hospitalisations and deaths began to decline, NHSEI issued a [letter](#) to the NHS on 29 April which called on community providers to:

- prepare for increased demand for COVID-19 aftercare and support needs
- continue to support care homes including elements of the enhanced health in care homes service specification
- sustain hospital discharge services and ensure safe discharges in line with IPC requirements
- continue essential services
- phase back in deprioritised community services based on local capacity and needs.

The main focus of the NHS's response to COVID-19 over the next few months will be on providing ongoing rehabilitation for people who were most seriously ill from the virus and maintaining surge capacity in case there is a second peak. The effectiveness of the NHS's recovery from COVID-19 is dependent on the community sector receiving additional resources (funding and workforce) to manage these competing demands.

Supporting COVID-19 patients' recovery

Given the nature of the virus, some COVID-19 patients will need complex aftercare following an episode of acute treatment in hospital. Leaders of community service providers describe this as a 'long tail' of patients who have suffered the effects of COVID-19. This therefore necessitates a real focus on supportive discharge, integrated care planning and rehabilitative care in the community. The rehabilitation landscape is complex and patients often need to move between both inpatient and outpatient services. Allied health professionals (AHPs) play a key role in navigating this complex landscape, and some COVID-19 pathways have been designed with teams of AHPs supporting pathway management across inpatient and outpatient services.

Some community providers are adapting existing services and flexing their inclusion criteria to meet COVID-19 patients' recovery needs. Relevant services include, but are not limited to, the following:

- community tracheostomy teams
- respiratory clinics (for breathlessness and fatigue management)
- therapy services
- psychology and counselling
- specialist allied health professional outpatient services, such as musculoskeletal conditions
- community reablement
- cardio-pulmonary rehabilitation (adapted for COVID-19 patients who are typically younger and do not have chronic respiratory disease)
- exercise referral schemes.

Other providers have created new services to respond specifically to the needs of COVID-19 patients on discharge from hospital. For example, [Nottingham University Hospitals NHS Trust](#) has set up a new multidisciplinary team to support patients with COVID-19 who received intensive care.

NHSEI announced a new [digital-first rehabilitation service](#) for COVID-19 patients on 5 July. The Your Covid Recovery service forms part of NHSEI's plans to expand access to COVID-19 services for people who have survived the virus but need ongoing physical and/or mental health support. This includes a face-to-face consultation with a local rehabilitation team, including physiotherapists, nurses and mental health specialists. Patients needing support will be offered a tailored online-based aftercare package for up to 12 weeks.

Restoring community health services

Community service providers welcomed the flexibility in NHSEI's letter on 29 April to make local decisions about the restoration of community services based on available capacity and local population needs. This was reinforced in the first half of the restoration of community services guidance, which covered children and young people's services (3 June). The second half of the restoration guidance for adult community health services is due to be published shortly. Rather than waiting for national guidance, community service providers were already making decisions about bringing services back online based on clinical judgement, workforce availability and ability to maintain COVID-19 surge capacity.

Priority services to be restored included community paediatric services (including home visits where there were child safeguarding concerns), immunisation programmes (antenatal and newborn) and full community nursing (including district nursing). Community service providers have been particularly concerned about bringing children's services back online, given the impacts of schools closing and drop in safeguarding referrals, as well as concerns about the long-term impact of not delivering these services in full.

4

What barriers and constraints did community health services face during the pandemic and how might they be addressed for the future?

This section gives an overview of the challenges that community service providers faced in responding to COVID-19.

Access to resources for infection prevention and control (IPC)

One of the key challenges community service providers faced during the pandemic was access to a reliable, adequate and timely supply of PPE. This was most challenging for community providers outside of the NHS trust supply chain, including social enterprises and CICs, who relied on emergency 'drops' from local resilience forums and mutual aid from trusts. All community service providers faced the specific challenge of distributing PPE to hundreds of different sites. As the NHS looks to restart elective care, community service providers need PPE supply on a predictable basis rather than 'just in time'.

Community service providers also faced challenges with accessing sufficient testing capacity with the rapid turnarounds required to manage services effectively. While the initial prioritisation of testing for staff in emergency departments and intensive care units was understandable, it was also frustrating given the risk to community staff who felt they were, once again, at the back of the queue.

Despite their commitment to returning as quickly as possible to meeting the needs of all patients and service users, community service providers face many challenges in restoring full service provision. Community providers will face ongoing capacity constraints because of the need to sustain IPC measures, including social distancing, rigorous cleaning and the use of PPE. This creates specific challenges for community service providers who often have hundreds of different premises that they need to ensure are safe working environments. In a recent survey, 73 per cent of trusts providing community services agreed that physical distancing reduces their capacity to restore full service provision (NHS Providers, June 2020). Community service providers are also taking into account the needs of staff who are tired and recovering from an extremely challenging period in their career.

National support and sector-specific guidance

Leaders of community service providers felt it often took too long for national COVID-19 guidance to be tailored to community settings, and national planning remained too focused on acute hospitals and bed capacity. This inequity was felt even more acutely in the social care sector. This speaks to the need for community health services and nuances of different types of providers to be adequately prioritised in government plans, and within the national NHS policy infrastructure at NHSEI going forward.

In some areas, IT infrastructure and information governance remained an issue, especially when collaborating with partners outside the statutory sector. Local integrated health and care records, and IT systems that speak to each other, are a key part of successful joined-up working across health and care organisations. National support on interoperability and investment in digital improvement programmes for the community sector are required to overcome these technological barriers.

Managing competing demands for care in the community

NHS community services describe five sources of competing demand that they anticipate will rise over the course of the coming months, including increasing numbers of:

- COVID-19 patients discharged from hospital with complex, ongoing care needs
- non-COVID-19 patients needing post-operative care in the community, as elective care restarts
- pent-up demand released as lockdown restrictions ease
- paused or scaled back community services being phased back in where local capacity is available
- people needing mental health support due to the negative impacts of lockdown and the economic downturn.

NHS community services will also need to continue to deliver the discharge to assess model and embed the clinical behaviours required, including hospital clinicians assessing patients' readiness for discharge on a daily basis and community teams pulling medically fit patients out of hospital. Care homes will also need ongoing support with staffing, IPC, and PPE. This points to the fact that the gap between capacity and demand in the community sector will grow, and community services will need increased funding and capital to manage competing demands and reshape service delivery.

Some community providers are concerned they may not have the staffing capacity to resume 'normal' services alongside the additional COVID-19 demands. Large numbers of staff have been redeployed from services that were stood down or scaled back into discharge hubs. It will be a real challenge for community services to sustain those services as well as restoring other essential services, so politicians, the national NHS bodies and the public will need to be realistic about what a new normal level of community services will look like. The use of technology will increase productivity to some extent, but this is offset by the impact of IPC measures, which will significantly reduce productivity – in many cases to about 60 per cent of pre-COVID-19 activity. There may also be demands on community health services to deliver a significantly bigger flu immunisation season and possibly a COVID-19 vaccination programme this winter, although uncertainty continues as to how likely this will be and how it will be administered.

Quantifying and addressing the backlog of care

While the acute sector will have an easily quantifiable backlog of demand, it is more difficult to quantify the number of patients who have waited longer for care in the community. Referral rates fell dramatically for almost all community services during COVID-19, and some services were paused or scaled back to focus resources on priority services.

While some community services may have waiting lists, the consequences of a deficit in service provision will not be as visible as for acute services. Community service providers are also concerned about unmet and under-met need in social care during the pandemic. The challenge for the community sector now is to quantify and meet this demand, at the same time as supporting the long-term health and care needs of people recovering from COVID-19. 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).

Other limiting factors include the capacity of primary care. The new PCN direct enhanced service (DES) contract must facilitate true and open collaboration and integration between primary and community care services. Community service providers are well placed to support PCNs and are ready to offer infrastructure and expertise in coordinating integrated care at neighbourhood and place level. The expectations and needs of care homes and domiciliary care providers must also be reviewed and supported in system plans. As elective care restarts, integrated care systems/ sustainability and transformation partnerships (ICs/STPs) should ensure they work hand in hand with community and social care providers to manage capacity across the system.

Preparing for winter and a second COVID-19 peak

Increased capacity and investment in community services is required to embed the transformation in service delivery, manage winter pressures and maintain flexibility in case COVID-19 spikes again, as referenced in the government's [recovery plan](#) on 10 May.

Whilst the highest number of COVID-19 hospitalisations in England was recorded in mid-April, NHS community health services experienced the peak of COVID-19 demand later than acute hospitals, from mid-May to early June, with variation across the country and different community health services. In some areas, community beds were at full capacity at the end of May. Local health and care systems only managed this rise in demand as acute bed capacity was so low that patients could remain in acute hospitals for recovery. Community providers are concerned about the lack of demand and capacity planning for community services at national level. We need to bring the same rigour of planning to community care that we do to acute activity planning. Given that acute bed capacity has absorbed some of the demand for community beds, the community sector will need to increase its bed base going into winter, as more acute beds are occupied in winter months. Some ICs/STPs are looking into expanding community based beds for patients recovering from COVID-19 and respiratory illnesses in preparation for winter. The NHS in Surrey Downs set up the Seacole centre in May as a recovery facility for patients with more complex care needs than could be supported at home. NHSEI has trailed the creation of further Seacole centres around the country.

While the Seacole centre model might work for some areas, the national bodies and ICs/STPs should review community rehabilitation services and discharge pathways in the round to ensure there is adequate supply of home-based rehab services and sufficient rehab beds for the minority of patients who need them. The pandemic is an opportunity to properly invest in more care in the community (including hospital at home and rapid response services), reconceptualise the way healthcare is delivered and establish 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. Some areas are already looking at moving intermediate care into more routine district nursing services, supported by a multidisciplinary 24/7 emergency response model.

Community providers welcomed the government announcement on 17 July that around £500 million of the additional £3 billion funding pot will be used to fund discharge to assess for the remainder of 2020/21, but the government will need to go further to address the wider challenge of expanding capacity in the community.

Local authority commissioning and funding concerns

Fragmented commissioning and frequent retendering of contracts has been a longstanding issue for community service providers. Given the scale and spread of NHS community health services, many providers manage several different contracts with various CCG and local authority commissioners. This often entails time-consuming performance management and transactional contract monitoring meetings.

While community service providers welcomed the suspension of transactional contracting during the COVID-19 response, there are now worrying reports of local authorities looking to retender contracts for NHS community health and public health services. It is not reasonable or feasible to expect community staff and services still operating in a Level 3 incident to divert time and energy to take part in competitive tendering processes this financial year. Competitive tendering risks damaging morale by creating an unnecessarily uncertain future for frontline staff who continue to risk their own safety to support the NHS response to the pandemic. It would also destabilise effective working relationships with both NHS and local authority commissioners.

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 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 commissioners 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 contracts they consider to be unsustainable because of these problems.

Local authority commissioned community and public health services remain at risk of further funding cuts. Local authorities face a £10.9 billion income shortfall for 2020/21, of which only £3.2 billion is currently covered by emergency COVID-19 funding.⁶ As local authorities have a legal requirement to balance their books, without rapid notice of where the remaining funding is coming from in year, they will have to start identifying savings. Community service providers believe significant cuts to community health and public health services commissioned from the NHS will inevitably follow, together with further pressure on already stretched social care services.

Pressures on the social care sector during COVID-19 have increased demand on NHS community health services. After years of underfunding and undelivered promises to find a sustainable funding and provision model for social care, the knock-on impacts on the NHS continue to grow. While COVID-19 has accelerated collaborative working and integrated care in the community in many parts of the country, there are still cultural, behavioural and structural barriers to overcome.

5 Moving forwards: embedding innovative practice and lessons learned

The COVID-19 response has led to rapid transformation in the provision of community health services, which could have taken years to accomplish. Community service providers want to lock in those transformations that are working well and reset to a new normal effectively. Some providers have now set up organisation or system-wide change programmes, based on quality improvement principles, to plan for and implement recovery and restoration. These programmes will help determine which old practices to let go or restart, and which new practices to stop or adopt/adapt.

For example, far more people with non-COVID-19 conditions are choosing to have their care in their own home rather than in hospital or a care home, which could lead to a permanent reduction in non-COVID-19 inpatient admissions and potentially lead to increasing numbers of care home providers exiting the market, requiring a subsequent shift to more care at home.

Community service providers, and local partners including social care, are clear that they want to embed the discharge to assess model on a permanent basis and not return to NHS Continuing Healthcare assessments in hospital beds. Suspending funding negotiations and lifting regulatory barriers has enabled patients to leave hospital as soon as they are medically fit and has improved flow through the health and care system. While national [guidance](#) issued on 31 July provided welcome confirmation that the government will continue to fund new health and care support for a period of up to six weeks following discharge from hospital, it also reinstated NHS Continuing Healthcare assessments from 1 September 2020. We are concerned that funding and workforce constraints will bring back tensions that the lack of bureaucracy during the pandemic bypassed.

The NHS workforce has benefited from working flexibly across teams and organisational boundaries. Community service providers report that staff enjoyed being redeployed, operating outside of the strict confines of their usual role, and broadening their professional experience. This led to staff sharing skills and developing mutual understanding across organisations, which will facilitate collaboration and integrated care going forwards. This flexibility in deployment and role definition must be maintained and will help support multidisciplinary team working in the community.

The use of digital technology has radically changed the way that some community health services are delivered. Digital consultations and virtual outpatient services have rapidly increased during the pandemic. Initial local evaluations show benefits for staff include reduced travel time and therefore increased capacity, and benefits for patients include flexible appointments and support while self-isolating or shielding. Patient satisfaction will likely be variable but initial results are positive. It is important to recognise that face-to-face visits and appointments have continued where necessary, and virtual care is based on risk assessments and clinical judgements. Patients will have different preferences, and community service providers are clear that the future model of service delivery will be a mixture of digital and face to face. As more services are delivered virtually, there is scope to rethink how community service providers use their estates.

Although the quality of local relationships continues to vary, in some areas, neighbourhood-level integration has been cemented thanks to COVID-19.⁷ However, the current workarounds on the enhanced health in care homes service specification need recurrent funding and community service providers are clear that the new PCN DES contract must build on the collaborative response to COVID-19, rather than focus on contractual and funding mechanisms. Community

service providers see a clear role for themselves in place- and system-level work to tackle the wider determinants of health inequalities, influence the local economy as anchor institutions, and engage with local communities to co-produce the restoration of services. The restoration of community services must build on the proactive care for shielded patients during the pandemic, in collaboration with the VCSE sector, and form a key part of population health approaches. There needs to be financial incentives for primary and community services to improve anticipatory care.

The pause in transactional contracting between providers and commissioners has been welcomed by community services, which historically suffer more than other sectors from competition law and retendering processes. This has created space for more strategic commissioning and collaborative relationships, which must continue beyond the pandemic.

All of this rapid transformation of community services has been enabled by the reduced burden of bureaucracy and performance management from national regulators. This environment that encourages clinical innovation must be maintained and fostered. System partnerships should continue to engage with the community providers within their local area, building on their expertise to 'lock in' successful innovations and ensuring community capacity remains central in meeting the local population's health and care needs as we move to a new normal.

Community providers would therefore welcome national support and an enabling system architecture to deliver more COVID-19 and non-COVID-19 care as close to home as possible. To support community providers in this endeavour the government must invest in:

- ensuring sufficient investment in the public health grant and local authority budgets
- agreeing a pause on the retendering of NHS community health and public health services contracts until the end of 2021/22 in line with the spirit of collaboration promoted by system working and to ensure services and frontline staff are not subjected to undue disruption
- mainstreaming the discharge to assess policies developed during the pandemic and reviewing cumbersome bureaucracy including around NHS Continuing Healthcare.

DHSC and NHSEI should:

- continue to invest in and develop the required level of policy infrastructure to work with the full range of stakeholders at the national level to support the critical contribution made by community services
- support investment in home-based community pathways as well as community beds to 'bolster' capacity
- help boost the community workforce with a national recruitment campaign and increased deployment of returners before winter pressures hit
- commit to fully fund the Agenda for Change pay uplift for staff employed on NHS contracts through health services now commissioned by local authorities
- work with NHSX and the community sector to create a digital improvement strategy, robust national dataset and national performance standards to standardise and spread best practice.

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Community

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