The voice of NHS leadership

Submission to HM Treasury for the Comprehensive Spending Review 2020

From the NHS Confederation: October 2020

About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Wales and Northern Ireland. In England, we represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems. Also, we run NHS Employers, which supports the health service in its role as the nation's largest employer, negotiating pay, supporting workforce development, and fostering good practice in recruitment and retention. In Wales, we represent local health boards, and in Northern Ireland, we represent health and social care trusts. We also run a European Office, based in Brussels, which focuses on EU legislation, Brexit developments and our international engagement.

1. Introduction

1.1 The health and care sector throughout the UK has been at the heart of the greatest challenge we have faced as a country for two generations. The NHS has shown dedication and expertise in meeting the initial shocks of COVID-19, but the pandemic struck a system already working at its limits. The NHS Confederation is calling for additional multi-year investment in the NHS so that it can meet the additional pressures arising from the pandemic and deliver the NHS Long Term Plan for England, and the equivalent plans in the devolved jurisdictions.[1]

1.2 It is now indisputable that there is a significant funding gap beyond the pre-COVID-19 NHS settlement of 2018 – as of July, this had required an additional £31.9 billion support for health services.[2] This funding gap has been caused by:

[1] The figures used in this document are for England only unless otherwise stated. It is assumed that any settlement for England will be adjusted in the light of the Barnett formula and applied throughout the UK.

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/898421/A_Plan_for_Jobs__Web_.pdf

1.2.1 The operational costs of COVID-19 response, including infection control measures, equipment, and additional staff.

1.2.2 The ongoing capacity constraints imposed by the need for infection control measures which reduce productivity.

1.2.3 The backlog of clinical demand, which was already substantial, created by the need to pause or suspend services earlier this year. At the end of July 2020, nearly half a million patients were waiting six weeks or more from referral for one of the 15 key diagnostic tests.[3]

1.3 These pressures were unknown and therefore not funded in 2018 – if the health service is to meet expectations in the coming period, these developments must be funded now. The emergency financial support offered thus far during the pandemic has been crucial in allowing the NHS to cope, but there is a need for a multi-year settlement that reflects these pressures, supports the NHS to stabilise, and enables it to get back on track with delivering the ambitions of the NHS Long Term Plan (LTP) and its equivalents. Although there is still much uncertainty, we do know the impact of the pandemic will be felt well beyond the current financial year, and we know, unfortunately, that we are entering a second challenging stage.

1.4 Continuing to fund this gap only through emergency financial support would be a significant missed opportunity in enabling the NHS to play its part in the transition we are making nationally from short-term crisis response to medium to longer-term management and recovery. For health and care, a key part of this transition will be building resilience and preparedness. We did not have adequate personal protective equipment (PPE), intensive care or respiratory capacity at the outset of the pandemic and we must not be in that position again.

1.5 The pandemic hit the NHS when the service was only one year into the ten-year plan set out in the Long Term Plan for England – a plan that members remain committed to delivering in the longer term. The service needs support to recalibrate, recover and capitalise on significant transformation already underway. This will enable progress towards the vital transformation and efficiencies in increased care in the community, as well as greater integration and digitalisation of services.

1.6 There is also a set of key issues that were not addressed in the previous funding settlement that need a multi-year plan – capital, training and education budgets, public health and social care – all of which are vital to the success of the Long Term Plan. The pandemic has highlighted the critical role that social

[3] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/09/DWTA-Report-July-2020_o1sd4.pdf

care plays in the delivery of health and care services. But it has also exacerbated the underlying weaknesses in social care and demonstrated the need for fundamental reform. Staff shortages, a severe lack of funding, the absence of robust data and access to PPE and testing, among other issues, have exposed the need for urgent government action to fix social care.

1.7 Despite the challenges of the fiscal position, it is more important than ever that the UK government's commitments to the NHS are met.

2. Key issues for the CSR

2.1 A settlement to stabilise, improve resilience and deliver long-term ambitions

2.1.1 Additional revenue funding over the next three years to offset COVID-19 impacts.

2.1.2 A multi-year capital funding settlement underpinned by a strategic, timely and efficient allocation process that goes beyond hospitals to address inadequacies in the mental health and community services estate. Capital budgets should meet the needs assessed in the Naylor Review.[4]

2.2 Supporting the current and future workforce

2.2.1 Prioritise additional investment for workforce growth, including in training places across all professions.

2.2.2 Recognise current staff efforts with a pay award that is fully-funded in NHS England's budget.

2.2.3 Improve the operational aspects of the apprenticeship policy and levy to make it functional and fit for purpose, including allowing health and social care employers to re-invest the money they have paid into the levy.

2.2.4 Retain the national wellbeing offer to ensure it is accessible to all staff.

2.2.5 Invest in digital literacy across the workforce, as outlined in the LTP.

2.3 Stabilising and enhancing social care

2.3.1 We need to ensure that we have a stable social care market to support an NHS dealing with COVID-19 and NHS backlogs in elective treatment. Adequate social care provision is also key to managing long-term demands on NHS services, especially from frail and elderly populations. NHS coverage of discharge arrangements has been useful and helped with the flow between hospital and social care.

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/607725/Naylor_review.pdf

2.3.2 As set out in the 2019 House of Lords' report, £8 billion investment was estimated to be needed immediately in order to return to 2010 levels of social care quality and access.[5]

2.3.3 Investment for the future by delivering a long-term plan and, where necessary, double running services to invest in the transformation desperately needed in the sector.

2.4 Meeting the coming surge in mental health care demand

2.4.1 Additional investment to enable the service to manage constrained capacity and meet the surge in demand, which some providers and commissioners estimate at between 20-30 per cent.

2.5 Taking action to reduce health inequalities

2.5.1 Restore the public health grant to 2015-16 levels: £1 billion.

2.5.2 A dedicated, ring-fenced fund for reducing health inequalities, which could cover service re-design and targeted accessibility measures.

2.5.3 Include poverty and inequality reduction criteria in the Green Book criteria for investment decisions and cross-departmental decision-making.

2.6 Investing in primary care infrastructure and supporting digital transformation

2.6.1 Reintroduce, improve and expand the Estates and Technology Transformation Fund (ETTF): £1 billion capital investment.

2.6.2 A public awareness campaign about virtual consultations and use of patient data.

2.7 Investing in community services

2.7.1 Demand for community services is set to increase considerably as more people experience long COVID.

2.7.2 Additional investment is required to: expand capacity for increasing pressures from COVID-19 rehabilitation needs, support to the acute sector, deliver more care within or as close to home as possible, rapid response and anticipatory care services.

2.7.3 Resolve the local authority funding gap to protect the public health grant, fully fund Agenda for Change pay uplifts and increase social care provision.

2.8 The NHS role in supporting economic recovery

2.8.1 Supporting and challenging the NHS – our largest employer – to maximise its impact in economic recovery.

2.8.2 Embedding inclusion, health and wellbeing in policy, investment and research.

[5] https://publications.parliament.uk/pa/ld201719/ldselect/ldeconaf/392/392.pdf

2.9 Supporting systems and integration

2.9.1 The move towards 'system by default' must be accompanied by a financial infrastructure that encourages and facilitates integration.

2.9.2 Systems must be put at the heart of future decisions around issues such as investment, planning and capital.

3. COVID-19 has reduced capacity in a system that was already under strain

3.1 Prior to COVID-19 the NHS was struggling under the weight of demand

3.1.1 The 95 per cent standard for four-hour A&E waits was last met in July 2015.

3.1.2 In January 2020, over 45,000 patients were waiting six weeks or more from referral for one of the 15 key diagnostic tests.

3.1.3 Progress on workforce commitments has been slow – for example, the target for an additional 19,000 mental health staff was missed by 9,500 at June 2020.[6]

3.1.4 Only around one in three children and young people with a mental health condition received treatment and support.[7]

3.2 Dealing with the first COVID-19 peak has left the system with a huge backlog

3.2.1 At the end of July 2020, nearly half a million patients were waiting six weeks or more from referral for one of the 15 key diagnostic tests – an increase of 1,200 per cent on the year before. We are expecting to see significant increases in the number of people requiring treatment, and it is likely that delayed treatment or unmet demand means symptoms may now be more severe.

3.2.2 The messaging to the public to reduce pressure on the NHS was extremely effective, with A&E attendance 57 per cent lower in April 2020 than it was a year before.

3.2.3 Primary care services are also expecting a significant surge in patients, particularly those with mental health needs, as well as a backlog of immunisations and screening.

3.2.4 COVID-19 is also impacting demand on community services with tens of thousands of patients in long-term recovery who require ongoing treatment and rehabilitation services, alongside existing unmet need for these services from people suffering from long-term conditions.

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[6] https://questions-statements.parliament.uk/written-questions/detail/2020-07-13/72921

[7] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

3.3 COVID-19 will continue to limit capacity across the service significantly

3.3.1 Workforce: reduced staff capacity, including accrued leave not taken during the pandemic, staff burnout and the time taken to don and doff PPE, which limits the time spent with patients.

3.3.2 Infection control: the increased burden of infection prevention and control measures associated with COVID-19, which our members have cited as a significant barrier in their ability to resume services quickly.

3.3.3 Physical space: social distancing for staff and patients faces space constraints in some sites which limits the volume of services that can be safely provided.

3.3.4 Second surge: the NHS has to retain spare capacity in the event of a second wave or local lockdowns. This is very difficult to plan for in light of so many uncertainties.

3.3.5 Testing: both for patients and staff, remains a critical barrier to recommencing services. The Prime Minister this month has conceded that the COVID-19 testing system nationally "has huge problems". These problems must be addressed by the government as a priority so that NHS staff, as well as those working in care homes, are able to get on with delivering care to patients as quickly and efficiently as possible.

3.3.6 NHS leaders cannot adequately predict demand due to ongoing uncertainties around COVID-19 – and this challenge comes when planning was already in a state of transition with the move towards system-level working. The timing and impacts of a potential vaccine are also unknown.

4. What action is needed at the CSR?

4.1 Funding a health and care system that can meet current pressures

4.1.1 The existing settlement is not sufficient to deliver the Long Term Plan, manifesto commitments and the COVID-19 response.

4.1.2 In a survey of 250 NHS Leaders due to be published by the NHS Confederation on 29 September, almost nine in ten respondents (88 per cent) were not confident that they can achieve the goals of the LTP within their existing revenue funding settlement, with workforce the most commonly cited pressure.

4.1.3 73 per cent of respondents do not consider their capital funding sufficient to deliver the LTP goals.

4.2 The NHS needs investment to stabilise, improve resilience and deliver long-term ambitions

4.2.1 The emergency COVID-19 funding to deal with the first peak has been crucial. Cases are now rising again as we approach winter.

4.2.2 The NHS needs a financial trajectory to support ongoing COVID-19 response, resilience, pandemic preparedness and a path back to stability and LTP goals.

4.2.3 We recommend setting a three-year funding profile for revenue at the CSR that enables a smooth transition from piecemeal crisis funding, to provide financial certainty, enable planning and restart stalled LTP transformation activities, many of which are predicated on digital revenue and capital investment.

4.2.4 This will enable the NHS to deal with the ongoing capacity and operating costs of COVID-19, meet increasing demand, for example in mental health, and get back on track with the LTP.

4.3 Both COVID-19 challenges and wider transformation require capital investment

4.3.1 Capital investment has been insufficient and lacked a strategic approach. The OECD average for capital spending on health is 0.51 per cent of GDP. England currently spends just over half this (0.27 per cent of GDP).[8] Insufficient revenue funding has seen the DHSC transferring capital funds across to pay for the day-to-day running of the NHS.

4.3.2 The CSR is an opportunity to ensure sufficient capital is provided for community services, primary care and mental health – as set out in the Health Infrastructure Plan. The planned hospital build programme alone will not deliver the transformation of services that the LTP envisages. It is vital that this is a multi-year investment to allow for longer-term strategic planning.

4.3.3 The mechanism for capital planning needs to reflect local system working, with responsibility for prioritising capital expenditure sitting at integrated care system level.

4.3.4 There is an ongoing significant maintenance backlog which must be prioritised, particularly where there is an imminent or potential threat to patient and/or staff safety, as detailed in the Naylor Review.

4.3.5 We support the inclusion of metrics more heavily weighted towards wellbeing in the pending review of the HM Treasury Green Book appraisal process.

4.3.6 We need to see a process for capital investment that is strategic, driven by providers' long-term transformational needs and timely, in terms of announcements of opportunities, to bid for funding and seeing monies come on-stream.

4.3.7 We need a long-term capital funding settlement over the next four years to enable transformation and to secure our existing estates.

[8] https://www.health.org.uk/publications/reports/failing-to-capitalise

5. Supporting the current and future workforce

5.1 Progress on vacancies is too slow and inequities must be addressed

5.1.1 The LTP, 2019 Interim People Plan and 2019 Conservative Party manifesto set out commitments to reduce the 100,000 clinical vacancies and enable the service transformation needed.

5.1.2 The long-standing supply and vacancy challenges were mitigated during the early stages of the pandemic by the reductions in non-COVID-19 work. As we resume these services, the CSR can support a longer-term national narrative which is desperately needed to give teams hope that the situation for them and their colleagues will improve. The impact of Brexit on staffing continues to be a concern for some of our members.

5.1.3 The disproportionate serious impact of the virus on ethnic minority communities was mirrored in the impact on black and minority (BME) staff. The long-standing differences in treatment between BME staff and their white colleagues was thrown into stark, and challenging, light. Our members want to address these long-standing inequities in their workplaces.

5.2 Meaningful action to grow the workforce is needed

5.2.1 Investment is needed to grow the clinical workforce and address long-standing and critical workforce challenges in, for example, mental health and learning disability nursing, smaller AHP professions.

5.2.2 Continued efforts are needed to deliver national attraction and recruitment campaigns for both health and social care for both employment and university healthcare training places.

5.2.3 Changes to the operational aspects of the apprenticeship policy and levy are needed to make it functional and fit for purpose, including allowing health and social care employers to re-invest the money they have paid into the levy.

5.2.4 A national investment narrative which speaks to the longer-term improvement in supply of vital clinical roles will give those working in the NHS some hope that the gaps in their rotas and teams will be filled before too long. Without that hope, the steps to support wellbeing and retention will only achieve so much.

5.3 Recognition of workforce: funded pay and reward offer

5.3.1 Fair investment in pay and reward is recognised to be part of the response to the immense contribution of our people during the pandemic but must not be at the expense of other priorities, particularly relating to improving supply.

5.3.2 A pay and reward offer that is funded and sustainable which recognises the skills and talents of our workforce.

5.3.3 The NHS Pension Scheme offers limited flexibilities in managing and growing pensions savings over the course of a career. We want to work with government to identify what new flexibilities for managing and growing pensions savings can be developed to reflect individual circumstances and

preferences for all of our staff, particularly for those employed in lower earning roles.

6. Stabilising and enhancing social care

6.1 The social care system is stretched beyond capacity

6.1.1 COVID-19 has tragically shown the shortcomings of the social care system, exposing the impact of staff shortages and vulnerabilities in funding, market stability, lack of data and access to PPE and testing.

6.1.2 At present, there are around 1.4 million older people who are not able to access the support they need – inevitably, this number will rise.[9]

6.1.3 As the NHS looks to a second wave of COVID-19 infections, restoring services in the wake of the pandemic and preparing for winter, its ability to do so is heavily dependent on a stable, well-funded, safe, social care sector.

6.1.4 Over the CSR period, social care reform is vital to support the millions of people at all stages of life who rely on care and support. Social care enables people to live independently and better for longer and is fundamental for demand management and the effective functioning of the NHS.

6.2 Urgent £8 billion investment to provide care quality and access, in line with House of Lords report

6.2.1 We agree with the HoL report on social care investment which, pre-COVID-19, placed the cost of returning to pre-austerity levels of provision and modestly widening access to further service users at £8 billion.

6.2.2 This was backed up by a 2019 report commissioned by the NHS Confederation, and undertaken by the Institute for Fiscal Studies and the Health Foundation, which calculated that social care funding would need to increase by 3.9 per cent a year to meet the needs of an ageing population and an increasing number of younger adults living with disabilities.[10]

6.2.3 Additional funds must be accompanied by reform and improved service delivery. Social care services and the NHS are working together to transform and integrate local care services, but they can only go so far when services are being placed under so much strain.

6.3 Invest for the future by delivering a long-term plan and, where necessary, double running services to invest in the transformation desperately needed in the sector

6.3.1 There is wide consensus that access to social care needs to be expanded to more people and a wider range of conditions. The case for investment in

[9] https://www.ageuk.org.uk/latest-press/articles/2018/july-2018/new-analysis-shows-number-of-older-people-with-unmet-care-needs-soars-to-record-high/

[10] https://www.ifs.org.uk/publications/12994

social care is in many respects a moral one concerning the treatment of vulnerable people, and our willingness as a society to protect them and support their independence. But it is also about targeting resources wisely and making sure investment in the NHS is used to best effect.

6.3.2 Social care needs sustainable funding, which should include funding necessary to deal with the current pandemic pressures for as long as necessary and prepare for future shocks.

6.3.3 Day centres and charitable organisations who also operate in the social care arena are struggling to remain open. Many have already closed. Ensuring their long-term financial stability will pay off in the long run, as the cost of re-establishing these micro and community level services will be significantly greater than supporting existing groups during this challenging period.

7. Mental health – current funding is not enough to meet the surge in demand

7.1 Mental health providers face a backlog, capacity constraints, increased costs and surge in demand

7.1.1 COVID-19 has and will continue to have huge implications for mental health providers and the individuals they support.

7.1.2 During the peak of the crisis, there was a 30-40 per cent reduction in mental health referrals. Since the lift in lockdown restrictions, providers anecdotally report that referrals are rising to above pre-COVID-19 levels. They are seeing patients with more significant needs; a higher proportion of patients are accessing services for the first time; and there are increased Mental Health Act presentations.

7.1.3 Work is ongoing nationally and locally by NHS trusts and commissioners to model what we may expect the increase in demand to look like. In advance of this, some providers are working on the expectation of a 20-30 per cent increase across all services.

7.1.4 Providers face increased costs from PPE, increased infection control and cleaning costs, ongoing costs related to new digital services, additional estate capacity due to social distancing, and locum and additional permanent staff.

7.1.5 While responding to this demand, they will face reductions in their capacity due to infection control and social distancing measures, with some providers estimating a 10–30 per cent reduction.

7.1.6 There is a strong link between economic downturns, unemployment and risk of suicide. Following the 2008 recession the full impact on the public's mental health was not felt until 2012, when suicide rates sadly peaked. This shows the need for a long-term approach that allows people to access quality services before they reach crisis.

7.2 This means existing funding is not sufficient

7.2.1 Part of the LTP funding earmarked for the final three years of the plan is needed this financial year – particularly funding for crisis and community services.

7.2.2 There are serious concerns that planned LTP funding will no longer be enough to cover the increases in demand and costs that providers now face following the pandemic. The scale of digital transformation within mental health settings has been significant and delivered at pace. Services are more likely to have a "blended" approach going forward, where service-users are given the choice between digital and face-to-face services. However, the implementation and maintenance of digital platforms have both short-term and long-term revenue and capital implications, which are not funded in the current financial envelope.

7.2.3 To provide good quality care that supports recovery, services need to be delivered from modern, therapeutic environments. As the Independent Review of the Mental Health Act stated, mental health estates are currently some of the worst in the system, and the sector has largely been left out of previous capital funding announcements. The £250 million earmarked to eradicate dormitory accommodation is welcome and will improve infection control, but this needs to be a down payment on longer-term, capital investment to bring estates into the 21st century.

7.2.4 It is known that 50 per cent of mental health problems in adults start by age 14, so it is important to implement preventative approaches and provide early intervention for this population. Mental health support teams are expected to be working in 25 per cent of schools by 2023/24, but given the likely increase in mental health needs, we need to expand on the current commitments and cover 100 per cent of the student population.

8. Taking action to reduce health inequalities, including public health

8.1 Health inequalities have been getting wider and COVID-19 has made the position worse

8.1.1 The pandemic has highlighted the avoidable and unfair differences in health outcomes; differences and biases in the access, quality and experience of care; and the critical importance of the wider determinants of health.

8.1.2 Health inequalities have been apparent for many decades and neither legislative provisions or policy directives have significantly reduced them. We know that COVID-19 has, and will continue to, widen the gap. A reset of the way we prioritise health equality is required.

8.1.3 In a survey of 250 NHS Leaders due to be published by the NHS Confederation on 29 September, 84 per cent of respondents believe that 'COVID-19 has demonstrated that the NHS must deliver a step change in how it cares for diverse and marginalised communities'.

8.2 Reducing health inequalities requires investment

8.2.1 There is commitment to tackling health inequalities but there are many competing pressures for limited funds; creating inclusive services requires investment. For example: new roles, such as translators, individual and community advocates or outreach workers; greater marketing budgets; or a hub and spoke model of services, where services can be embedded in communities and more accessible to excluded groups, such as the homeless population.

8.2.2 We recommend prioritising this agenda through a dedicated, ring-fenced fund on health inequalities owned by local integrated care systems and available to NHS leaders to ensure that their services are accessible and target those most in need.

8.2.3 This is likely to enable earlier interventions and help reduce acuity later on. Enhancing access to cancer screening programmes is a good example, where people from BME and poorer backgrounds are less likely to participate in such initiatives, as currently designed.

8.2.4 While we support the existing funding formula for CCGs and the LTP policy direction, the widening picture of inequality shows we must do more – and signal to both patients and the NHS that this is a priority.

8.3 £1 billion public health investment must be restored

8.3.1 Also of paramount importance is the restoration of £1 billion in public health funding in real terms per year, secured for the long term. This is alongside strong maintenance of a strengthened public health approach to the nation's health. This would require careful thought in light of the abolishment of Public Health England. We are happy to be contributing to these debates as stakeholders involved in the establishment of the new National Institute for Health Protection.

8.3.2 As we exit the European Union we urge the government to bring forward proposals to replace the European Social Fund with a UK Shared Prosperity Fund which focuses on job creation and developing new skills among the workforce, with a focus on social inclusion and fairer job opportunities.

8.3.3 Maintaining funding levels for NHS-led research and innovation is also needed to address emerging public health risks and to ensure that the UK remains at the forefront of global medicine post EU Exit.

8.3.4 Putting health, wellbeing and inequality at the heart of spending decisions and cross-departmental policymaking is also essential to address the wider determinants of health. Poverty and inequality reduction criteria should be

included in the Green Book criteria for investment decisions and cross-departmental decision-making.

9. Investing in primary care infrastructure and supporting digital

9.1 Primary care has adapted well during COVID-19 in spite of its physical and digital infrastructure

9.1.1 There have been many years of underinvestment in capital and estates in primary care.

9.1.2 In many cases, equipment and infrastructure are not robust enough to capitalise on new 'digital-first' ways of working, and staff training is not in place.

9.1.3 The pandemic has exposed the lack of physical space and poor facilities in many areas of the country. Investment in capital and equipment is needed to ensure that the NHS is ready to deal with a second wave of COVID-19 or indeed any other future surge in demand as well as fulfilling the transformational objectives of primary care networks (PCNs).

9.2 Reintroduce, improve and expand the Estates and Technology Transformation Fund (ETTF)

9.2.1 Recent capital investment in the NHS has been largely focused on secondary care facilities. The need in primary care is urgent and we recommend reintroducing the ETTF to target this. This will support the ambition in the Long Term Plan that by 2021 all patients will have access to digital-first primary care, including digital consultations.

9.2.2 From 2015/16 to 2019/20 the ETTF was worth £900 million. This amount should be made available again until 2023/24, but in real terms, amounting to just over £1 billion.

9.2.3 A new, enhanced ETTF needs to be more accessible for GPs and others across primary care to ensure strong take up.

9.2.4 This funding should be made available to support either physical or digital infrastructure investments as part of PCN 'estate strategies'. As outlined by the National Association of Primary Care, such strategies should be produced in collaboration with other partners such as providers and ICSs to ensure that system-wide solutions are being developed.

9.3 A public awareness campaign about virtual consultations and use of patient data

9.3.1 The government should make funding available to support clear communications to patients at national level about issues such as when and how they can access their own records and data, how they can opt out of certain data-gathering if they wish and the value of digital platforms. The cost

of funding a public awareness campaign would be low (approximately £3-5 million) but could have significant impact.

9.3.2 Patients should be signposted to support if they are unable to access or use new platforms and this information should be accessible to as many demographics as possible (e.g. available in multiple languages).

10. Delivering community services

10.1 Community services have, and will continue to, play a vital role in COVID-19 response

10.1.1 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:

10.1.1.1 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.

10.1.1.2 Set up discharge-to-assess processes within days and expanded rapid response teams to support admission avoidance.

10.1.1.3 Rapidly prioritised services and redeployed staff to care for COVID-19 and non-COVID-19 patients with complex needs in the community.

10.1.1.4 Improved effectiveness by using digital technology.

10.1.2 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 bolstering 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.

10.2 This requires investment in community services

10.2.1 Invest in expanding capacity in the community across all pathways, including but not confined to beds, to: support ongoing COVID-19 rehabilitation needs; offer appropriate support to the acute sector to 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. In implementing this

investment, lessons should be learned from the experience of the Mental Health Investment Standard.

10.2.2 It is vital that we resolve the local authority funding gap to protect the public health grant, fully fund Agenda for Change pay uplifts and increase social care provision.

10.2.3 Given the changed context due to COVID-19, expedite existing LTP investment commitment in rapid response and anticipatory care services.

10.2.4 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.

10.2.5 Without this support for community services, 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.

11. The NHS is our largest employer and can support the wider economic recovery

11.1 The health service will have a significant role to play in the wider recovery and rebuilding of our local economy and communities

11.1.1 During a time of unprecedented economic and social disruption, the NHS's impact as our largest employer and the role of its organisations as local anchor institutions has become even more important. For example, recent Greater London Authority data shows health and social care as the only sector predicted to grow its workforce in 2021.[11]

11.1.2 We need to support and challenge the service to work beyond traditional sectoral boundaries and use the greater system approach to align with wider place-based reset and recovery planning to increase population health and wellbeing.

11.1.3 There is the potential for new and innovative local partnerships focused on issues such as workforce and supply chain development, community working, new forms of funding and population health.

11.1.4 At the heart of this approach is the underpinning message that health is an investment – perhaps in the coming months and years the most vital and economically-stimulating investment we can make.

11.2 Health and wellbeing in government policy, investment and research

11.2.1 The government should increase health research and development spending in areas with widening inequalities. Given local strengths and the challenges to be addressed, expanding the share of research and innovation funding for

[11] https://www.london.gov.uk/moderngovmb/documents/s67897/04a%20Impact%20of%20Covid-19%20-%20LRB%20September.pdf

health-related work would generate significant regional and national benefits, as well as forming a critical part of the government's planned re-industrialisation of the UK through the 'levelling up' agenda.

11.2.2 The government should give greater priority to wellbeing in investment decisions. Plans to emphasise wellbeing alongside efforts to narrow productivity gaps in the Green Book are welcome. The government should ensure that any changes in technical rules are aligned to broader post-COVID-19 recovery strategies and accompanied by a shift in culture.

11.2.3 The government should ensure health is included as an outcome in all economic development policies and as a priority for all departments. Conversely, the government should also ensure that all new NHS hospitals built should explicitly measure the local economic and social impact derived from the investment.

12. Systems and integration

12.1 'System by default' needs a financial infrastructure that encourages and facilitates integration

12.1.1 Efforts to promote integration have been hampered by a financial and legislative framework that was developed to promote competition.

12.1.2 The government must look to establish new financial models to enable system-wide activity, ideally with powers for integrated care systems – working with clinical commissioning groups – to prioritise according to their population health requirements, set their own incentives and direct funds as they see fit within their boundaries. This needs to address areas of historical under-funding, such as community services.

12.1.3 It is welcome that funding allocations for the second half of 2020/21 represent a move away from market principles, with incentives and penalties dependent solely on system level performance, as opposed to that of individual organisations. This represents a positive direction of travel for future financial arrangements

12.2 Systems must be put at the heart of future decisions on investment, planning and capital

12.2.1 As set out in the LTP, systems are at the centre of many ambitions on integration and population health. However, this needs to be accompanied by local autonomy on strategy and how resources are used. In practice, this means that when it comes to investment in capital and estates, systems should have the authority to decide where funding is directed within their boundaries – ideally as part of a multiyear settlement that allows for long-term planning rather than piecemeal funding year-on-year.

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