NHS COMMUNITY SERVICES

TAKING CENTRE STAGE

NHSProviders

FOREWORD

Welcome to the third edition in our series of reports that examine the state of the NHS provider sector. Our latest assessment sets out to provide a valuable commentary on how the community services provider sector is performing, the challenges that community service providers are facing, and the solutions that will enable success as we head towards a longer term funding settlement.

This is a crucial area of care for the NHS as it covers a diverse range of services delivered in the community that help keep people well throughout their lifetime. As they work closely with primary, social and acute care, community services can be considered as the glue that holds the wider health and care system together.

Community services need to be at the heart of local health and care provision in all systems, but for too long they have been marginalised and not given enough priority at national and local level. That needs to change and our report makes the case for why community services need to be centre stage as we move towards more integrated health and care systems.

Despite the fact that the NHS has long been committed to expanding and strengthening community services, and the birth of sustainability and transformation partnerships should have provided an ideal opportunity for this, this expansion and strengthening has not happened. Our research has identified seven key barriers that need national attention to make the rhetoric of strengthening and expanding community services a reality.

The report provides a unique combination of our own policy analysis and commentary, published data, and, most importantly, the views of the chairs and chief executives who run community, hospital, mental health, and ambulance services in England. We also interviewed several leaders of community interest companies to ensure their contribution to and perspective on the health and care system is taken into account.

We are grateful to the trust chairs and chief executives, and community interest company leaders, who took the time to complete the survey and participate in interviews. The report would not be possible without these contributions, and we hope our report does justice to them.

Chris Hopson
Chief Executive, NHS Providers

THE STATE OF THE NHS PROVIDER SECTOR

We produce two reports per year in our series, *The state of the NHS provider sector*. Our winter report provides a comprehensive overview of the key challenges and opportunities facing hospitals, mental health, community and ambulance services across the provider sector.

Our spring report examines a specific part of the provider sector in more detail. Last year we reported on the challenges faced by mental health trusts, and the progress that has been achieved. This time we are focusing on the community services sector.

The centrepiece of each report is a survey of trust chairs and chief executives. This presents an opportunity to assess in detail the concerns and recommendations of trust leaders as they endeavour to protect and enhance standards of care for patients and service users at a time of rising demand, severe financial pressures and workforce constraints.

A STRONGER VOICE FOR NHS COMMUNITY SERVICES

NHS Providers has joined forces with the NHS Confederation to establish the Community Network. The network will make the case for community services to play a leading role in the development of integrated systems, and for sufficient funding and investment to be made available to support ambitions to strengthen community services. The network will also have a strong emphasis on promoting the link between community services and the rest of the health and care system, including primary care and social care services.

Community
NETWORK

CONTENTS

KEY POINTS

- There have been a number of national commitments, over many years, to shift care from hospitals into the community and give the community sector a key strategic role in improving the health and wellbeing of local populations. This argument has primarily been made because the NHS needs to move away from treating episodic illnesses to promoting health and wellbeing, as a way of coping with increases in demand caused by the changing disease burden and ageing population.

- It is generally accepted that treating people in the community and in their homes is better for patient outcomes and experience, and the financial sustainability of the NHS. However, year on year, this ambition has not been realised. This report highlights seven reasons why this shift has failed to occur.

  1 Community services play a fundamental role in the NHS. However, there is insufficient understanding of these services at a national and local level, perhaps due to the diversity of services, organisations and commissioning arrangements involved.

  2 Community services have had insufficient profile and prioritisation at both national and local levels. Over nine in ten respondents to our survey of NHS trust chairs and chief executives said that community services receive less national-level focus, priority and attention than other sectors do, which means the expansion of care in the community has struggled to gain wider momentum, recognition or investment at a local level. There needs to be stronger leadership of community services at a national level to ensure ambitions for the community sector are realised.

  3 Community services need additional investment after a long period of under-funding, which is partly due to the general financial squeeze on the NHS, but also due to community sector-specific challenges such as the use of block contracts and the squeeze on local authority funding. Over half of trusts providing community services reported that their funding for these services has been reduced in 2018/19.

  4 Community services are struggling to meet increases in demand, which is already outstripping capacity. In our survey, nine in ten trusts think that the gap between funding and demand for community services will increase or substantially increase over the next 12 months.

  5 A set of workforce challenges has led to mounting pressure across community services. The supply of community staff has not kept pace with demand and trusts face worrying shortages in key staff groups, such as district nursing and health visitors. Trusts are also struggling to recruit and retain the staff they need to deliver high-quality care, due to the low profile of the community sector.

Two thirds of trust leaders that responded to our survey are "worried" or "very worried" that they will not have the right numbers, quality and mix of staff to deliver high-quality care in one year's time.

6 Community service providers are being distracted from their core strategic task due to complex commissioning arrangements and frequent retendering of contracts. These providers are disproportionately affected by procurement rules compared to other parts of the NHS provider sector. This leads to a lot of wasted time and resource, and some trust leaders that we interviewed warned that this can risk the quality of care.

7 A lack of robust national data, quality metrics and performance targets means that there is less national focus on, and no national improvement approach for, community services. Although national performance targets and quality indicators would be a double-edged sword for trusts, they would still welcome the opportunity to better quantify changes in demand, activity, funding and quality at a national level. Developing a standardised national dataset is crucial in this endeavour.

- Community services are delivered by a diverse range of providers, and community interest companies (CICs) are a key component of that landscape. While much of their perspective on the challenges facing the community provider sector resonates with that of trust leaders, there are some nuances that should be taken into account when considering the overall provision of community services.

- The drive to create integrated local care systems provides a great opportunity to invest in and develop community services. However, despite this opportunity, trust leaders responding to our survey generally felt that sustainability and transformation partnerships (STPs) were an acute-focused model of transformation, focused on the demand on and reconfiguration of acute services, rather than planning to strengthen and expand community services. Only two thirds of trust leaders said community services in their local area were somewhat influential in shaping their STP. If new care models, STPs and integrated care systems (ICSs) are to flourish, it is vital that community services and the prevention agenda are at the centre of these plans.

INTRODUCTION

For many years now, successive national NHS policies have stated that community services should play a more central role in the future health and care system than they do at present. The most recent iteration of this ambition was the *Five year forward view* (FYFV) (NHS England, October 2014), but this initiative was only the latest in a long line of NHS strategic plans that sought to strengthen the position of the community sector and deliver care closer to people's homes.[1]

This argument in favour of stronger, expanded community services has been made for three overarching reasons:

1 The NHS must radically improve its ability to prevent illness and support people to ensure their own wellbeing if it is going to be financially sustainable. As the Wanless report showed, the financial burden of the existing NHS model, which focuses primarily on treating illness, is in danger of becoming untenable. This is due to demographic changes, including an ageing population (Wanless D., December 2003). Strengthened community services are crucial to bringing the right focus on preventing ill health, improving the population's health and wellbeing, and tackling health inequalities.

2 The disease burden is shifting as people are living much longer with multiple long-term conditions that cannot be permanently cured by hospital intervention. Conditions such as diabetes and hypertension require a very different type of interaction with patients and the public than, for example, a traumatic injury. Community services offer the most appropriate way to promote good health and prevention and provide joined-up care for an ageing population.

3 Acute inpatient services, in both hospitals and mental health services, are under huge pressure and they are currently being used unnecessarily and inappropriately for patients who could and should be treated closer to home. It is better for patient care, better for performance outcomes, and better for the NHS budget to treat as many patients as close to home as possible, with community services once again at the heart of provision.

However, while the burning platform for this shift in the provision of care is the financial and operational pressures in the acute sector, the real driver for community services lies in good population health and prevention at scale. We have, for far too long, largely made the case for community services in relation to "moving care closer to home", when it is the combination of all three reasons that makes the case. Concentrating solely on this defines community services in relation to what they are

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1 The recent King's Fund report *Reimagining community services* provides a comprehensive summary of how these attempts to reorganise the structure of community services provision have often been unsuccessful and merely fragmented the landscape of provision further, rather than improving services (January 2018).

not, rather than what they are. This then colours the debate around community services, which continues to be acute-focused and about shifting services between settings rather than acknowledging the positive reasons for strengthening community services.

Our analysis for this report is informed by an online survey of NHS trust chairs and chief executives. We invited responses from all types of trust, regardless of whether they provide community services or not, seeking their views on the state of the community sector. We received responses from nearly a third of all trust leaders, representing 51 trusts that provided community services and 20 that did not. The contribution of these 51 trusts means that we heard from over half of all trusts that we define as currently providing a substantial amount of community services. To complement our survey we carried out a number of interviews to gain a richer understanding of the issues facing community providers. As part of this we conducted five interviews with chief executives of community trusts and four interviews with leaders of CICs.[2]

Despite the potential of community services, our survey and analysis found seven reasons why ambitions for the community sector have not yet been realised. And, in doing so, this report provides a clear manifesto for what needs to happen next if we are able to deliver the shift we all know the NHS needs to make. The seven reasons are:

1 There is insufficient understanding of community services and the community provider sector among the national bodies, the Department of Health and Social Care, commissioners, politicians, patients and the public.

2 Community services have been, and continue to be, an inconsistent national and local priority.

3 There needs to be greater financial investment in community services.

4 Demand for community services is outstripping capacity and supply.

5 Structural inequity means that competition and procurement disproportionately affect community service providers.

6 There are worrying staff shortages in key roles.

7 There is a lack of national-level data and a national focus on an improvement approach for community services.

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2   CICs are a form of social enterprise and not-for-profit organisation that provide all types of community services. We have included their perspectives in this report as many CICs were spun out of Primary Care Trusts in 2008 under the *Transforming community services* programme and therefore play an important role in many health and care systems.

The NHS has needed to make this fundamental shift to building up community health service provision for many years now and yet this ambition has not been achieved, despite having the extraordinary transformation of mental health care over the last 30 years, with the closure of inpatient facilities and the transfer of care to community provision, as a good example of the shift that needs to happen (The King's Fund, February 2014a).

With the current emphasis on population health at STP/ICS level and the recent report published by The King's Fund (January 2018), the forthcoming Carter report on operational productivity and performance in English NHS mental health and community health services, and now this publication – the time has come to make the ambition for community services a reality.

NHS COMMUNITY SERVICES

Transforming the way care is delivered –
meeting the needs of local people

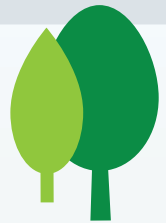**We surveyed 71 NHS trusts...**

100m
contacts a year

60%
said community care was high quality

6,000
fewer nurses in community services

52%
said income for community services had reduced in real terms

93%
feel community services receive less national attention than other sectors do

44%
fewer district nurses

19%
fewer health visitors

62%
worried about future numbers and skill mix of staff

Diverse group of services delivered in the community to support people's health and wellbeing

59%
said demand for adult community services is unmet

18%
said community services are very influential in STPs/ICSs

9 out of **10**
said the gap between funding and demand will increase

4 out of **5**
worried about insufficient investment to achieve FYFV's ambitions

9.5%
vacancy rate

1 £
There needs to be greater financial investment in and support for community services

2
Community services need to be a consistent national and local priority

3
Rapid action is needed to address staff shortages in key community roles

THREE KEY ACTIONS

INSUFFICIENT UNDERSTANDING

1

Community services are a fundamental element of the system's architecture, however there is insufficient understanding of community services and the community health provider sector among the national bodies, the Department of Health and Social Care, commissioners, politicians, patients and the public. This is partly because the community sector is characterised by its diversity, which can be attributed to the fact that there are many types of community services, many different types of providers, a range of commissioners and a multiplicity of contracts.

In addition, community services are often provided across several different geographic areas (footprints) by the same provider, or different sets of services are provided in the same footprint by each different provider. Broadly speaking, community service providers deliver a range of services across a range of footprints. However, this diversity should be celebrated and not act as a barrier that impedes our understanding of the role and importance of community services.

What are community services?

Community services deliver a significant proportion of NHS care in England, totalling 100 million contacts every year (The Health Foundation, April 2017). However, the scope, breadth and impact of the community health offer is often not well understood at a local or national level. There are several reasons why community service providers – both trusts and CICs – face a key challenge to describe themselves and their place in the health and care system:

- Community services encompass a heterogeneous group of physical health and care services that are delivered in a variety of community settings such as clinics, community centres, homes and schools. This complexity makes it unhelpful to reduce them to a single, simple definition.

- Community services are not easily grouped together as they cover various different types of care that span a person's lifetime, from macro-level public health services for whole populations, to micro-level specialist interventions for individuals with long-term conditions, as well as rehabilitation following hospital admissions.

- A diverse range of organisations deliver community services. These organisations may have some services in common, but often provide a large number of different services.

- Community services do not have the same propensity to make headlines, impact elections or generate national controversy as hospitals do; they do not have a distinct clinician body, so they are often missing from policy and public agendas.

Due to their diverse nature, the community health provider sector has often been subject to sweeping generalisations and narrow simplifications, and has historically been described through the deficit lens of what they are not, such as 'out of hospital' or 'non-acute' services, rather than what they are. This phraseology does not do justice to the breadth of services offered in the community and the wide-reaching impact they have on people's lives (which is often described, in an echo of the NHS' founding premise, as "from cradle to grave").

For the purpose of this report, our definition excludes services provided by GPs or mental health teams, but includes some local authority-commissioned services. We recognise that in reality, local arrangements are far more complex than this artificial separation of mental and physical health and that community teams work particularly closely with primary and social care.

Mental health services are an important component of care delivered in the community. Mental health trusts often deliver a wider range of community services, which themselves fit well within the personalised nature of mental health care. There is a specific set of issues around delivering mental health services in the community. For example, there are concerns about capacity as some mental health support services in the community are being decommissioned. While we decided not to cover these issues in detail in this report, the experience and learning from community mental health teams has much to offer to the transformation agenda of community services.

As organisations move towards integrating care across organisational boundaries, this cross-sector approach to providing seamless care around a person's needs is crucial. Indeed, some areas are drawing up an integrated care offer that spans the whole health and care system.

If hospital care is the illness service, then care in the community is truly the health service.
Chief executive, community trust

Given all this complexity, it helps to identify what makes community services unique. The most distinct feature is their connection to individual patients. Community services often have an ongoing relationship with a patient, compared with an episode of acute care. This has a knock-on effect on the ethos, dynamics and personalisation of these services. In addition, demographic changes, demand challenges and technological developments mean that staff are managing increasing levels of acuity and risk in people's homes and community-based settings. They undertake complex decision-making in a highly independent way, and therefore push at the boundaries of traditional community nursing.

Another defining characteristic is that prevention in the true sense of the word is at the core of community services. This does not simply mean

reducing emergency admissions, but rather preventing ill health and tackling health inequalities across geographies, communities and socio-economic groups. Strengthening community services is synonymous with a policy shift to prevention.

Shape of services

The main types of services delivered in the community include, but are not limited to:

- adult community services (e.g. district nursing, intermediate care, end of life care)

- specialist long term condition nursing (e.g. heart failure, diabetes, cancer)

- planned community services (e.g. podiatry, speech and language therapy, physiotherapy)

- children's 0-19 services (e.g. health visitors and school nursing)

- health and wellbeing services (e.g. sexual health, smoking cessation, weight management)

- inpatient community services (e.g. inpatient services).

The most common community services delivered by the 51 trusts providing community services that responded to our survey include community nursing teams (including district nursing), community specialist nurses, community physiotherapy and community palliative care. While these services are common to many trusts that provide community services, there are other services that were less common, including prison healthcare, sexual health services and school nursing.

Case studies

Given that the national picture of community service provision is so complex and, more importantly, community services are not a homogenous group, it is useful to take a deep dive into specific aspects of community services in order to demonstrate their role in the health and care system and the value they add. We have included case studies from the following trusts to illustrate this point:

Shape of the provider landscape

The landscape of community service providers is often characterised in a negative way as complex, fragmented and atomised, with previous national policy initiatives to restructure services demonstrating how community services, following the life course of an individual, have never been a comfortable fit anywhere in the NHS. While there is often a main provider of community services in a local area, it is not uncommon for there to be several different providers running a variety of community services in the same footprint, or for a provider to operate across numerous footprints.

Out of the 230 NHS trusts and foundation trusts in England, we understand that there are 136 NHS providers registered by Care Quality Commission (CQC) to deliver community services (Care Quality Commission, March 2018); out of these we estimate that around 97 (42%) are providing a substantial amount of community services. These trusts include standalone community trusts and combined community and mental health or community and acute trusts. Of the 51 providers who reported in the survey that they provide community services, the average percentage of community health service provision at their trust was 50%. Trusts that solely provide community services reported that, on average, over 90% of the services they delivered were in the community. While trusts deliver most of these services themselves, a third of trusts providing community services reported that they subcontract some community services to other providers such as GPs, sexual health and palliative care services.

CASE STUDY

Cambridgeshire Community Services NHS Trust

Community trusts have an opportunity to embed their services firmly into their communities, developing close relationships across health, education, social care, justice and the third sector. Cambridgeshire Community Services NHS Trust has successfully integrated contraception and sexual health services (iCaSH) to meet the needs of local people, often in hard to reach communities. Innovation and service redesign have resulted in standardised, cost effective, high quality services. These include a 'one stop shop' where people with symptoms can have an initial appointment, diagnosis and treatment in one visit. There is also quick and easy STI and HIV testing for people with no symptoms, using an online and postal service without the need to visit a clinic.

In addition to trusts, other types of organisation provide community services, including CICs, social enterprises and private providers.

The plurality inherent in this "mixed economy of types and sizes of provider[s]" means that there is a variety of models of providing community services to a local population; it depends on the local population size and demographic, the geography of the local area, and the local history of how services have evolved in the area, among other things (The King's Fund, January 2018). This can be complicated as services can be fragmented, which can lead to them being badly co-ordinated from a patient's perspective, and patients can be treated by different community providers within the same footprint. However, community service providers stress that the heterogeneous nature of community services is actually a strength, rather than a weakness.

The fragmentation of the community sector is also due to the private provider share of the community health service market being much larger than in other sectors of the NHS. Research undertaken by The Health Foundation (April 2017) showed that private providers tend to hold small, single service contracts in a particular area rather than very large contracts across a large footprint. In terms of turnover, NHS trusts hold over half (53%) of the total annual value of contracts awarded for community services. In comparison, private providers hold 5% of the total annual value (figure 1).
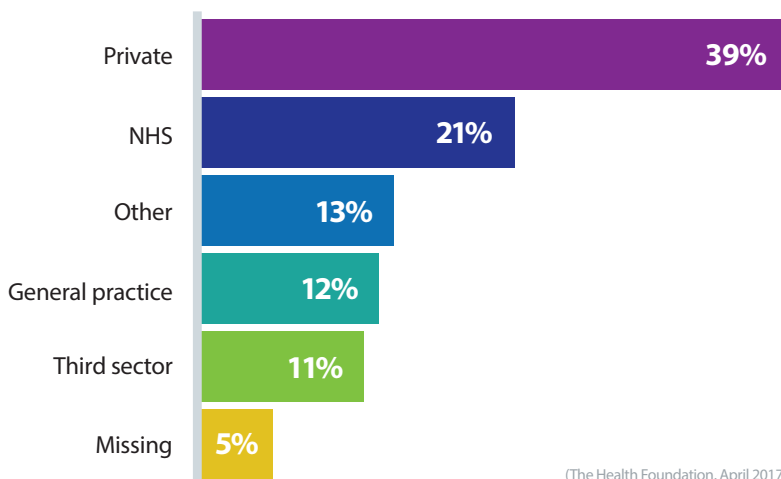
Figure 1
Share of total and annual contract values by provider category (%).
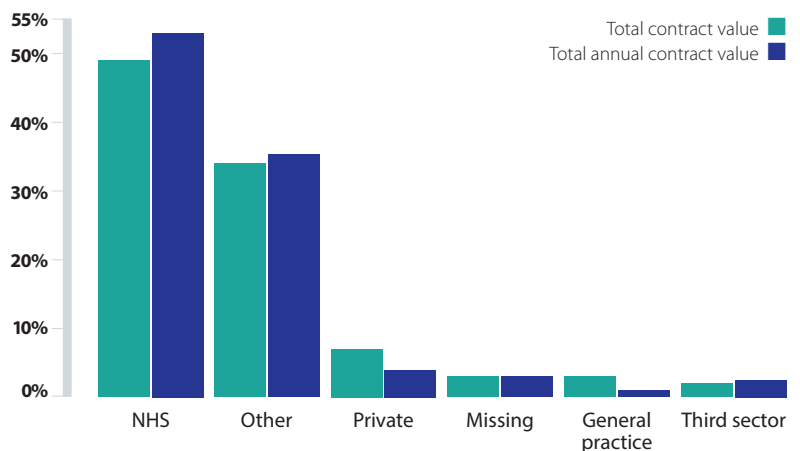
(The Health Foundation, April 2017)

However, in terms of the number of contracts, private providers hold the highest proportion of contracts – 39% of the total number (figure 2).

Figure 2

Share of contracts per provider category, by volume.

(n = 161)

Category	Share
Private	39%
NHS	21%
Other	13%
General practice	12%
Third sector	11%
Missing	5%

(The Health Foundation, April 2017)

These findings show that while private providers generally hold a large number of low value contracts, NHS trusts hold the relatively small number of high value contracts.

The shape of the provider landscape has also been affected by the development of new care models. One of the key challenges the vanguards addressed was how best to integrate community services with primary, social and mental health care across a geographic footprint to provide more joined-up care to the population. These forms of vertical integration include multispecialty community providers (MCPs), which deliver integrated services in the community through multidisciplinary teams of primary, community, mental health, acute hospital and social care staff, and primary and acute care systems (PACS) that bring together primary, community, mental health and hospital providers to better co-ordinate services for a local population. This blurring of the boundaries between all types of provision means it is important to see community services as part of the wider integration agenda. This is reflected through new care models, integrated care organisations, STPs and ICSs.

What does the community sector workforce look like?

Data on the entire community sector workforce is scarce. The most recent data is from 2008 which states that the community health sector employs around one fifth of NHS staff (Department of Health, July 2008). This workforce is predominantly non-medical, with the majority of staff being nurses and allied health professionals, but there are some consultant-

led community services, such as sexual health services. There is also an increasing number of consultant roles that cross over hospital and community settings.

While the number of nurses in the acute sector has increased since the Francis report (Francis R., February 2013) and the subsequent drive to improve safety through staffing ratios, the community nursing workforce has decreased. Since May 2010, the community nursing workforce has contracted by 14%, which amounts to a loss of 6,000 posts. Over the same period, the workforce has grown in acute adult settings by 6%, representing over 10,000 posts (NHS Digital). Workforce capacity in the community needs to be strengthened before services can be expanded, but the nursing workforce, which plays a crucial role in community services, is shrinking rather than growing.

How community services are commissioned

The challenges facing community services are compounded by the fractured and complex nature of commissioning arrangements in the community sector. The commissioning landscape is comprised of clinical commissioning groups (CCGs), local authorities and NHS England. Respondents to our survey told us that the majority of their community service budgets are derived from their local CCGs (77%), while 17% of the budget came from local authorities and 5% was commissioned by NHS England (table 1).

Table 1

In 2018/19, what proportion of your overall community services budget derives from commissioning by NHS CCGs, NHS England, local authorities or other commissioners?

Commissioner	Example of type of service they commission	Proportion of trust's community service budget they commissioned
NHS CCGs	Adult NHS community services	77%
NHS England	Specialist services including dentistry and immunisations	5%
Local authority	Children's services, public health services	17%
Other	–	1%

While these findings are probably similar for other NHS provider sectors, the difference for trusts providing community services is that they hold contracts with a much higher number of commissioners. On average, trusts providing community services were commissioned by more than five different organisations, and for some this was as high as 10 commissioners. This fractured nature of commissioning creates additional burden for organisations delivering community services as it means providers spend more time managing contracts. Fractured commissioning also places a bigger burden on trusts as different commissioners have different requirements, with a more complex process of collecting information and reporting. It also means that commissioners will not necessarily have a strategic focus around community services.

77%

of respondents said the majority of their budget for community services is derived from their local CCG

The trust leaders that we interviewed reported that while some CCGs are striving to strengthen and expand community services, others are distracted by significant performance and quality challenges within the acute sector. This variability in CCG approach can mean that even successful, evidence-based initiatives to treat more patients in the community are not rolled out across a geographic footprint. Trusts across the country are striving to resolve this challenge through aligned incentive contracts and risk sharing agreements across all providers in a footprint. Other CCGs are encouraging community service providers to collaborate and bid collectively for a bundle of contracts, to overcome the risks of a disjointed community service offer in a footprint.

One of the key strengths of the community services sector is its diversity in terms of different providers delivering different services in a way that responds specifically to local needs. But the disadvantage of this diversity is that it makes it more difficult for policy makers, commissioners and politicians to understand and value the community services sector. If we are to achieve the stronger community services we need, opinion makers have to make more of an effort to understand and positively value this diversity instead of using it as an excuse to ignore or undervalue the sector.

AN INCONSISTENT
PRIORITY

Despite longstanding top-level commitments to community services in national strategy documents, these services have lacked sufficient profile or recognition of their importance in both national and local debates, as well as in successive NHS planning rounds. The latest NHS strategy document, in the form of the FYFV, aimed to close the health and wellbeing gap, the care and quality gap, and the financial gap, by reducing hospital activity and shifting more care into community-based settings. However, these ambitions have proven hard to achieve due to inadequate sustained investment in transformation, the workforce, and lack of national leadership and direction for the community services agenda.

Subsequent planning documents have not upheld this ambition, with a continued focus on the acute sector and acute-focused targets. It is also disappointing that the plan to develop a forward view for community services was in development but then later dropped (Health Service Journal, February 2018), clearly illustrating the failure of national leaders to value and appreciate the vital role of community services.

Across the NHS provider sector, trusts recognise that the community sector is less of a national priority. As figure 3 shows, 93% of all respondents to our survey said that community services receive less national-level focus, priority and attention than other sectors do. The breakdown of responses shows a similarity between community service providers and non-providers, showing that both types of provider acknowledge this disparity. As one trust leader expressed: "The ambition is there and matched by the rhetoric, but the lack of the publication of a FYFV for community services is reflective of the value placed upon the services".

The themes from trusts' comments on the survey question include concerns about a lack of national leadership on community services from NHS England and NHS Improvement, which is necessary to bring about change in the system.

Figure 3

Do you think community services receive the same national level focus, priority and attention that other sectors do?

(n = 70)

|	
Less focus	**93%**
Same focus	**3%**
More focus	**4%**

While the national focus is on acute services, performance targets and constitutional standards, trust leaders have little confidence that community services will see any new investment or resources. Over three quarters of all respondents are worried or very worried that current resources and investment will not deliver the acute to community shift and move care closer to home for patients within the next five years (figure 4). The CIC leaders that we interviewed were similarly frustrated that national policy and rhetoric has not been matched with funding and resources.

Figure 4

How confident are you that the resources and investment will deliver the acute to community shift and move care closer to home for patients within the next five years?

(n=71)
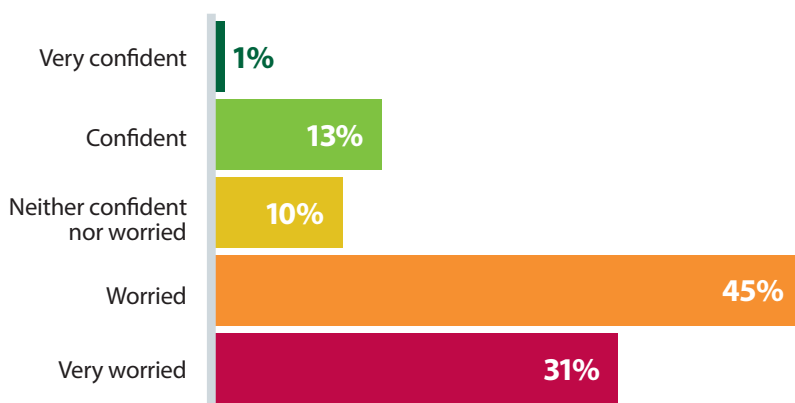
It is clear that the NHS still needs to create a strong economic case for investment in community services, as has been done successfully for mental health services. Currently there is only a small evidence base that care in the community achieves financial savings. Research shows that financial benefits are at best only valid in certain circumstances and do not always reduce costs (Nuffield Trust, March 2017). However, even if community-based models of delivering care may not produce large financial savings, their primary purpose is to promote prevention and self-care, to best meet the needs of the population. The focus on the value of community services needs to shift from cost savings to improving patient care and benefiting society. It should be the case that the public is concerned when a patient is admitted to hospital in the first place, rather than about discharge delays. The narrative needs to be shifted.

The national policy focus on collaborative working, system-based planning and integrated health and care systems presents the best opportunity to transform the community sector. This is not just about reducing pressures on the acute sector, but rather about transforming the way that health and care is delivered. It is about population health, which

includes preventing ill health by addressing the wider determinants of health and tackling health inequalities.

This national ambition is being delivered through STPs and ICSs that aim to provide more joined up care for their local population. However, much has already been delivered through the development of new care models, such as MCPs and PACS, that focus on population health by strengthening the provision of health and care services in the community. While the vanguards have seen lower per capita emergency admissions growth rates than the rest of England (NHS England, March 2017), their overarching focus has been on vertically integrating health and care services to improve patient care. Community services are central to these vertical models of integration, and their learning should be central to the development of STPs and ICSs.

CASE STUDY

Bridgewater Community Healthcare NHS Foundation Trust

Integrated community services in Wigan have shown how a range of community based providers can collaborate to help people live independently, taking into account all aspects of their daily lives at home, and so helping to prevent hospital admissions. In one example, they worked with a woman who was admitted to hospital six times with suspected sepsis from leg ulcers. The team at Bridgewater Community Healthcare NHS Foundation Trust developed a plan for her needs to be jointly assessed by a community matron and social worker. Under a management plan linked to her GP, she was re-housed, and given weight management support and physiotherapy. Since then she has not been admitted to hospital.

STPs and ICSs are being used on the ground as a catalyst to plan and support discussions about day-to-day operational collaboration, as well as to help reconfigure services, share workforce and as a means of driving new models of delivering patient care. Strengthened community services can provide continuous and sustainable solutions to prevent further ill health by weaving patients into the fabric of community life. They not only provide continuity of care and deliver efficiency savings, but also ensure individuals are more connected with other community assets through their networks.

However there has been mixed progress in making community services and prevention a priority at STP or ICS level, despite their focus on

integrated care. While prevention and strengthening community services were two prominent aspects in the majority of the initial STP plans, many partnerships have been tied up with operational and financial challenges that largely sit with the acute trust sector, rather than investing in prevention and transforming care to provide sustainable solutions in the community (National Audit Office, January 2018).

It is now widely acknowledged that initial targets of up to 30% reductions in hospital activity over several years will be difficult to realise (Nuffield Trust, March 2017). Figure 1 below shows how over half of respondents to our survey said that community services were very much included in local STP/ICS plans, but it is concerning that 34% of all trusts that responded to the survey described there being only "a little" focus on community services in reality (figure 5). If STPs and ICSs are to flourish, it is vital that community services and their prevention agenda are at the centre of these plans, operations and the integration process more broadly. However, local plans to reduce hospital capacity and increase community capacity have not been supported by national leadership or investment, and there needs to be a clearer national focus on prevention.

34%

of respondents said there was only "a little" focus on community services in their local STP plans

Figure 5

To what extent is the future of community services included in your local STP/ICS plans?

(n=71)

Very much	**55%**
A little	**34%**
Not much	**8%**
Not at all	**3%**
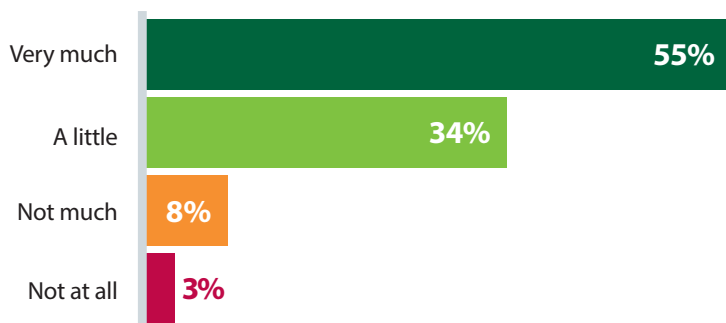
Our survey results highlight the variability in prioritisation of community services, as well as variation in the level of their engagement in STPs and ICSs, demonstrating how the strengthening and expansion of community services has not happened at scale. Around two thirds (65%) of all trust leaders felt that community services in their local area were "somewhat influential" in shaping their STP (figure 6). Given the prioritisation of transferring more care into the community that was integral to the original STP plans, it is worrying that only 18% feel that their own or other community services are "very influential" and 18% feel "not at all influential". This variation in STP engagement is comparable to the views of the CIC leaders that we interviewed.

Figure 6

Trusts providing community services: How influential have you/community services in your local health economy been in shaping your STP(s)?

(n=51)

- 🟩 Very influential
- 🟨 Somewhat influential
- 🟥 Not at all influential

18% 18%

65%
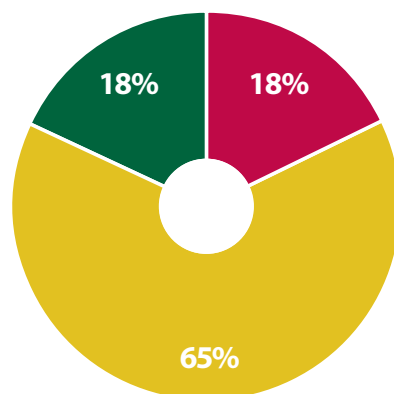
Respondents generally felt that STPs were an acute-focused model of transformation, and were focusing on the reconfiguration of acute services or finding solutions to demand on acute services rather than planning to strengthen and expand community services. However, some trusts providing community services report being very involved in STPs/ICSs and feel that they are seen as an important part of the system architecture by the rest of the NHS provider sector. Some community service providers, such as Sarah Dugan from Worcestershire Health and Care NHS Trust, are leading their STP. Other trusts providing community services are leading STP workstreams, developing sub-STP place-based plans, and leading new models of care such as MCPs.

In addition, some STPs/ICSs are developing plans to share financial and operational risk across the system for defined population groups or reducing acute activity. Others are focusing on providing integrated care with acute, social care and GP colleagues, or developing primary care at scale. Although there are some success stories, others are grappling with big challenges, such as transforming care when double running services with non-recurrent funding and amidst unwavering demand.

Where there is local recognition, it is, however, not supported by visible national leadership or strategic planning. There is real enthusiasm among community service providers about the major role they should play in developing and delivering new models of care, but there has been mixed progress in strengthening and expanding community services. There has also been widespread frustration amongst both trusts and CICs that the rhetoric of the FYFV has not been translated into reality on the ground. While local systems will want to develop their community services in different ways depending on the current landscape of provision and local population needs, STPs and ICSs provide an opportunity to apply a degree of consistency and standardisation to community services that has been lacking up till now.

Alongside the main seven barriers to strengthening community services that we cite in this report, there are some additional and more specific issues that are holding some community service providers back from driving the STP/ICS agenda, including:

- The centre focusing STPs on restoring financial balance and constitutional targets, rather than prevention and strengthening community services.

- Acute trusts tend to dominate STPs, both in leadership and issues such as their challenging financial situation and the reconfiguration of hospital services. It is difficult to innovate and develop new models of care when there is no financial headroom to do that at system level.

- Decades of structural reorganisation have led to the fragmentation of community health service provision across an STP footprint or across several STP footprints, so it is more challenging for a community trust to have a strong voice at STP level.

- Community services do not have a strong narrative and national voice to explain their service offer and role in the system. This is exacerbated by there being no visible leadership for the community sector within NHS England, NHS Improvement and Department of Health and Social Care.

- As some trusts providing community services do not employ consultant medical staff, there is no strong clinician voice to push forward their agenda.

The lack of visible national leadership and prioritisation of community services is epitomised by the fact that the FYFV on community services was abandoned.

There is a stark contrast between the stated strategic level commitment to strengthening community services in policy documents like the FYFV and the detailed planning required to make it happen. It is worrying that despite STPs offering an important opportunity to deliver strengthened community services, it is becoming increasingly clear that this is not being consistently delivered.

To achieve stronger community services, as the NHS has done in the mental health sector, there needs to be movement beyond the top-level platitude of 'moving care closer to home' to create a concrete, detailed vision and plan of what is required to strengthen community services and how this will be achieved. This requires appropriate, well-resourced national leadership from the national bodies and the Department of Health and Social Care. It also means community services being given appropriate priority in all key decisions and policy and strategic frameworks.
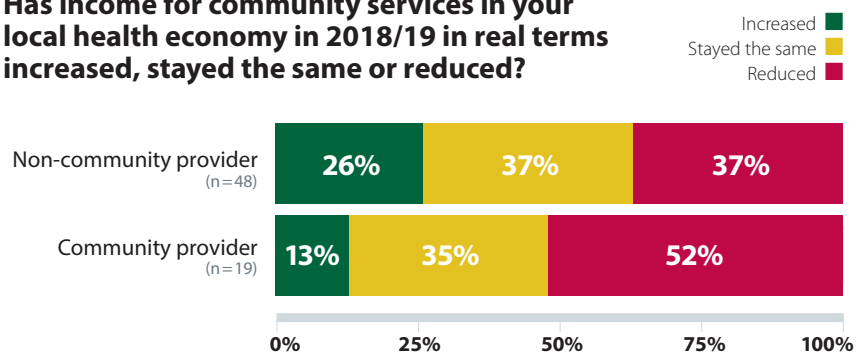
65%
of trust leaders felt that community services were "somewhat influential" in shaping their STP

NEED FOR GREATER FINANCIAL INVESTMENT

3

Community services have suffered insufficient investment for many years. This is partly the result of the long-term funding squeeze on the NHS. While the amount of government spending on the community sector varies according to different sources (partly because there is no national data and partly because there are different ways to delineate which services to include), mostly it is accepted that around £10bn of the NHS budget is spent every year on care in the community. Increases in demand for community-based care and the national focus on strengthening community services have not been accompanied by a shift in resources, which has resulted in more services being delivered for less money. Community services are following a similar journey to mental health services in terms of their priority and financial investment.

This longstanding underfunding is borne out by our survey. Over half (52%) of trusts providing community services said that the income for community services in their local health economy had decreased in real terms in 2018/19 (figure 7). However, in comparison, only 37% of trusts that do not provide community services thought that funding for community services had reduced in their local area.

Our survey therefore highlights the disparity between different perspectives within the provider sector, suggesting there is no clear view of, or transparency over, the level of investment in community services. Similarly, while only 13% of trusts that provide community services responded that funding had increased in their local area, 26% of trusts that do not provide community services reported that it had increased.

Figure 7

Has income for community services in your local health economy in 2018/19 in real terms increased, stayed the same or reduced?

■ Increased
■ Stayed the same
■ Reduced

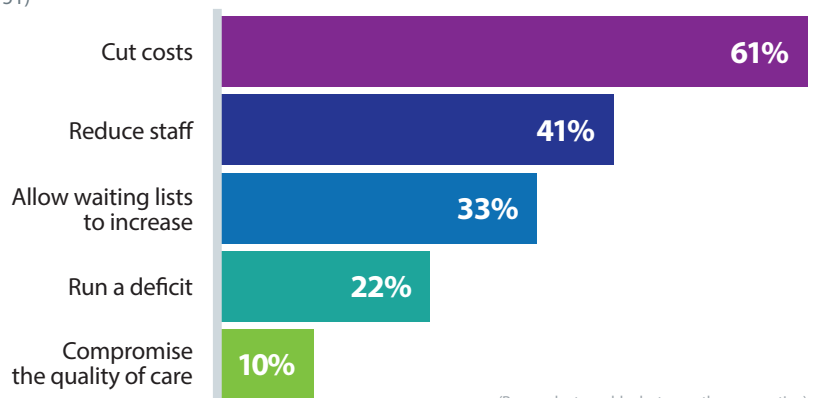|	Increased	Stayed the same	Reduced
Non-community provider (n=48)	26%	37%	37%
Community provider (n=19)	13%	35%	52%

0%　25%　50%　75%　100%

Contracting arrangements

In addition to this context of financial constraint and underinvestment, there are some community service sector-specific issues in the way that these services are contracted, particularly through the use of block contracts. The majority of community services are commissioned under block contracts that provide a fixed annual payment for a service. Under this type of contract, funding is not directly linked to the volume of activity as it is in payment by results) used to fund acute services. When using a block contract, if a provider ends up seeing more patients or undertaking more activity than they are contracted to do so, they must absorb the cost of this, which can impact on the quality of care provided. In the context of constrained resources across the NHS, block contracts can be used as a way for commissioners to manage financial pressures in the wider system. These funding arrangements epitomise how community services are at a structural disadvantage within the NHS provider sector; it is not about the quality or quantity of results, but about buying a portion of indiscriminate care.

Unlike on a hospital ward where activity is limited to the number of beds, community services are forced to absorb demand increases and cost pressures by increasing caseload size, reducing the number of staff, changing the skill mix of staff or raising the eligibility criteria for access to services. Our survey illustrates the actions taken by trusts providing community services as a result of financial and demand pressures; 61% of trusts were cutting costs, 41% had reduced staff and 33% had allowed waiting lists to increase (figure 8).

Figure 8
**Trusts providing community services:
Have financial/demand pressures led you
to do any of the following:**

(n=51)

Cut costs	61%
Reduce staff	41%
Allow waiting lists to increase	33%
Run a deficit	22%
Compromise the quality of care	10%

(Respondents could select more than one option)

As one trust leader put it, "with financial envelopes being reduced, the margin on winning a successful tender does not generally contribute fully to the mobilisation and running costs of the service". In general, trusts providing community services are keen to move away from activity measures towards outcome-based contracts that incentivise prevention and offer capitated payments based on patient outcomes, or aligned contracts with incentives for all community, mental health and acute providers within the system.

Payment systems

One of the reasons why block contracts are used for community services is because the payment system for these services is less developed compared with other NHS sectors (The Health Foundation and NHS Providers, October 2017). There are concerns that current payment systems, such as payment by results, do not incentivise the right behaviours across the wider health and care system. One trust leader that we interviewed explained that in the last five years, their trust's income for community services had reduced by 3.5%, but the trust had calculated that if the community services contract was on payment by results, it would have gone up by 11%. This puts them at a structural disadvantage compared to providers operating on a payment by results contract.

The National Audit Office's (NAO) report reinforces the need for a new payment system that will support the community sector and manage demand, and flags the inconsistent approach between NHS England and NHS Improvement. More generally, there seems to be a lack of alignment in the national bodies' intentions for new payment systems and what the rules currently allow, as the report states: "commissioners have been given conflicting messages on the current payment system, with NHS England giving commissioners a clear steer to explore other payment systems to help manage demand, while NHS Improvement has encouraged trusts to use payment by results to maximise their income" (National Audit Office, January 2018).

Work is underway at a national level to develop currencies for the new pricing and payment system for community services. The new currencies and tariff structures will need to accurately reflect the delivery of care in community-based settings and include incentives to improve the transfer of care into the community, people's health and wellbeing, and prevention. These currencies will need to focus on care pathways rather than individual services, and be based on the resources required to deliver outcomes for a group of people with similar health and care needs, such as frailty or long-term conditions. They need to be relevant to

52%

of trusts providing community services said income for these had decreased in real terms in 2018/19

the patient, meaningful at a local and national level, and linked to patient outcomes. Work is also underway at a local level as some health and care systems are exploring more blended payment systems or capitation-based budgets. These new payment systems include risk and gain share agreements that take the financial risk of activity away from the acute sector, where it currently sits.

The national bodies must recognise that strengthening and expanding community services will require the double-running of services and the importance of additional investment to do this, which is simply unavailable in the current environment. A dedicated transformation fund, in the form of the sustainability and transformation fund (now called the provider sustainability fund), has had to be used to support the financial sustainability of the trust sector, which has meant that new models of care that prioritise prevention and care in the community have not been invested in significantly.

This lack of additional investment to increase capacity in the community means there needs to be new funding to achieve the successful transformation of community services, as set out in the FYFV. There is widespread agreement that it is not appropriate to take funding away from acute hospitals to invest in community services (The King's Fund, January 2018). As Figure 9 shows, four out of five trusts are worried or very worried that community services will not receive the investment needed to achieve the ambition set out in the FYFV to move care into the community.

Figure 9
How confident are you that community health services will receive the investment needed to achieve the ambition set out in the *Five year forward view* to move care into the community?

(n=70)

Very confident	0%
Confident	3%
Neither confident or worried	14%
Worried	51%
Very worried	31%
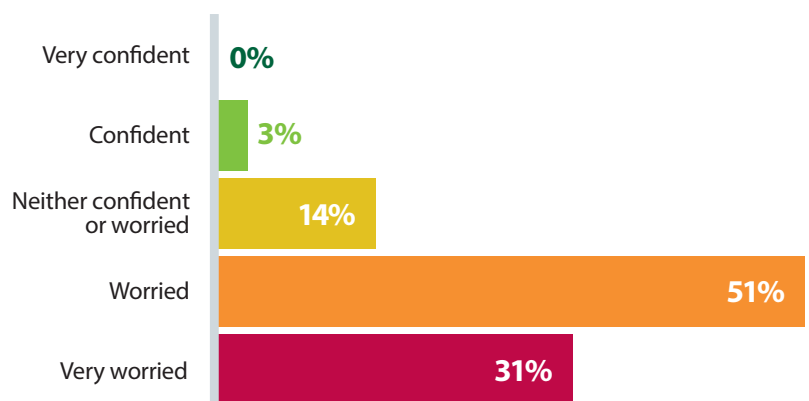
For the NHS to have a robust community sector, it is clear that proper investment in community services is necessary. The recently announced "multi-year" funding plan is an opportunity to address this as a fundamental part of the sustainable solution for the NHS. In our survey, respondents from all parts of the provider sector commented that they would prioritise funding on issues such as integration with other parts of the health and care system including social care, the community workforce, such as community nurses and health visitors, and admissions avoidance through rapid response teams and step-down beds. In addition, there is a lot of variability across England around historic community funding arrangements, so any long-term settlement should work this out through a standardised method based on population needs and best practice.

However, there is a concern that any extra investment in the community service infrastructure would reveal high levels of unmet need and increase demand for services, or it would only tackle the lower end of the acuity spectrum of unmet need rather than the top end. Another concern is that it could potentially just reduce the pressure on primary care. To mitigate these risks, the extra investment needs to focus on changing referral patterns, patient expectations and care pathways, as well as ensuring that new system working allows savings to hospital services to be diverted to community services.

While standalone community and combined community and mental health trusts tend to currently be in a better financial position than acute trusts, they still have to meet stretching control totals – a financial target decided by NHS Improvement and which all trusts are required to achieve in order to unlock additional funding (NHS Providers, March 2018). Trusts providing community services will do all they can to meet their financial targets and retain a healthy financial position, but there is a real risk of compelling trusts to make levels of efficiency savings that they believe are impossible (NHS Providers, March 2018).

The recently published Kirkup Review into failings of care at Liverpool Community Health NHS Trust highlights the potential implications of prioritising efficiency savings over the quality of care: "unless there are exceptional circumstances, an annual cost improvement programme of 4% is generally regarded as the upper end of achievability" (Kirkup B, January 2018). However, trusts are working hard to maintain the quality of and access to services despite these financial challenges, and only 7% of respondents to our survey said they were compromising the quality of care as a result of financial and demand pressures. Trusts are clearly working hard to protect patient care.

Local authority funding

The squeeze on local authority funding has also had an adverse impact on many community service providers. Trusts providing community services (particularly those that hold more local authority contracts than NHS commissioned contracts) tend to be more concerned about the precarious nature of funding for local authority-commissioned services – particularly public health services – than CCG allocations as there have been cuts to preventative, public health and wellbeing services.[3] In some areas, smoking cessation services are being decommissioned which concerns trusts.

There are now concerns that reforms to local authorities' finances, namely the abolition of general grant funding from 2020 and retention of council tax and business rates, risk increasing the funding gap for adult social care (The Institute for Fiscal Studies, March 2018).

Underfunding is therefore a major barrier to developing community services. Community services need proper investment commensurate with the strategic priority of building up community services. Community service providers face particular challenges in the form of block contracts, current payment systems and the squeeze on local authority funding. This combination of under-investment and specific funding challenges contributes to concerns about maintaining quality standards. Trusts providing community services need adequate financial investment to strengthen and expand community services, as well as new payment systems and contracting models.

10%

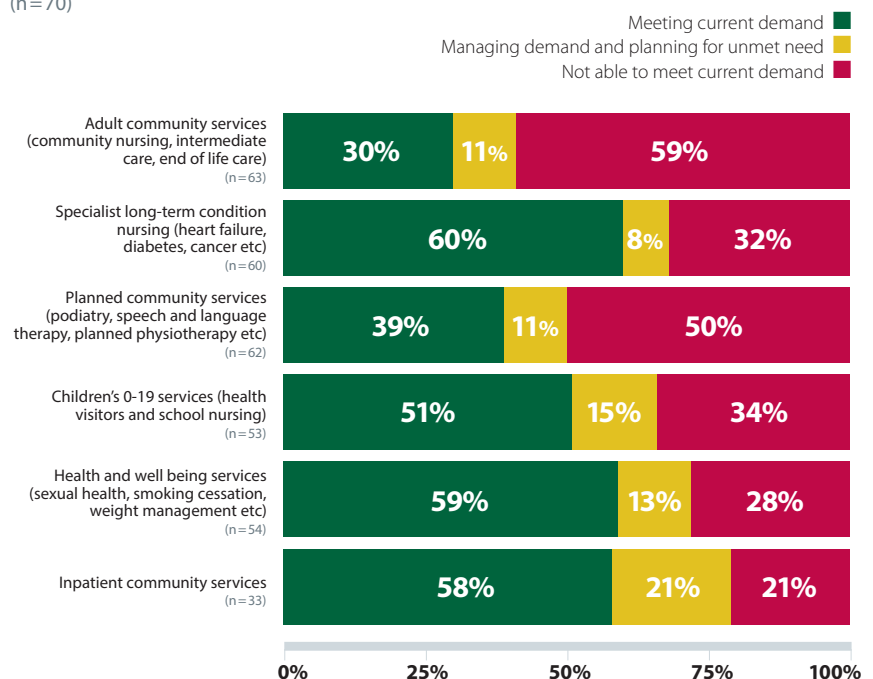**said they were compromising the quality of care as a result of financial and demand pressures**

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3   The King's Fund report (March 2017) found that financial pressures were having the greatest impact on services including genitourinary medicine and district nursing.

RISING DEMAND

Demand for community services continues to increase as a result of the growing ageing population and burden of chronic disease. Funding constraints on the NHS and local authorities have exacerbated the challenge trusts providing community services face in terms of having enough capacity to meet this demand. In addition to demographic changes, other factors contribute to this increased demand, including medical advances meaning more care can be conducted in the community, increasing patient expectations and pressures on other sectors such as primary, social and acute care.

Community services cannot absorb any extra demand in the current context of financial pressures and workforce shortages. As one trust leader that we interviewed said: "The community sector is being squeezed from all angles". In our survey, trust leaders reported that demand is already outstripping current capacity and resources (figure 10). For example, 59% of all trusts said their local community service provision was not able to meet the current demand for adult community services. Half of respondents also said the demand for planned community services such as physiotherapy and podiatry was not being met. One trust leader that we interviewed said that demand for some services had gone up by almost 50%.

Figure 10

How would you rate the level of service provision within your population for which you are commissioned to provide services?

(n=70)

Legend:
- Meeting current demand
- Managing demand and planning for unmet need
- Not able to meet current demand

Service	Meeting current demand	Managing demand and planning for unmet need	Not able to meet current demand
Adult community services (community nursing, intermediate care, end of life care) (n=63)	30%	11%	59%
Specialist long-term condition nursing (heart failure, diabetes, cancer etc) (n=60)	60%	8%	32%
Planned community services (podiatry, speech and language therapy, planned physiotherapy etc) (n=62)	39%	11%	50%
Children's 0-19 services (health visitors and school nursing) (n=53)	51%	15%	34%
Health and well being services (sexual health, smoking cessation, weight management etc) (n=54)	59%	13%	28%
Inpatient community services (n=33)	58%	21%	21%

The way that trusts deal with this increase in demand depends on the type of community health provision. For example, waiting times have increased for planned community services that are based in clinics (e.g. dentistry, musculoskeletal services [MSK]). The median waiting time for any first outpatient appointment is on average three days longer for a standalone community trust (32 days) than across all trusts (29 days) (QualityWatch, November 2017).

It is also harder to manage increases in demand for services that do not have a fixed number of beds or appointments. Home visiting services, such as adult community nursing, use clinical prioritisation to ensure people are not left waiting for care when they really need it, which means that staff feel the pressure in their increased caseloads. While technology has enabled multiple interventions to be carried out at home or in community settings rather than in hospital, and innovations such as telehealth and mobile wards enable staff to help patients manage their own care needs, these advances cannot stem the growing tide of demand.

59%

of trusts said their local community service provision was not able to meet the current demand for adult community services

Demand for community healthcare is rising primarily due to the shift in disease burden, as people live much longer with long-term conditions that cannot be cured by episodes of acute hospital treatment. Demand is largely, but not exclusively, driven by this growing, ageing population who are living longer in poorer health, with frailty, multiple long-term conditions and complex co-morbidities on the rise. The ageing population puts pressure on the NHS as a whole due to the costs of delivering health care increasing rapidly with age. Long-term conditions now account for 70% of the total health and care spend in England (Department of Health, May 2012) and it costs three times more to look after a 75 year old and five times more to care for an 80 year old than a 30 year old (NHS England, March 2017).

Given that there are half a million more people aged over 75 than there were in 2010, and there will be two million more within the next decade, helping older people stay healthy and out of hospital is not only better for them but also crucial to the sustainability of the NHS (NHS England, March 2017). There were over 1.6 million emergency admissions for people in the last year of their life in 2016, costing the NHS £2.5bn and amounting to around 11 million days in hospital (Marie Curie, March 2018). Potential savings are therefore often associated with less acute care and more community-based support.
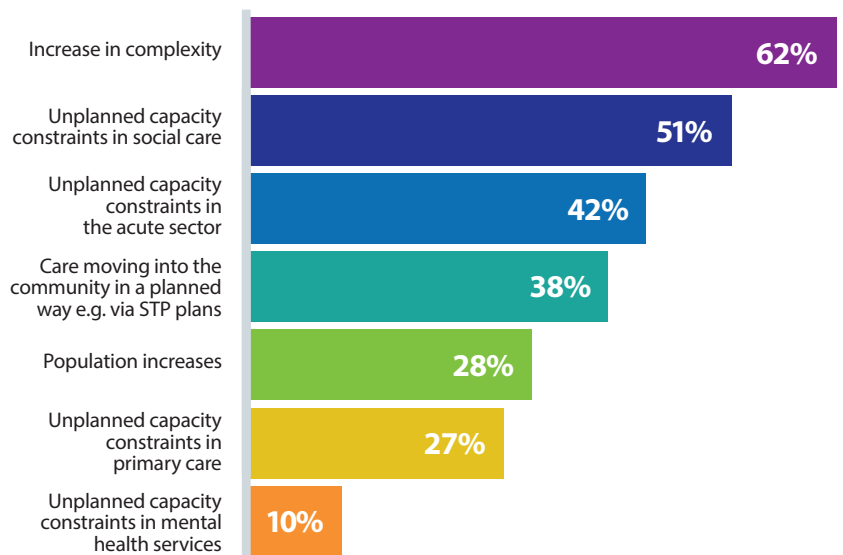
CASE STUDY

Sussex Community NHS Foundation Trust

In the Hospital@Home service run by Sussex Community NHS Foundation Trust (SCFT) in partnership with Brighton and Sussex University Hospital, community nurses and therapists look after patients with complex needs at home. Patient feedback is positive and the scheme is popular with staff who have the opportunity to develop and practice skills that would normally be used in an acute setting. The pilot launched in 2016/17 to 60 patients per month, and the scheme has now been extended to more than 500 people. SCFT say the scheme is delivering financial benefits as well, with the cost of a patient cared for by Hospital@Home 27% less than if they were looked after in an acute setting over the same period.

However, more often than not it is not the volume of patients but rather the complexity and acuity of care needs that is most challenging for community services. In our survey, increased complexity of care needs and unplanned capacity constraints in social and acute care were the top reasons all trusts, regardless of whether they provide community services or not, felt demand will increase for community services (figure 11).

Figure 11

The top three reasons why providers think demand for community services will increase.

(n=71)

Increase in complexity	62%
Unplanned capacity constraints in social care	51%
Unplanned capacity constraints in the acute sector	42%
Care moving into the community in a planned way e.g. via STP plans	38%
Population increases	28%
Unplanned capacity constraints in primary care	27%
Unplanned capacity constraints in mental health services	10%

These results demonstrate that the strain on community services is compounded by pressures to other services. The community sector is particularly interdependent with other parts of the health and care sector, particularly general practice, social care and the voluntary sector. The House of Lords Select Committee, on the long-term sustainability of the NHS, described pressures in social care as "the greatest external threat to […] the NHS", due to demand outstripping funding, the cuts in the number of people who are eligible to access local authority-funded social care, high vacancy rates and retention issues (April 2017).

The impact of unplanned rises in demand on community services due to constraints in social and acute care is particularly great over winter. In our 2017 *Winter warning* publication, trusts reported that in winter 2016/17, demand overwhelmed available capacity across all parts of the health and care system, with 76% of respondents to our survey highlighting a lack of community capacity (NHS Providers, June 2017).

70%

of the total health and care spend in England is now on long-term conditions

Pressures on the acute sector have led to more patients being discharged into the community with increased levels of acuity and a greater range of medical and support needs. For example, patients who used to be looked after in nursing homes are now being looked after in residential care, and nursing homes are doing the job of palliative services. While assistive technology and a highly skilled workforce have enabled care that used to be delivered in hospitals to be delivered safely in the community to a certain extent, the current provision of services in the community is struggling to keep up.

Community service providers are clear that, properly staffed and funded, they can manage complex cases with higher acuity than many hospital consultants believe is possible. But it is important that there is a careful, agreed, definition of what level of acuity can be treated by community service providers and that they are appropriately funded and staffed to cope with this demand.

The community sector does not currently have the capacity or resources to meet demand increases in a sustainable way. In our survey, 91% of trusts think that, based on current trends, the gap between funding and demand for services will increase or substantially increase over the next 12 months (figure 12). Insufficient capacity in the community can lead to worse patient outcomes; it is widely stated that a person over 80 who spends 10 days in bed in hospital, loses the equivalent of 10 years of muscle ageing and often, subsequently, their independence.

4

Figure 12

**Based on current trends, do you think that over
the next 12 months the gap between what services
are funded and demand for community services
will increase of decrease?**

(n=69)

Substantially decrease	0%
Decrease	1%
Stay the same	7%
Increase	62%
Substantially increase	29%
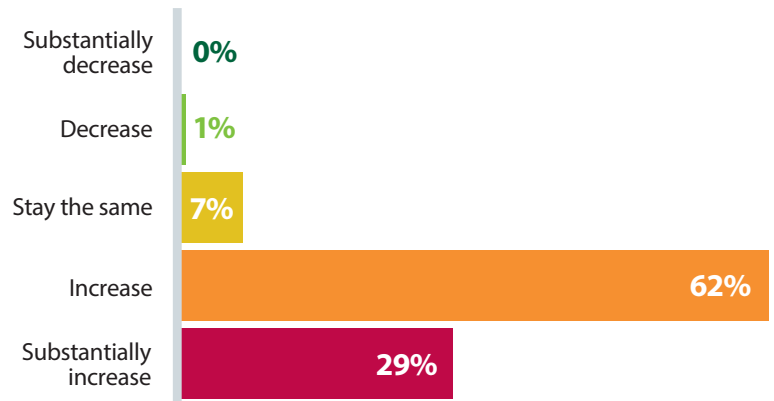
A lack of community capacity can also lead to growing unmet need,
which has a huge impact on the wider health and care system;
insufficient funding of and capacity in community care means that
people who should be cared for at home or in the community are
presenting at acute services. At a time when investment in prevention
should be increasing, demand and acuity are driven back into the acute
sector. Demand pressures arising from demographic changes create an
imperative for the NHS to adapt through transforming the way services
are delivered. Community services have a crucial role to play in providing
care in the community that not only reduces avoidable NHS activity but
improves quality of life and keeps people well for longer.

CASE STUDY

South West Yorkshire Partnership NHS Foundation Trust

Rehabilitation services delivered by community providers help people return home from hospital more quickly, re-establishing independent living and, where appropriate, a return to work or education. Neuro rehabilitation provided by South West Yorkshire Partnership NHS Foundation Trust supports patients with traumatic brain or spinal cord injury and stroke. New and established interventions are used to deliver efficient and effective rehabilitation, seven days a week. The trust's activities exemplify the key contribution community services play across a range of priorities including public health, prevention and palliative care. They include stop smoking services with the highest proportion of stop smoking quitters in England. In addition, mental health nurses further work within the multi-disciplinary care home support team in Wakefield. The team is made up of a range of specialist staff who provide personally-tailored care plans to help residents stay well.

Significant demand increases, and the increased complexity of care needs, are making the task to strengthen and expand community services more challenging, as trusts cannot keep up with current demand within the funding envelope. Trusts providing community services need to be appropriately funded and staffed to keep up with this demand in a sustainable way. They therefore need national recognition that demographic and disease trends necessitate a renewed focus on prevention, health improvement and self-care, to ensure a sustainable NHS now and in the future. Instead of seeing the changing profile of disease as a burden, community services are keen to take a more positive approach to good health and wellbeing, and see it as a community asset.

91%

91% of respondents said the gap between funding and demand is going to increase

WORKFORCE CHALLENGES

5

Trusts providing community services need to have the right staff with the right skills to deliver high-quality care for patients. However, the supply of community staff has not kept pace with increases in demand and trusts delivering community services now face considerable workforce challenges. In addition, trusts providing community services face recruitment and retention issues as they struggle to attract staff in to the community. This set of workforce challenges has led to mounting pressures across community services, which mirrors the experience of the wider NHS.

There are ongoing workforce shortages in various professions, particularly in district nursing and health visitors, which need to be addressed rapidly and effectively. While the number of nurses in the acute sector has increased since the Francis report and the subsequent drive to improve safety through staffing ratios, the community nursing workforce has decreased. Since May 2010, the community nursing workforce has contracted by 14%, which amounts to a loss of 6,000 posts. Over the same period, the workforce has grown in acute adult settings by 6%, representing over 10,000 posts (NHS Digital).
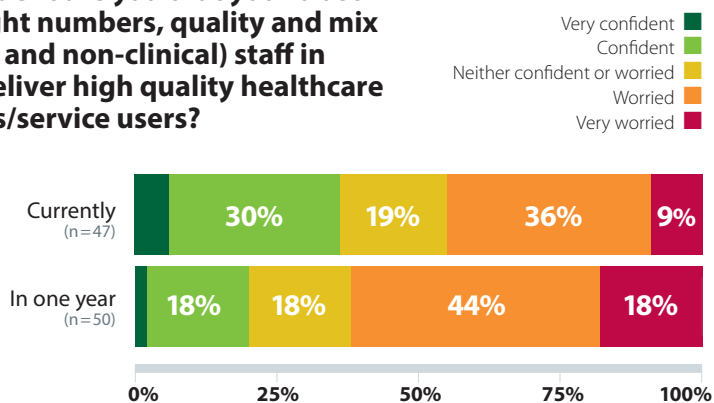
Within the community nursing workforce, the specialist role of the 'district nurse' is vital, but the number of district nurses has reduced by 44% since May 2010 (NHS Digital).The current community nursing vacancy rate is estimated at 9.5% and there is some evidence that these nursing shortages are risking the quality of patient care in community settings (House of Commons health committee, January 2018) as they put pressure on staff and their caseloads (The King's Fund, September 2016a).

Our survey showed that 45% of trusts that provide community services are "worried" or "very worried" about their current ability to maintain the right numbers, quality and mix of (clinical and non-clinical) staff to deliver high-quality care (see figure 13). When asked what the picture would look like in one year, their level of confidence decreased and 62% were "worried" or "very worried".

14%

contraction in community nursing workforce since May 2010

Figure 13

Trusts providing community services: How confident are you that your trust has the right numbers, quality and mix of (clinical and non-clinical) staff in place to deliver high quality healthcare to patients/service users?

Very confident
Confident
Neither confident or worried
Worried
Very worried

Currently (n=47)	30%	19%	36%	9%
In one year (n=50)	18%	18%	44%	18%

0%   25%   50%   75%   100%

District nurses play a vital role in supporting people with long-term conditions, helping older people often with complex co-morbidities, and caring for those who are recently discharged from hospital or near end of life. In a patient's eyes, they are often the linchpin between primary and social care, hospital teams and care homes.

However, there are not enough district nurses to meet current or future demand, and district nursing has an ageing workforce making supply an even more pressing issue. National policy has had some impact in increasing the supply of community staff in the past. The national target to boost the number of health visitors by 4,200 between 2011-15 was missed, but did cause numbers to rise (Department of Health, October 2012). Since the target was not renewed in 2015, the number of health visitors has fallen by 19%, showing how when the national impetus falls away, so do the results (NHS Digital).

Health Education England began a review into community nursing training in February 2018, after struggling to fill post-registration courses, and has increased the number of school and district nursing training places commissioned for 2018/19. However, the wider workforce strategy will need to consider the workforce in social care alongside community services as staff often move between the two and the capacity and capability of staff in both sectors is vital for supporting patients in the community.

In addition to district nursing, trusts providing community services are facing other issues and are particularly struggling to recruit and retain the staff they need. The community sector has a nursing staff turnover of 14.6%, which is 3% worse than acute trusts (Health Education England, December 2017). The trust leaders that we interviewed report that it is
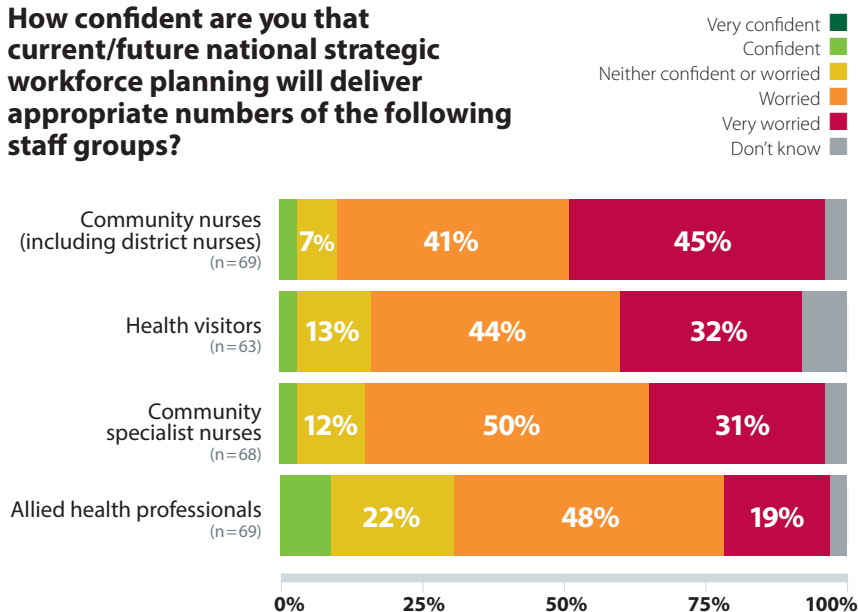
difficult to attract staff to work in the community as working in a hospital is still considered to be more 'glamorous'. It is also difficult to promote community services as an attractive career option.

There is some innovative work underway across the country to address the continued professional development needs of community staff, such as offering rotational posts that span organisational boundaries, and to deliver care more effectively, such as new care models redesigning the skill mix in multidisciplinary teams. However, these measures need to be supported to roll out across the country.

The imminent national workforce strategy needs to deliver the appropriate number of community staff and raise the profile of careers in the community sector. Across all types of trust, levels of confidence in national workforce planning are low. As figure 14 shows, 86% of trust leaders are worried or very worried that national strategic workforce planning will not deliver appropriate numbers of community nurses.

It is particularly concerning that 59% of respondents stated demand was not being met in adult community services (figure 10) and 45% are very worried about having the appropriate numbers of staff for these services (figure 14). One trust leader that we interviewed commented that the changes to nursing education were concerning, especially as they happened at the same time as medical training being protected and expanded.

Figure 14

How confident are you that current/future national strategic workforce planning will deliver appropriate numbers of the following staff groups?

Very confident ■
Confident ■
Neither confident or worried ■
Worried ■
Very worried ■
Don't know ■

Community nurses (including district nurses) (n=69): 7%, 41%, 45%

Health visitors (n=63): 13%, 44%, 32%

Community specialist nurses (n=68): 12%, 50%, 31%

Allied health professionals (n=69): 22%, 48%, 19%

0% — 25% — 50% — 75% — 100%

19%

**fall in
the number
of health
visitors**

The mismatch between the inadequate supply of core community health staff and the national policy ambition to move more care into the community will need to be resolved in future. To make this ambition a reality, it is crucial to increase workforce capacity before strengthening and expanding the provision of care in the community, so Health Education England's national workforce strategy must ensure appropriate priority is given to the supply of community nurses. Staff will need to be redesigned, upskilled and supported to work according to different models of care and a population health approach, if this is not already happening. The community sector needs a more flexible workforce that can take a holistic approach to care.

STPs and ICSs provide an opportunity for strategic system-wide workforce planning to address shortages in the health and care workforce (including social care staff). This will ensure organisations are not competing for the same limited pool of staff, and enable development opportunities across the footprint.

Workforce capacity in the community needs to be strengthened in line with the expansion of community services. The gap between the current supply of community staff and the demand for services means that staff are already working flat out to provide high-quality care. Trust leaders are increasingly concerned about having the right staff with the right skills in the future. In addition to worrying staff shortages, trusts are also grappling with recruitment and retention issues. There needs to be appropriate priority given to the supply of community staff at a national level, as well as a focus on the community workforce at local system level.

STRUCTURAL INEQUITY

National policy and legislation, and the subsequent diversity within the landscape of the community provider sector, mean that community service providers are disproportionately affected by procurement rules compared with other parts of the NHS. This means that trusts providing community services are subject to frequent competitive retendering, which can be a burdensome distraction from their core strategic task. This has led to structural inequity between community service provision and other NHS trusts.

The *Transforming community services* programme (2008) and Health and Social Care Act 2012 left the community health provider sector particularly exposed to regular and lengthy procurement processes. Competition affects community service providers in particular because barriers to entry are relatively low, so under the concept of any qualified provider (a policy which aims to enable patients to choose from any type of provider, be they an NHS, private or voluntary sector organisation), the voluntary and private sector can more easily enter and bid for service contracts. This means it is almost always a legal requirement for commissioners to go out to tender competitively for community services.

Tendering for contracts is therefore much more competitive in the community sector than in the acute sector, and contracts are sometimes won on cost savings, rather than improvements in the quality of care. Consequently, private providers have a greater presence in the community provider sector.

This mixed landscape of providers raises the question of whether NHS and private providers are on a level playing field when competing for contracts. There seems to be significant disparity regarding the potential capabilities of a private provider in comparison to an NHS provider when dealing with this heightened competition.

Firstly, a national private provider can make a loss on a contract, which can be balanced out by their national operations. This is harder for a local trust to achieve if they are, for example, a standalone community trust that does not operate at the necessary scale.

Secondly, a private provider can bid for and lose a contract, but continue with their national operations. In contrast, if a trust loses a contract, it may be forced to restructure how it delivers services, which is costly and disruptive, or the loss could potentially make a trust unviable and unsustainable, which is a disproportionate impact. In addition to the financial loss, experience, processes and efficiencies can be lost along with a contract too. One trust leader gave their insight into the negative impacts of losing a contract: "When we lost one contract [...] this impacted on stranded costs with no centralised funding."

Thirdly, a private provider can bid for multiple contracts simultaneously and use economies of scale and experience to do better than NHS competitors. For a trust, this expertise and scale is not possible as years of cuts to the number of administrative and management staff mean that trusts have less well-resourced bidding teams; the number of managers in trusts has fallen by 13% since May 2010 (NHS Digital). This means that each trust spends lots of money individually on contract support. In addition, as patient acuity levels continue to increase, there is a danger of private providers bidding for contracts on the lower end of the acuity scale, leaving the more expensive service users to the NHS community (and acute) sector. Finally, some private providers are often cited as under-bidding and/or under-delivering on contracts. This is obviously bad for patients and service users and erodes perceptions of the value of community services, in both financial and strategic terms. The NHS is often the provider of last resort, stepping in when private providers hand back contracts which prove unviable.

The mismatch of the level of competition between community and acute providers has become increasingly apparent as the acute sector continues to push at the boundaries of what is possible under competition law (including mergers and collaborative working). Meanwhile community service providers spend a lot of time dealing with the implications of competition law. As one trust leader revealed: "Everyone in the community sector is falling over themselves worrying about competition".

71%

of trusts said the process of submitting a bid for a community contract did not feel proportionate

Providers often have to manage multiple contracts as community services are often broken off in to individual tenders, meaning that providers often deliver some community services in an area rather than the full range of comprehensive community services to the local population. While some CCGs are supporting collaborative approaches whereby one lead community provider leads a consortium of other providers to collectively win a contract, other CCGs remain intent on frequently re-tendering or decommissioning individual service contracts, driven by compliance with procurement rules. However this unfortunately often involves "salami slicing" services and can risk the continuity and quality of care if services are moving frequently between providers.

In our survey, we asked all trust leaders whether they had submitted a bid for a community services contract in the last three years. Over half of respondents said they had. Trusts providing community services were more likely to have placed a bid than trusts that did not provide a community service. However, three trusts who do not currently provide community services said they submitted a bid in the last three years, demonstrating that other types of providers are trying to move into this

space. When asked how many bids they had submitted in the last three years, trusts that already provide community services submitted on average 4.8 bids (figure 15). The highest number of bids submitted by a trust was 20.

Figure 15

**How many bids have you submitted in the last three years?**

(n=71)
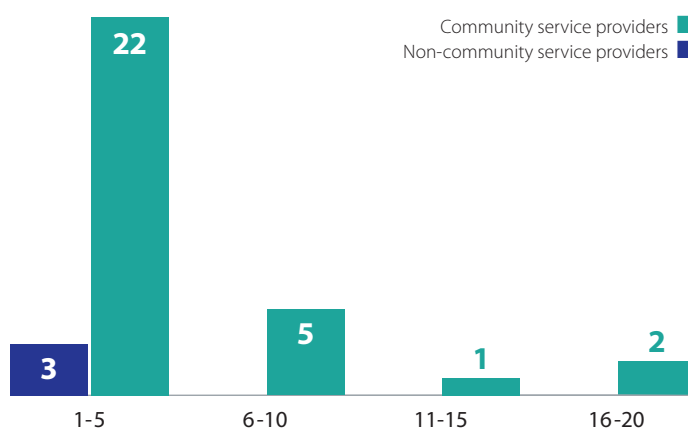
Typically, an NHS tendering process includes, but is not limited to, a written submission in response to the invitation to tender, as well as presentations and interviews. The amount of work involved in the tender depends on the size of the contract; the larger the contract, the more paperwork and engagement is necessary throughout the tendering process. Both trusts and CICs report that engaging with the tendering process leads to a lot of wasted time and resource in the system. Providers also tend to hold a significant number of community service contracts from a number of commissioners. These complex, fractured commissioning arrangements mean that a lot of financial and human resources are spent on bidding for contracts. Trusts feel this time and money could be better spent on improving services.

We asked all providers who said they had submitted a bid for a community contract in the last three years whether the process felt proportionate in terms of the time and resource put into it. Almost three quarters (71%) of trusts said that it was not proportionate (figure 16). Feedback strongly suggests that trusts are frustrated about the distraction caused by frequent re-tendering as it takes both clinical and non-clinical staff away from other commitments, to an extent that is disproportionate for the size of the contract. It is also important to consider the costs of tendering to CCGs, and therefore to the system as a whole.

Figure 16

Did the process feel proportionate in terms of time and resource put into it?

(n = 34)

■ Yes
■ No
■ Don't know

21%

9%

71%
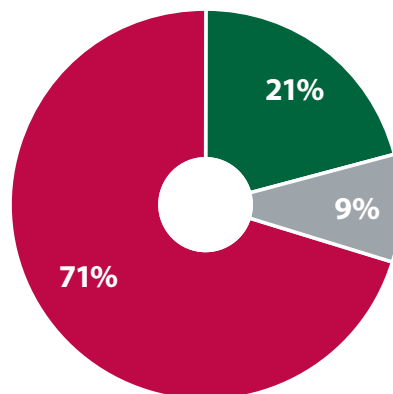
This frequent retendering can be destabilising for trusts providing community services because there is no certainty over whether they will retain existing revenue streams through current contracts in a few years time. It may also be the case that a provider loses the contract for one part of the services that it provides, but this has a destabilising impact on the whole organisation. This causes problems for long-term planning, investment and staff recruitment and retention.

In addition, often when retendering for a contract, the renewed contract will expect the provider to deliver the same service to more patients for less money. Although trusts are working hard to realise efficiency savings across community services, demand is ever increasing and the scale of the challenge is palpable. Trusts that we interviewed are clear that they cannot continue to provide the same amount of services on existing block contracts, and are having to consider reducing the level of service or staff, which risks the quality of the service.

Competitive procurement, fragmented commissioning and the use of frequent retendering act as a barrier to building up community services. While some CCGs are striving to do more strategic commissioning and avoid unnecessary retendering, others are still focused on contractual monitoring. If we are to build up community services to better meet the needs of the population now and in the future, services need to be commissioned in a way that strengthens, not burdens, community service providers. The tender process needs to be less burdensome, less frequent and better support the integration and improvement of services. Commissioners should make the most of the opportunity to commission community services in a way that will strengthen their role.

LACK OF NATIONAL IMPROVEMENT APPROACH

7

There is a lack of data collection, quality measures and performance indicators for community services at a national level. This historic problem continues to act as a barrier to strengthening the position of community service providers within the provider sector – as well as a barrier to improving patient care – because there is consequently less understanding of, and focus on, the community sector. Historically, the limited national data collection for community services has been an underlying reason for not strengthening their contribution to the health and care system. Community services therefore need national investment in an improvement approach to put them on an equal footing with other parts of the NHS provider sector.

There are currently no national measurements of quality or performance targets for trusts providing community services to meet, although trusts collect and use performance and quality indicators at a local level. Implementing national performance and quality indicators would be a double-edged sword, but trusts agree that overall they would have a positive impact.

The current lack of national quality indicators means it is harder to see the effects of operational and financial pressures on quality. These circumstances risk creating the conditions for the deterioration in quality of care to go unnoticed, as highlighted in the Kirkup Review (Kirkup B. February 2018). Dr Bill Kirkup raised concerns that community services are often underrated by national leaders and require a more strategic approach (Health Service Journal, March 2018). Dr Kirkup also flagged that while there is a perception at a national level that community services are inherently lower risk than acute services, this is not true – especially as growing levels of acuity are treated in the community. Our survey also raises this concern as trusts commented that quality is becoming more difficult to deliver because of financial constraints, demand pressures, and the legacy of the fragmentation of services and commissioning.

Trusts would welcome a renewed national approach to define what good looks like in community services. CQC has criteria against which it inspects and rates the quality of care delivered by community services. As of 31 July 2017, the majority of community services were rated as providing good (66%) or outstanding (5%) care. The highest number of requires improvement ratings were under the safe key question and CQC had some concerns about workforce shortages and variation of caseload size (Care Quality Commission, October 2017).
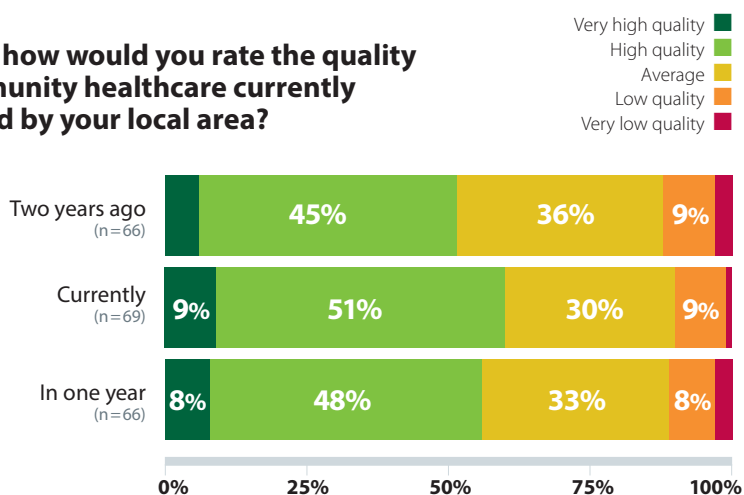
However, this only paints part of the national picture. This is due to a lack of national quality metrics to capture and benchmark meaningful data on the value of care delivered by community services. While there is a small number of national data sources such as the friends and family test, staff

survey and workforce statistics that give a rough idea of some aspects of quality in the community sector, information on the quality of care in community services is much more limited compared to other parts of the health care sector. A recent QualityWatch report pointed out that this lack of insight into quality is "concerning" when national policy aims to shift more care into the community (November 2017).

Previous attempts to come up with a common definition of good quality care in community services have made some progress, but lack national support and implementation. NHS Benchmarking provides a useful tool for trusts providing community services to benchmark their performance with peers in all aspects of service provision including activity, access, workforce, finance, quality and outcomes. Similarly, NHS Improvement has developed a set of community indicators that trusts can use to compare their performance to peers, regarding staff and patient experience, and how responsive and effective they are (NHS Improvement, May 2017).

In the meantime, trusts have developed their own quality metrics, indicators and reports covering themes such as staff engagement, patient experience, safety and clinical effectiveness. However, there is variation across the sector in how they define their services, what they measure and how they report them. This means it is challenging to build an accurate picture of quality from the ground up. In our survey we asked all respondents how they would rate the quality of community healthcare currently provided in their local area. While 51% of respondents thought the quality of care was "high" or "very high" two years ago, this compares with 60% who think that currently and 56% who think that will be the case in one year's time (figure 17). It seems that trusts feel there is plenty of high-quality care being delivered, but there is no national attempt to raise its profile.

Figure 17

Overall, how would you rate the quality of community healthcare currently provided by your local area?

Legend:
- Very high quality
- High quality
- Average
- Low quality
- Very low quality

	Very high	High	Average	Low
Two years ago (n=66)		45%	36%	9%
Currently (n=69)	9%	51%	30%	9%
In one year (n=66)	8%	48%	33%	8%

0% 25% 50% 75% 100%

71%

**of community services
are rated by CQC
as providing good
or outstanding
care**

The underlying challenge in all these attempts to create quality metrics is the difficulties relating to trying to collect outcomes data in community-based care: "Much of what community services provide involves long-term care that helps to prevent more serious problems... As such, it does not always lend itself to clear short-term clinical outcomes in the same way a defined episode of treatment for an illness might" (The King's Fund, December 2014). As care in the community is not about curing people but about providing long-term care and enhancing quality of life, patient experience measures are generally seen to be very important in measuring the quality of community services. Similarly, it is harder to define what a safe caseload looks like than a number of beds on a ward. The National Quality Board pointed out that a safe caseload depends on the size of the geographic area, population spread and population needs (January 2018).

However, it is important that the national bodies persevere with this work and develop a more accurate picture of what high-quality care looks like in the community sector. Having national-level quality metrics and indicators would raise the profile of community services and provide a sufficient evidence base for providers to improve and standardise services. The trusts we interviewed believed that while national quality indicators would not fully demonstrate the value of community services, they would be a step in the right direction. Trusts could use them as a performance improvement tool and evidence of the quality of services to commissioners, as well as to show the affect of funding squeezes on patient care. Trusts would also welcome a framework to measure, assess and benchmark the quality of care. However, these measures would be best across pathways and systems, rather than specifically for the community sector.

In addition, there are no national performance targets on which to assess and benchmark community service providers. This means that community services are not in the spotlight and it is harder to build an evidence base of operational performance and productivity. Many community service providers want to demonstrate productivity gains and eliminate unwarranted variation at scale through the standardisation of services, but are limited by delayed access to national operational efficiency programmes such as *Getting it right first time* (GIRFT).

The national focus on delayed transfers of care (DTOCs) last winter highlighted the role of the acute hospital sector, but capacity and patient flow significantly affect all parts of the NHS provider sector, and trusts that provide community services have a key role to play. They have been working hard throughout winter and beyond to tackle DTOCs in their own organisations and across local systems, although the nature of these whole system pressures have proved difficult to overcome. For example,

some trusts have worked hard to improve how hospital and community teams communicate and organise discharges. This can include building hospital clinicians' confidence in community services by creating joint pathways and protocols between hospitals and community-based settings.

Up to half the beds in some hospitals are now occupied by older people who are medically fit but face delays in getting into residential care or back home. The main reason for the increase in delays was patients waiting for continued non-acute NHS care, rather than social care. Trusts that we interviewed highlighted the importance of seeing care homes as part of the system's overall capacity as it is hard for community service providers to reduce DTOCs if there is a dearth of domiciliary or social care providers. Community teams such as rapid response services have also been working hard to manage clinically avoidable admissions, although it has proven difficult for trusts to measure them and their impact.

CASE STUDY

Harrogate and District NHS Foundation Trust

Community based teams working to support discharge from hospital are able to make a clear judgement about which patients are fit to leave and the support they will need back in their place of residence. The work carried out by the supported discharge service at Harrogate and District NHS Foundation Trust shows how, with the right support, patients often make a quicker recovery than if they remained in hospital. During the team's first 32 weeks of operation, the service discharged home 394 patients, resulting in an estimated 975 patient bed days saved.

Once again, the trusts we interviewed agreed it would broadly be better for the community sector overall if there were national performance targets. While the national focus may bring improvements and increased recognition to the community sector, such targets can risk bringing about unintended consequences such as distorting clinical priorities. Due to the range of services and care provided by trusts providing community health service, any national metrics will need to be carefully considered to ensure they are specific and sensitive enough to be used across the sector, while also having value for local organisations.

One possible approach to creating national metrics would be to stratify the population according to risk, calculate the amount of resource needed to support a certain number of the population with similar

health and care needs according to best practice, and then turn this into standard metrics. Trusts that we interviewed said that these kinds of conversations were harder to have since public health functions moved across to local authorities.

In summary, the lack of national performance targets and quality measures acts as a barrier to raising the profile of community services. Underpinning this barrier is the well-known fact that there is very limited national data on activity, quality and investment. These limitations make it hard to quantify changes in demand, activity, staff, funding and quality. It is also difficult to demonstrate the value and outcomes of care provided in the community at scale.

There have been attempts at a local and national level to address this longstanding dearth of national data. The community sector has previously worked on developing a common, evidence based clinical effectiveness framework which is bespoke to community services as the primary means of determining effectiveness and efficiency.[4] This work was supported by the national bodies, but funded by individual trusts. While individual trusts are using this framework, it is not being used at a national level and local datasets remain difficult to reliably compare with one another. NHS Benchmarking has also gone some way to address this problem, and local data collections are also used by providers and commissioners.

NHS Digital is currently developing a new national community services data set (CSDS) to address the lack of national datasets and provide a sense of patient outcomes and quality indicators. The CSDS is an activity based data set that extends the existing children and young people's data set to include adults. It aims to provide national standards for data on patients using community services (demographics, diagnoses, care contacts, activities), help trusts benchmark performance at a national level, help CCGs assess the value and performance of services, and track variation and the flow of resources. The CSDS is still in development and tackling data quality issues, so it will take time to be useful. It needs to develop at pace and have a much broader coverage of services than its initial iteration.

All of the national bodies need to prioritise a national data collection like the CSDS to support the development of quality metrics and performance indicators. In this data-driven age, trusts are frustrated that issues with data collection and validation have meant community services have been delayed access to operational efficiency programmes

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4   Further information on this framework can be found here:
     http://communityfirstnhs.uk/projects

such as Carter and GIRFT. There is currently no systematic way for community service providers to evaluate, evidence and benchmark their performance at a national level; they need national support to develop a consistent, meaningful evidence base so that they can prove their value of being front and centre of the future NHS.

60%

of respondents think the quality of care in the community is currently high or very high

The lack of standardisation across local performance and quality measures, and the limited national data collection, means that community services have historically been out of the limelight. In order to strengthen and expand community services, we need to have a national data collection that has the confidence of providers and commissioners behind it to ensure inroads are made into the task of securing effective commissioning, as well as the support of a framework and national policy ambition.

This data collection then needs to be used in a sustained effort to develop national quality metrics and performance indicators with the provider sector. Given that expanding community services and prevention are national priorities, there needs to be investment in developing a better understanding of the quality of care provided in the community and recognition of the value – on an individual, societal and financial level – of preventative measures.

COMMUNITY INTEREST COMPANIES

CICs are a form of social enterprise and not-for-profit organisation; they exist for the good of their community and reinvest any surpluses into their services. Many CICs were spun out of primary care trusts (PCTs) in 2008 as the *Transforming community services* programme compelled PCTs to divest themselves of community services. CICs therefore play an important role within many local health and care systems as they provide all types of community services, ranging from district nursing to prison healthcare, primary care and care homes.

While some CICs provide health and care services in community settings only, others run community hospitals too, focusing on rehabilitation and reablement. CICs can hold both NHS and local authority commissioned contracts, and operate within a diverse delivery model. We held structured conversations with CIC leaders to identify their perspectives on the general and specific challenges facing community services.

Table 2

Profiles of a small, medium and large CIC

Size	Small and specialist	Medium	Large
Name	Accelerate CIC	North Somerset Community Partnership (CIC)	City Health Care Partnership (CIC)
Annual turnover	£2.2m	£28m	£115.7m
Geographic footprint	The treatment centre receives referrals from 30 CCGs from across London, the East, South East and beyond	North Somerset (small amount of in-reach to Bristol and South Gloucestershire)	Hull, the East Riding of Yorkshire, Knowsley, St Helens and Wigan
Service lines	● Tower Hamlets CCG community specialist wound and lymphoedema service plus dressing optimisation scheme ● City and Hackney community lymphoedema service plus dressing optimisation scheme and treatment centre for complex wound/ lymphoedema patients: MDT (nursing, therapy, podiatry and dermatology)	● health visiting ● school nursing ● district nursing ● specialist nursing services including lymphoedema, tissue viability, home oxygen ● specialist therapy services including podiatry, SALT, neuro rehabilitation ● rapid response ● geriatrician led frailty service ● care home support team ● end of life care ● continuing health care ● minor injuries ● learning disabilities ● community rehabilitation (discharge to assess) ● MSK interface ● MSK physiotherapy ● personal health budget management	100 separate contracts (92 covering health care services via NHS contracts and a further 16 public health contracts) This diverse portfolio of health and care services includes: ● integrated community and urgent care services ● 0-19 children and young people's services (such as health visitors and school nurses) ● dental health ● prison health ● sexual and public health services ● primary care services ● pharmacies
No of staff	31	750	2081

There is variation across the country around how CICs feel they are perceived in the health and care system. While some feel highly regarded and well understood, others said they face a double prejudice as the NHS at a local and national level does not appreciate community services, nor does it understand CICs as an organisational form. For example, CICs need to manage themselves in a commercial way, so attach great importance to their continued viability and balance sheet responsibilities. While CICs see this strong financial position and governance as a positive contribution to contracts and the wider local health economy, their budget discipline to innovate and meet increases in demand while remaining in the black, is often misunderstood or not recognised.

In fact, there are several benefits of a CIC delivering a community health service, given their non-NHS status. First, CICs are independent organisations that operate at scale, meaning they have more financial freedoms and can borrow money more easily. This financial flexibility can be used to help services or other parts of the local health and care system, but is often overlooked. Secondly, CICs are nationally regulated but locally managed, and exist for the benefit of their communities so are well-placed to understand their concerns and involve them in system-wide decision-making processes. This makes them ideally placed to engage hard to reach communities and tackle health inequalities, which in turn can reduce hospital use and bring about cost savings.

CICs feel that the differential between them and trusts is that they have retained NHS values and deliver NHS services, but do so working in a commercially sustainable model that drives innovation and high levels of employee engagement.

While the CICs we interviewed agree that strengthening and expanding community services is the way forward, they are similarly frustrated that national policy ambition and rhetoric have not been matched with funding and resources. CICs want to focus on changing care pathways, improving case management and maximising the opportunities of technology.

There is variation across England as to how engaged CICs are in STPs and ICSs. Some CICs feel like an equal strategic partner on STP decision-making boards as they are relied upon to alleviate patient flow across the system. As one CIC put it: "we are part of the machinery". However, some CICs can be wary of engaging with STPs as they are seen as driven by the NHS and the associated agenda of "big is best", which is not palatable for many CICs. Other CICs feel that although the wider health and care system sees them as part of the solution, in general there is a sense of not being "loved and valued" for what they offer in their footprint. One major issue for CICs in STPs is that they are excluded from any access to capital; only NHS organisations can access capital investment.

The CICs that we interviewed mentioned similar financial and funding issues to NHS trusts. CICs feel that their funding has been reduced under block contracts and they are struggling to meet demand pressures due to demographic changes. When CICs were spun out of PCTs, they were left with running costs and only a small amount of contingency money which has proved to be an unsustainable level of funding.

CICs are having to deal with increased demand in different ways under their block contracts, including restricting access and making efficiencies. Short-term contracts mean that it is hard for CICs to unlock the long-term investment needed to ensure they have the right infrastructure in place to meet rising demand. Despite their ability to access capital and social finance, it is hard to convince an investor with a business case of anything less than five years. CICs therefore need contracts with a longer-term horizon to attain capital and transform on a bigger scale.

CICs also agree that the current payment systems disincentivise prevention and care in the community because payment by results awards admittance. They also support the development of well-designed, co-produced community tariffs. While CICs have worked hard to demonstrate their efficiencies, they find it hard to translate productivity into cashable savings, and there are usually only marginal gains.

In our interviews, the CIC leaders highlighted similar workforce challenges to NHS trusts. For example, CICs also struggle with recruitment and retention. They are losing nurses to general practices in particular, as primary care can offer a less pressurised working environment. While CICs are proud of their staff engagement and satisfaction scores, they flagged that these scores have started to decrease and sickness absence rates are starting to rise. These measures show that staff are feeling the pressure of increased demand on services, which potentially risks the quality of care. While technologies such as mobile working have relieved some of the demand pressure on the workforce, they can only have a limited impact and there needs to be greater investment in training to help staff make the best use of IT and technology.

CIC leaders also highlighted that the traditional routes into community nursing are not providing the supply of staff that is needed to meet demand for services. CICs would like to see a cohesive central function driving workforce strategy across the NHS, social care and public health; this could include a national target for health visitors and district nurses, or development bids specifically for community services. One CIC leader stated: "District nurses are the glue that holds the whole health and care system together".

CICs report similar challenges around procurement rules, competition and frequent retendering for contracts as NHS trusts, including the associated transactional costs and resource intensive nature of re-tendering, as well as the more general cultural impact on the organisation of competing for business. In some areas this has created strong relationships between commissioners and CICs. For example, in an area with more than one CIC, commissioners have made a strategic decision to recommission all community services in a single contract and therefore push the CICs to bid collaboratively through partnership arrangements. However, in other areas, commissioners are retendering for services frequently and requiring more provision for the same or less money.

CICs want to maintain the quality of services but also have to deal with a substantially reduced contract value. Many CICs are now agreeing to limitations to specifications, reductions in services and decommissioning of services. However, it is hard to manage staff redundancies as there are no redeployment opportunities, as there are for an NHS organisation.

CICs are also affected by the lack of national performance targets and quality metrics for community services. Commissioners find it hard to compare different data sets on CICs and NHS organisations when deciding who to award a contract to. While CICs report on many key performance indicators through contracting arrangements, they feel they are over-measured for the services they deliver and warned that these measures are of more use internally than they are externally as each community service offer is different.

While high-level demand and activity data could be of use nationally, CICs warn it risks losing meaning further down in the organisation. For example, activity measures of district nursing visits are not useful as they could last five minutes for an insulin shot or three hours for a more comprehensive assessment. It would be better to focus on outcomes, such as the amount of time that services are keeping people well and out of hospital, or reducing readmission. Overall, CICs are extremely proud of the quality reports they produce and take their accountability to their community very seriously.

It is clear that while CICs face similar challenges to NHS community service providers, there are further nuances to these challenges that need addressing at both a national and local level to improve the integration of care for patients. CICs would like to see some clarity of national policy direction so that their businesses can understand the scope of health and care systems in the future. They would also like to see more alignment, and perhaps pooling, between local authority, NHS England and CCG commissioning. Finally, CICs would like to help the community sector as a whole to build the case for change and use savings for advancing the prevention agenda.

SOLUTIONS FOR SUCCESS

The pressures outlined in this report act as a barrier to scaling up the much-needed focus on care in the community, in addition to financial and operational pressures on the NHS as a whole. The result is that there has been mixed progress in building up care in the community at scale and therefore NHS service delivery is moving away from the direction of travel set out in the FYFV (it is now generally acknowledged that the NHS has not been able to deliver this strategy).

In fact, there is a real opportunity for community services to not only contribute to but take a leading role in the transformation and sustainability of future models of care given their ability to:

- act as system integrators as they offer a valuable interface with other parts of the health and care system, particularly with primary and social care, and work across organisational boundaries

- understand local populations, hard to reach groups and place-based working, meaning they are well placed to tackle health inequalities

- address population health as they work collaboratively with and within multiple other parts of the public sector, such as schools and care homes, so can help tackle the wider determinants of health (social, economic and environmental)

- promote public health through universal interventions and local relationships with other public sector organisations, given their spread across a geographic area, as well as encourage self-care and patient activation

- spread the learning from their work in vanguards testing new models of care, particularly from multispecialty community providers where community services have been working together with general practitioners, nurses, hospital specialists, mental health and social care services to deliver integrated care in the community

- identify, strengthen and bring together community assets to promote health and wellbeing (e.g. voluntary organisations, informal networks).

In order to achieve the robust community sector that the NHS needs, community service providers need the following solutions to be implemented at a national and local level:

- realism about demand increasing, recognising that this trend will continue as acute care capacity becomes more strained and the ambition to strengthen and expand community services is pursued

- adequate financial investment, which targets specific services that can demonstrate an impact on system pressures, and support to build up community services

- greater priority on community services within STPs and ICSs, including the role of community services in driving transformational change

- a greater priority placed on community services at a national level and key initiatives to turn these priorities into reality, such as completing the *Forward view* for community services to support STPs in their ambition to redesign services

- national support and investment in the development of an evidence-based clinical effectiveness framework, rather than using acute hospital measures of performance

- action to address staff shortages in community services, such as focusing on the supply of community nurses in the new workforce strategy or funding for continuing professional development for community nurses

- support for community services to develop their links with the wider health and care sector, such as housing, and drive the prevention agenda

- develop contracting and payment systems that incentivise care in the community.

- support to ensure that NHS community providers and social enterprises remain a continuing public service, in the face of competition with the private sector

- the headspace, time and investment to focus on prevention, improve patient outcomes and move care into the community at scale

- prioritisation of tackling health inequalities in the upcoming long-term plan for the NHS, as committed to by the secretary of state for health and social care.

This report shows the vital role that community services can play in preventing ill health and improving population health and wellbeing, which is more important now than ever due to the growing ageing population and prevalence of chronic disease. But it also reveals how the potential contribution of community services is being held back due to a lack of funding, staff and national or local prioritisation. It is vital that national leaders address these barriers and ensure community services are at the heart of the future health and care system.

References

Care Quality Commission. (March 2018). *CQC care directory*. [online]
Available at: http://www.cqc.org.uk/about-us/transparency/using-cqc-data
[Accessed 14 May 2018]

Care Quality Commission. (October 2017). *The state of health and adult social care in England 2016/17*. [pdf] Available at:
http://www.cqc.org.uk/sites/default/files/20171123_stateofcare1617_report.pdf
[Accessed 13 April 2018]

Darzi, A. (April 2018). *Review of Health and Care: Interim report*. [pdf]
Available at: https://www.ippr.org/publications/darzi-review-interim-report [Accessed 2 May 2018]

Department of Health. (October 2012). *Health visitor implementation plan quarterly progress report*. [pdf] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216944/Health-Visiting-2nd-Quarterly-Report-September-2012.pdf
[Accessed 26 April 2018]

Department of Health. (May 2012). *Long-term conditions compendium of information: 3rd edition*. [online] Available at: https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition [Accessed 9 April 2018]

Department of Health. (Jan 2009). T*ransforming community services: enabling new patterns of provision*. [pdf] Available at:
http://webarchive.nationalarchives.gov.uk/20130105000040/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093196.pdf [Accessed 10 April 2018]

Department of Health. (July 2008). *NHS next stage review: our vision for primary and community care*. [online] Available at: http://www.nhshistory.net/dhvisionphc.pdf [Accessed 9 April 2018]

Department of Health. (January 2006). O*ur health, our care, our say: a new direction for community services*. [online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf [Accessed 28 February 2018]

Francis, R. (February 2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. [pdf]
Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf [Accessed 18 May 2018]

Health Education England. (December 2017). *Facing the Facts, Shaping the Future: A draft health and care workforce strategy for England to 2027*. [online]
Available at: https://hee.nhs.uk/our-work/workforce-strategy [Accessed 10 April 2018]

Health Service Journal. (March 2018). *Kirkup warnings over scrapped community services 'forward view'*. [online] Available at: https://www.hsj.co.uk/commissioning/kirkup-warnings-over-scrapped-community-services-forward-view/7021897.article [Accessed 11 April 2018]

Health Service Journal. (February 2018). *NHS England abandoned 'forward view' for community services*. Available at: https://www.hsj.co.uk/community-services/exclusive-nhs-england-abandoned-forward-view-for-community-services/7021614.article [Accessed 16 May 2018]

House of Commons Health Committee. (January 2018). *The Nursing Workforce*. [online]
Available at: https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/353/35302.htm
[Accessed 4 April 2018]

House of Lords Select Committee. (April 2017). *The Long-term Sustainability of the NHS and adult social care*. [online]
Available at: https://publications.parliament.uk/pa/ld201617/ldselect/ldnhssus/151/151.pdf
[Accessed 28 February 2018]

Kirkup, B. (January 2018). *Report of the Liverpool Community Health Independent Review*. [online]
Available at: https://improvement.nhs.uk/news-alerts/independent-review-liverpool-community-health-nhs-trust-published/ [Accessed 20 April 2018]

Marie Curie. (March 2018). *Emergency admissions data briefing*. [pdf]
Available at: https://www.mariecurie.org.uk/globalassets/media/documents/policy/policy-publications/2018/emergency-admissions-briefing-paper-2018.pdf [Accessed 3 May 2018]

Monitor. (January 2015). *Commissioning better community services for NHS patients*. [pdf]
Available at: https://www.gov.uk/government/publications/improving-community-services
[Accessed 3 May 2018]

National Audit Office. (January 2018). *Sustainability and transformation in the NHS*. [online] Available at: https://www.nao.org.uk/wp-content/uploads/2018/01/Sustainability-and-transformation-in-the-NHS.pdf [Accessed 10 April 2018]

National Quality Board. (January 2018). *Safe, sustainable and productive staffing: an improvement resource for the district nursing service*. [pdf] Available at: https://improvement.nhs.uk/documents/816/Safe_staffing_District_Nursing_final.pdf [Accessed 9 April 2018]

NHS Benchmarking Network. (November 2017). *National audit of intermediary care*. [online Available at: https://s3.eu-west-2.amazonaws.com/nhsbn-static/NAIC%20(Providers)/2017/NAIC%20England%20Summary%20Report%20-%20upload%202.pdf [Accessed 3 April 2018]

NHS Digital. *NHS Hospital & Community Health Service monthly workforce statistics*. [online]. Available at: https://digital.nhs.uk/binaries/content/documents/corporate-website/publication-system/statistical/nhs-workforce-statistics/nhs-workforce-statistics---january-2018/content/content/publicationsystem%3AAttachments-v3%5B5%5D/publicationsystem%3AattachmentResource [Accessed 26 April 2018]

NHS England. (March 2018). Board paper: "Scene setter" on current trends in health inequalities. [pdf] Available at: https://www.england.nhs.uk/wp-content/uploads/2018/03/09-pb-29-03-2018-scene-setter-on-current-trends-health-inequalities.pdf [Accessed 4 May 2018]

NHS England. (February 2018). *Refreshing NHS Plans for 2018/19*. [pdf] Available at: https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf [Accessed 5 April 2018]

NHS England. (March 2017). *Next steps on the five year forward view*. [pdf] Available at: https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf [Accessed 5 April 2018]

NHS England. (October 2014). *Five year forward view*. [pdf] Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf [Accessed 5 April 2018]

NHS Improvement. (May 2017). *Community indicators project*. [online] Available at: https://improvement.nhs.uk/resources/community-indicators-project/ [Accessed 5 March 2018]

NHS Providers. (March 2018). *Tough task: the NHS delivering for patients and staff in 2018/19*. [pdf] Available at: https://nhsproviders.org/media/4606/tough-task-the-nhs-delivering-pdf.pdf [Accessed 1 May 2018]

NHS Providers (August 2017). *The rise of delayed transfers of care*. [online] Available at: https://nhsproviders.org/the-rise-of-delayed-transfers-of-care [Accessed 14 May 2018]

NHS Providers. (June 2017). *Winter warning*. [online] Available at: https://nhsproviders.org/nhs-winter-warning [Accessed 13 April 2018]

NHS Providers. (November 2016). *State of the provider sector*. [pdf] Available at: https://nhsproviders.org/media/3281/state-of-the-nhs-provider-sector_07-17.pdf [Accessed 13 April 2018]

Nuffield Trust. (April 2018a). *Managing the hospital and social care interface: interventions for older adults*. [online] Available at: https://www.nuffieldtrust.org.uk/research/managing-the-hospital-and-social-care-interface?utm_medium=email&utm_campaign=Weekly%20newsletter%2029032018&utm_content=Weekly%20newsletter%2029032018+CID_19a99dde1acd6dffe948fce1898ec606&utm_source=Email%20marketing%20software&utm_term=report#recommendations-for-local-hospital-leaders [Accessed 11 April 2018]

Nuffield Trust. (April 2018b). *Transforming health care in nursing homes*. [pdf] Available at: https://www.nuffieldtrust.org.uk/files/2018-04/transforming-care-report-final-web.pdf?utm_source=The%20King%27s%20Fund%20newsletters&utm_medium=email&utm_campaign=9354133_NEWSL_HMP%202018-04-10&dm_i=21A8,5KHP1,P2UXR0,LMH3T,1 [Accessed 20 April 2018]

Nuffield Trust. (March 2017). *Shifting the balance of care: great expectations*. [online] Available at: https://www.nuffieldtrust.org.uk/files/2017-02/shifting-the-balance-of-care-report-web-final.pdf [Accessed 1 March 2018]

Public Health England. (February 2015). *A guide to community-centred approaches for health and wellbeing*. [pdf] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/417515/A_guide_to_community-centred_approaches_for_health_and_wellbeing__full_report_.pdf [Accessed 5 April 2018]

QualityWatch. (November 2017). *Community services: what do we know about quality?* [online] Available at: https://www.health.org.uk/publication/community-services-what-do-we-know-about-quality [Accessed 5 April 2018]

The Health Foundation and NHS Providers. (October 2017). *Towards an effective NHS payment system: eight principles.* [online] Available at: https://www.health.org.uk/sites/health/files/EffectivePaymentSystemEightPrinciples.pdf [Accessed 10 April 2018]

The Health Foundation. (April 2017). *Provision of community care: who, what, how much?* [online] Available at: https://www.health.org.uk/publication/provision-community-care-who-what-how-much [Accessed 9 April 2018]

The Institute for Fiscal Studies. (March 2018). *Adult social care funding: a local or national responsibility?* [pdf] Available at: https://www.ifs.org.uk/uploads/BN227.pdf [Accessed 20 April 2018]

The King's Fund. (April 2018). *Developing new models of care in the PACS vanguards: A new national approach to large-scale change?* [pdf] Available at: https://www.kingsfund.org.uk/sites/default/files/2018-04/PACs-new-models-Kings-Fund-April-2018.pdf [Accessed on 3 May 2018]

The King's Fund. (January 2018). *Reimagining community services.* [pdf] Available at: https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining_community_services_report.pdf [Accessed 2 February 2018]

The King's Fund. (December 2017). *Enhanced health in care homes.* [online] Available at: https://www.kingsfund.org.uk/projects/nhs-five-year-forward-view/enhanced-health-in-care-homes [Accessed 5 March 2018]

The King's Fund. (March 2017). *Understanding NHS financial pressures: how are they affecting patient care?* [online] Available at: https://www.kingsfund.org.uk/publications/understanding-nhs-financial-pressures [Accessed 2 March 2018]

The King's Fund. (February 2017). *Delivering Sustainability and Transformation Plans: From ambitious proposals to credible plans.* [online] Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/STPs_proposals_to_plans_Kings_Fund_Feb_2017_0.pdf [Accessed 2 March 2018]

The King's Fund. (September 2016a). *Understanding quality in district nursing services.* [online] Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/quality_district_nursing_aug_2016.pdf [Accessed 1 March 2018]

The King's Fund. (September 2016b). *Social care for older people: home truths.* [pdf] Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Social_care_older_people_Kings_Fund_Sep_2016.pdf [Accessed 5 March 2018]

The King's Fund. (May 2016). *Understanding pressures in general practice.* [online] Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf [Accessed 5 March 2018]

The King's Fund. (December 2014). *Managing quality in community services.* [online] Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/managing-quality-in-community-health-care-services.pdf [Accessed 1 March 2018]

The King's Fund. (October 2014). S*pecialists in out of hospital settings – findings from six case studies.* [online] Available at: https://www.kingsfund.org.uk/publications/specialists-out-hospital-settings [Accessed 28 February 2018]

The King's Fund. (February 2014a). *Service transformation: lessons from mental health.* [pdf] Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/service-transformation-lessons-mental-health-4-feb-2014.pdf [Accessed 20 April 2018]

The King's Fund. (February 2014b). *Community services: how can they transform care?* [pdf] Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/community-services-nigel-edwards-feb14.pdf [Accessed 9 April 2018]

The King's Fund. (April 2009). *Shaping PCT provider services.* [online] Available at: https://www.kingsfund.org.uk/sites/default/files/Shaping-PCT-Provider-Services-the-future-of-community-health-Candace-Imison-The-Kings-Fund-April-2009_0.pdf [Accessed 2 March 2018]

Wanless, D. (December 2003). *Securing good health for the whole population: population health trends.* [pdf] Available at: http://www.nhshistory.net/wanless_health_trends203.pdf [Accessed 18 April 2018]
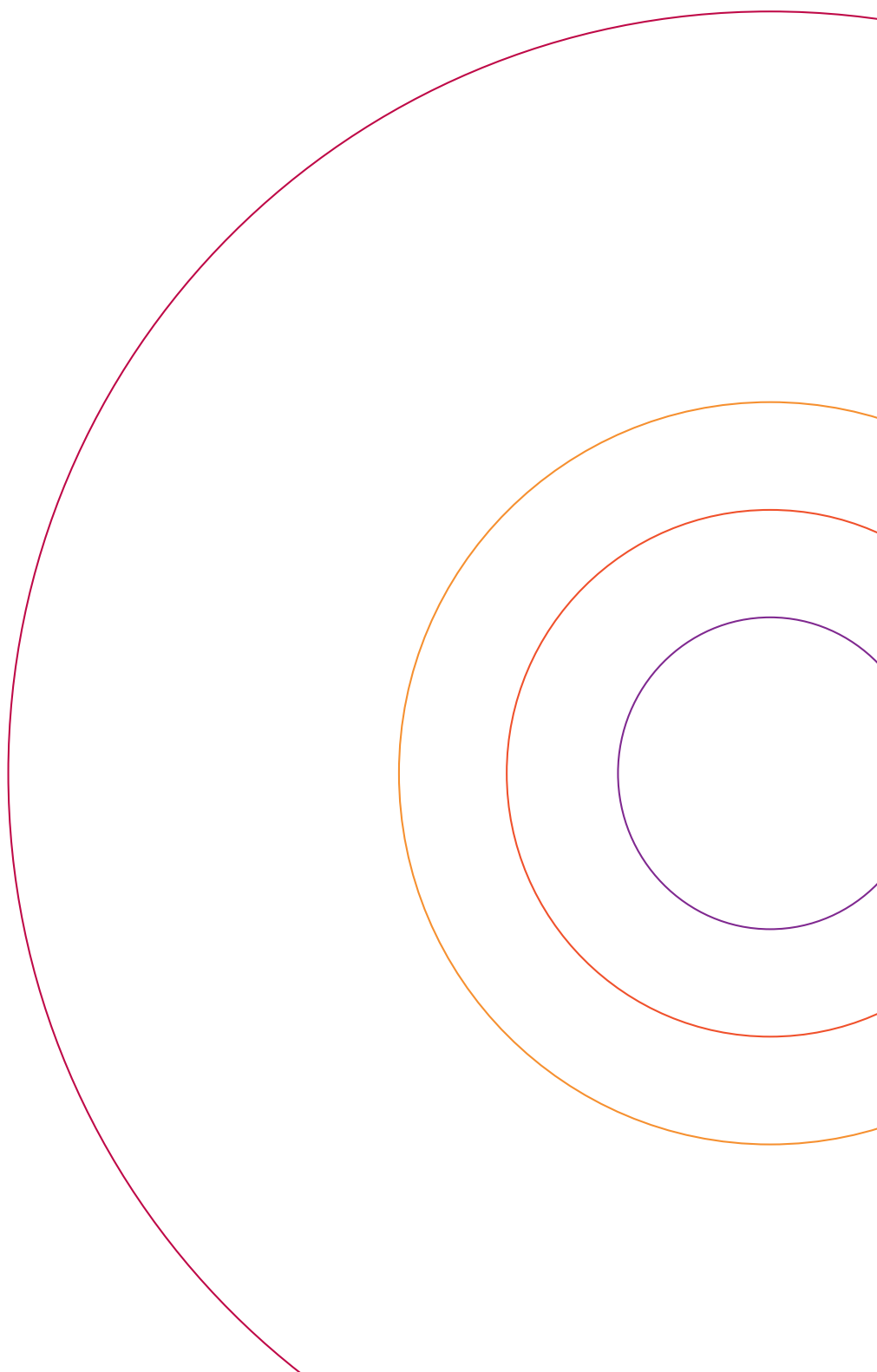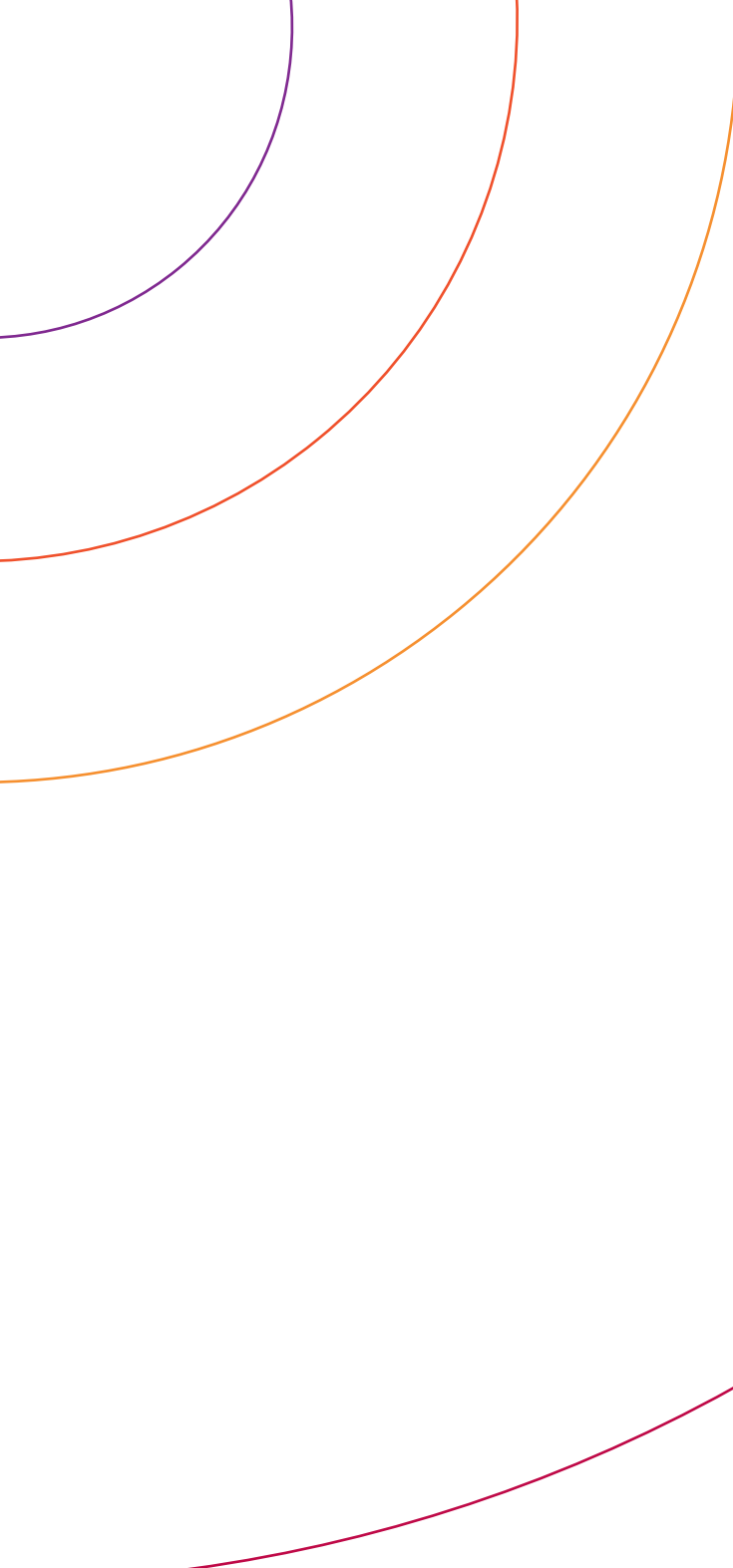
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