

# Comprehensive Spending Review 2021: Submission from the Community Network

In September 2021, the government announced an additional £5.4bn for the NHS in the second half of this financial year, including £478m for discharge to assess. Alongside this, the government announced an additional £15.8bn revenue funding for the NHS in England, and £5.4bn for social care over the next three years. While this additional investment is welcome, NHS Providers and NHS Confederation have jointly raised concerns about whether it will be sufficient to meet the continuing costs of COVID-19 and recover care backlogs in all services. We estimate a shortfall of over £3bn in 2022/23<sup>1</sup>. There is still a lack of clarity about how much of the additional funding will flow to community health services.

While the NHS revenue settlement has already been announced, the comprehensive spending review (CSR) on 27 October will be pivotal in confirming a multi-year capital settlement for the NHS, the public health grant, local authority budgets and Health Education England's (HEE's) budget.

This submission therefore reiterates a series of existing funding priorities for community providers which seem unlikely to have been fully met by the recent revenue settlement, as well as setting out what the community sector needs from the CSR process:

1. Permanent central funding from government to support the discharge to assess model.
2. Adequate resources to clear community backlogs and meet increased demand.
3. Sufficient funding for long-term COVID-19 related costs.
4. A mechanism to ensure that the NHS Long Term Plan (LTP) investment in community health services reaches providers.
5. An increase in the overall HEE budget and investment in the community workforce.
6. Urgent investment in public health, reversing years of under-investment.
7. Funded reform to place the social care system on a sustainable footing.
8. Increased capital investment in community health services, including improved access to capital and revenue funding for digital transformation in the community.

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<sup>1</sup> <https://nhsproviders.org/resource-library/briefings/a-reckoning-the-continuing-cost-of-covid-19>

## Context

The NHS LTP sets a helpful direction of travel towards more preventative and community-based provision of health and care services, which aims to deliver improved outcomes for patients, and a more efficient system which is not unduly reliant on acute, hospital-based services. Sir Mike Richard's recent report on community diagnostics similarly supports the case for investment in community-based provision. The pandemic accelerated the direction of travel towards a 'home first' model, enhancing digital services and person-centred community services either from, or within, the home, or in community-based settings.

In fact, it is clear that community providers played a pivotal role during the pandemic in preventing the system as a whole from becoming overwhelmed. Central to the response was the decision to discharge medically fit patients out of hospital in a timely way to maintain patient flow and support improved outcomes and experience out of a hospital setting. Community providers were also pivotal in helping to lead and deliver the COVID-19 vaccination programme in partnership with primary care colleagues and others. However, despite its achievements during the pandemic, the health service remains under significant pressure, with record high levels of demand, restricted capacity and an exhausted workforce. Demand for community health services has increased by 15%<sup>2</sup> compared to pre pandemic levels, and care backlogs are significant in key services, including for children and young people.

It is worth emphasising that the community sector entered the pandemic with a significant mismatch between the demand for community health services and available funding. Income for community health services increased by only 4% compared to an average of 7% across all sectors, and 8% for mental health services, between 2018/19 and 2019/20.<sup>3</sup> Community providers have also had less access to capital investment than other sectors. In addition, many community providers deliver public health services commissioned by councils which have been repeatedly negatively impacted by the squeeze on local authority budgets and the public health grant. Community providers need sufficient, transparent revenue and capital funding – and prioritisation in national and system level allocation decisions – to provide accessible, high-quality care to all who need it.

## Funding priorities for the community sector

Community health services need support and resources dedicated to tackling care backlogs, and to managing new and increasing demand for services. Thus far,

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<sup>2</sup> NHSE/I data, January 2020

<sup>3</sup> Department for Health and Social Care, Consolidated provider accounts, Comparison of income from patient care activities between 2018/19 and [2019/20](#)

government funding announcements have focused on recovery in the acute sector. This section sets out four priority areas that should receive dedicated central funding.

- 1. Provide permanent central funding from government for the discharge to assess model to support recovery and the future sustainability of services**

Since the start of the pandemic, discharge to assess has brought significant benefits to patients, the public purse, and the health and care system. We welcomed the £478m funding for discharge to assess for the second half of this year but we are concerned there is no mention of dedicated funding for the model within the three-year revenue settlement. There is a consensus across stakeholders in the health and care sector that ceasing central funding for the discharge to assess model would risk reversing the very clear improvements seen during the COVID-19 pandemic and a long-term policy direction towards a 'home first' model which is better for patients, and more sustainable for the health and care system.

More details can be found in this NHS Providers and NHS Confederation [briefing paper](#), but a summary of the improvements delivered by the discharge to assess model include:

- I. Reduced length of stay in hospital, with a 28% reduction in patients staying over 21 days in hospital between winter 2019/20 and winter 2020/21, alongside a 23% reduction in patients staying over 14 days and a 17% reduction in patients staying over seven days.<sup>4</sup>
- II. Improved outcomes for patients, by reducing the number of prolonged hospital stays (where not medically necessary), which can be detrimental to patients, increase pressures on unpaid carers and the social care system, and create significant additional cost to public finances.
- III. Reduced avoidable admissions to acute settings, which are distressing for patients and unpaid carers, and costly for the health and care system (an estimated [annual cost of £1.6bn](#)).
- IV. Increased the number of timely discharges and patient flow, freeing up 30,000 acute beds in Spring 2020<sup>5</sup>, and in places, bringing acute hospital capacity down from ~90% to 50-60%.
- V. Support for wider NHS ambitions around collaboration, system working and delivering more care in the community. For instance, discharge to assess has support the social care sector, because, with better use of short-term recovery services, there has been reduced need for care and support packages.

Beyond the pandemic, discharge to assess models have a critical role to play in recovery, and in supporting a more sustainable and efficient health and care system, reflected in its

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<sup>4</sup> <https://www.england.nhs.uk/statistics/statistical-work-areas/uec-sitrep/urgent-and-emergency-care-daily-situation-reports-2020-21/>

<sup>5</sup> <https://www.nao.org.uk/wp-content/uploads/2020/06/Readying-the-NHS-and-adult-social-care-in-England-for-COVID-19-Summary.pdf>

inclusion in primary legislation as part of the Health and Care Bill. Central funding has been essential to delivering these benefits, and we are concerned that some systems will be unable to fund discharge to assess properly on an ongoing basis within existing, stretched NHS and local authority budgets, which could lead to increases in length of stay and delayed discharges. The lack of investment in community provision will ultimately exacerbate pressures on the urgent and emergency care pathway and limit acute capacity to drive forward the elective recovery programme.

## **2. Ensure that the resourcing requirements of community health services are factored into any plan to clear care backlogs and meet increased demand**

While much of the national policy focus centres on addressing backlogs of care in the acute sector, community providers are also facing increased demand for services (up 15% since last year<sup>6</sup>), growing waiting lists and greater complexity in care needs. In a recent NHS Providers survey, 96% of trusts providing community health services reported that the current level of demand was significantly or moderately increasing across all services, and 91% stated that the complexity and acuity of patient need had significantly or moderately increased across all services compared to before the pandemic.<sup>7</sup> This is compounded by the fact that, even before COVID-19, there was a mismatch between the demand for community health services and the funding available to deliver them.

NHSE/I data from June 2021 shows that nearly half (47%) of restored community health services are still reporting a backlog.<sup>8</sup> Within this, there are some significant pinch points in the backlog of care in community health services, particularly in children and young people's (CYP) services. The community services with the greatest instances of backlogs are CYP vision screening, CYP screening and immunisations services, and CYP therapy interventions, where 80% and over of submitting organisations report a backlog.<sup>9</sup> There are concerns about the longer-term impacts that these delays will have on children's development, and their wider life chances. As children develop quickly, long waiting times for some services can negate the value of that service by the time it is delivered. Furthermore, community providers report a rise in referrals relating to safeguarding and abuse, after a fall of around 30% during the pandemic. Taken together, these factors are contributing to greater unmet needs and complexity in care needs among children.

Despite these pressures, income for community health services increased by only 4% compared to an average of 7% across all sectors, and 8% for mental health services

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<sup>6</sup> NHSE/I data, January 2020

<sup>7</sup> NHS Providers backlog of care survey, September 2021

<sup>8</sup> NHSE/I data, June 2021

<sup>9</sup> NHSE/I data, June 2021

between 2018/19 and 2019/20.<sup>10</sup> Alongside slower than average income increases in community health services, community providers are also unable to access the Elective Recovery Fund (ERF), which, in the first half of the year, allocated an extra £1bn of non-recurrent funding to trusts to recover elective care backlogs. One community trust tells us that although Child Development Centres are at 116% of pre-COVID activity, they have no additional funds to meet this demand as the ERF does not apply, meaning that important additional funding is not accessible to community providers. These funding constraints can limit the capacity of community providers to manage the backlog and new demands on services.

There must be a whole system approach to recovering the backlog, with sufficient funding for community providers to address their own waiting lists. To effectively and sustainably clear care backlogs across the NHS, the community sector must be considered in national plans and given access to any extra dedicated funding provided on top of the long-term settlement and the money that has already been set aside for extra COVID costs.

### **3. Ensure there is sufficient funding for long-term COVID-19 related costs in the community sector, on top of existing funding**

Community health services have played a central role in delivering key parts of the health system's response to COVID-19. Community providers are at the forefront of delivering care for people suffering with Long COVID, and many are leading aspects of the COVID-19 vaccination programme. While the future of managing COVID-related demands is uncertain, it is clear that these new pressures will be with us for the foreseeable future, and dedicated resource must be allocated with this in mind.

The COVID-19 vaccination programme has been hugely successful, with [3 in 4 UK adults now fully vaccinated](#). However, this is just the beginning; services are now being asked to plan for a [booster campaign during Autumn and Winter 2021/22](#), and it is possible that an annual vaccination programme may be required. To deliver the first phase of the COVID vaccination programme at pace, many community providers redeployed a significant portion of their workforce to deliver vaccinations, with some community providers reporting redeploying up to a third of their workforce to support this. While an impressive feat, this at scale redeployment of staff is not sustainable, especially as community providers seek to clear the backlog and recover services. Policy must move away from crisis response into a fully planned and resourced vaccination programme.

Furthermore, the latest data from the ONS shows that approximately 962,000 people in the UK (1.5% of the population) are living with Long COVID. Primary care and community

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<sup>10</sup> Department for Health and Social Care, Consolidated provider accounts, Comparison of income from patient care activities between 2018/19 and [2019/20](#)

services are delivering a significant portion of Long COVID care, and are working hard to address these new care needs, for instance by expanding multi-disciplinary teams.

Community providers are also concerned about the impact that Long COVID demand has on capacity to address care backlogs and waiting times for other services. In June 2021, government announced £100m of funding for the expansion of Long COVID care (with £70m for long COVID clinics and £30m for primary care). While this is welcome additional funding for diagnostics and initial assessments, there must be sufficient funding to support long term delivery of Long COVID services by community teams. Community providers note that there are challenges with developing the workforce required to deliver these high-profile services within a fixed term funding structure. Managing a temporary workforce to deliver this type of care creates risks for this service itself, and for other services where staff have been seconded to support the vaccination programme. We are therefore calling for a long-term funding plan to support delivery of this programme.

#### **4. Create a mechanism to ensure that the LTP investment for community health services reaches providers**

In the LTP, NHSE/I committed to primary and community services funding being at least £4.5bn higher by 2023/24. This increase in funding was welcome given there were growing pressures on community health services, which have now been exacerbated by the pandemic. However, the combined nature of this funding commitment has made it difficult to track the flow of LTP funding into community health services specifically (rather than primary care), and community providers are concerned about this lack of transparency. These concerns are compounded by the fact that, unlike in other sectors, there are no mechanisms available to ensure this LTP funding reaches the sector (for instance there is the PCN DES contract for primary care and the mental health investment standard). In a 2019 survey of trust chairs and chief executives, only 13% of trusts that provide community health services said that funding had increased in their local areas despite LTP ambitions to shift more care and resources downstream into the community.

Considering these challenges, we are calling for a robust national policy mechanism, such as an investment standard for the community sector, to ensure that the funding allocated to community health services reaches providers for the benefit of patients and the wider health and care system. We are working closely with community providers and NHSE/I colleagues to help to secure minimum investment in community services, and ensure parity of esteem with other sectors.

At present, there are limitations to national data on community health services, and while there are huge efforts to improve data collection and quality being led by NHSE/I and supported by the Community Network, this is likely to take some time to develop. In the interim, steps must be taken to ensure that LTP funding reaches community providers. As

discussed above, there are significant workforce constraints within the community sector and any investment standard must come alongside investment in the community workforce to ensure to support service delivery.

We are concerned that the three-year NHS revenue settlement will not cover all the additional COVID-19 costs, the national priority of clearing elective backlogs and delivery of existing LTP commitments. The community sector had several important national priorities in the LTP, which set out a clear vision for delivering more care in the community. These commitments and ambitions for the community sector must remain fully funded, as they will deliver better outcomes for patients and ensure people are treated in the right place at the right time.

## Pivotal funding settlements in the CSR

The government should ensure the funding settlements for HEE, public health and NHS capital support greater resilience and sustainability in the community sector. The four priorities below set out what the community sector needs in these additional settlements.

### **5. Invest further in the existing community workforce and increase overall HEE budget with targeted allocations for community roles**

Prior to the pandemic, the community sector faced significant workforce related challenges. The number of community nurses fell by 12% between 2010-2020<sup>11</sup>, while the number of NHS health visitor posts fell by a third between 2015 and 2019<sup>12</sup>, despite rising demand for community health services. These workforce pressures have been exacerbated by the pandemic. Community providers now report significant issues relating to staff exhaustion, low morale and an increase in mental health absences across the NHS. The community workforce therefore requires additional investment, particularly as we know that access to training and development opportunities is a main driver of retention.

While the £260m funding boost for HEE at the 2020 CSR<sup>13</sup> provided some headroom for short-term investment in training and development across the NHS, it fell short of enabling longer term workforce planning and does not address the real terms cut to the HEE budget since it was established in 2013/14<sup>14</sup>. We are therefore calling for a sustainable increase in the overall HEE budget, with a view to ringfencing a significant proportion of targeted investment for the community workforce. Staff recruitment and retention is

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<sup>11</sup> <https://www.health.org.uk/news-and-comment/news/risk-to-pandemic-recovery-due-to-nursing-shortages>

<sup>12</sup> NHS Digital, NHS Workforce Statistics, September 2019

<sup>13</sup> <https://www.kingsfund.org.uk/blog/2020/11/what-does-autumn-2020-spending-review-mean-health-and-care>

<sup>14</sup> <https://nhsproviders.org/the-nhs-funding-settlement-recovering-lost-ground/other-recovery-required>



important across the health and care sector, but pre-existing workforce constraints, historic under-investment and rising demand for services mean that it will be crucial that there is targeted investment in the community sector.

- 6. Urgent investment in public health reversing years of under-investment; and**
- 7. Fund reform to place the social care system on a sustainable footing**

The COVID-19 pandemic has highlighted the interconnectedness of the NHS, public health and social care. Realising the full benefits of greater system working means we cannot view these services as separate entities. It is therefore imperative that investment in the NHS goes hand-in-hand with long-term investment in public health and social care.

Local authorities have faced significant funding cuts over recent years. The real-terms value of the public health grant has fallen 22% in real terms between 2015/16 and 2020/21<sup>15</sup>. This funding gap has reduced access to key public health services delivered by community providers, which is problematic given the pandemic has driven up demand for these services further and exacerbated existing health inequalities. Despite the fact that at the 2020 CSR the government committed to setting out “further action that it is taking to improve the population’s health in the coming months”, still no details have been provided. Going forward, the public health grant must be protected and increased to match the task at hand.

In addition, local authorities are not funded to accommodate nationally agreed pay uplifts for NHS staff on Agenda for Change (AfC) contracts. Ultimately, this means that community providers will need to absorb the costs of pay uplifts for staff on AfC contract from their own budgets, which are already stretched, potentially affecting the quality of services, and causing some providers to scale back services. This is a longstanding, unresolved issue in which national policy approaches remain uncoordinated creating cost pressures at the frontline. Uncertainty around central funding for AfC pay uplifts has re-emerged this year; there must be a long-term solution to this recurrent funding issue to ensure fairness for staff and sustainability of service delivery. The government’s [‘Build Back Better’](#) policy paper (7 September 2021) states that “the Government will ensure Local Authorities have access to sustainable funding for core budgets at the [CSR]”, and this commitment must be upheld.

Alongside this, the social care system has experienced similar levels of under-investment, with the funding gap estimated to range between £2.1bn and £12.2bn by 2023/24<sup>16</sup>. Historic underfunding of social care has left hundreds of thousands of people without the

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<sup>15</sup> <https://www.kingsfund.org.uk/projects/positions/public-health>

<sup>16</sup> <https://www.health.org.uk/news-and-comment/charts-and-infographics/REAL-social-care-funding-gap>



care they need<sup>17</sup> and also has a negative impact on the NHS – particularly for community health services as unmet or under-met social care need results in greater reliance on more costly community health services as preventative opportunities are not realised and admissions not avoided.

While the government's recent announcement of additional funding for the social care sector and introduction of some reforms, including a cap on lifetime care costs from October 2023, are welcome, we are concerned that they are insufficient to deliver the level or pace of reform required. The challenge is greater than finding the correct funding mechanism or introducing a cap. We also need to secure a stable provider market providing the right model of care, and a sustainable workforce, properly valued and respected for this vitally important work.

The government must use the CSR to provide clarity on its social care funding and reform plans, and ensure local systems are equipped to respond to the health challenges their communities face by properly resourcing public health services and infrastructure. Without this, avoidable pressures on the NHS will continue to grow and investment in the NHS will be devalued.

**8. Increased capital investment in community health services, including improved access to capital and revenue funding for digital transformation in the community.**

A properly funded, multi-year capital settlement is essential for the NHS to improve patient access and experience, deliver increased efficiency and productivity, and accelerate integrated care. Community providers are too often overlooked in national capital allocations, such as the health infrastructure plan (September 2019), the £1.5bn capital investment for the NHS in 2020/21 (June 2020), and the government's manifesto pledge to provide £3.7bn to build 40 new hospitals by 2030. This focus on acute capital needs, and an increasing recognition of mental health capital needs, must now be replicated for community health services so they can adapt to COVID-19 issues and achieve the transformational aspirations in the NHS LTP. The CSR represents a pivotal opportunity to rectify under-investment in community capital budgets and set aside capital funding specifically for community providers.

In a recent survey conducted by NHS Providers on capital spending<sup>18</sup>, standalone and combined community trusts raised concerns about the limitations of the Capital Departmental Expenditure Limit and the fact that, in some systems, ICS allocations are being directed to addressing elective care backlogs rather than system needs in the

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<sup>17</sup> <https://www.health.org.uk/publications/long-reads/whole-of-society-will-benefit-from-social-care-reform>

<sup>18</sup> <https://nhsproviders.org/media/692149/rebuilding-our-nhs.pdf>

round. Community providers noted that access to capital funding would support increased digital transformation, diagnostic capacity, and integrated community hubs.

Sir Mike Richard's report *Diagnostics: Recovery and Renewal*<sup>19</sup> (October 2020) sets out the case for investing in delivering more NHS diagnostic services in the community to meet the rising demand for critical services including cancer and elective pathways. One of the key recommendations is to establish community diagnostic hubs away from acute trusts. These new services will require additional investment in facilities, digital technology, equipment and workforce, which is urgently needed given the backlog of patients waiting more than six weeks for diagnostics. Community providers are therefore calling for a fully funded implementation plan, as part of the CSR capital settlement and three-year revenue allocation, as these hubs will be a key component in elective recovery plans.

Digital transformation has also been a key NHS priority for many years and is critical to achieving multiple goals within the NHS LTP (including the ambition to deliver more care in the community), and to supporting COVID-19 recovery efforts. Although the pandemic has accelerated digital improvement across sectors, and in the last year there has been an increased national focus on digital transformation in the community sector, the potential for digital transformation within community health services has still received relatively little national support, prioritisation or targeted funding to date.

This is especially the case for non-NHS providers, such as community interest companies, who have generally been excluded from accessing central funding, even during the COVID-19 pandemic. In a recent survey of community provider finance directors<sup>20</sup>, 64% of respondents felt that they did not have access to sufficient capital funding, and 84% felt that they did not have access to sufficient revenue funding. This is notable because ongoing revenue funding is increasingly required as software moves to a subscription model for cloud-based services.

Targeted capital investment in the community sector is needed to standardise the level of digital maturity and core infrastructure across providers. This is necessary to support new remote and flexible ways of working, prevent a postcode lottery in terms of digital access, and ensure the interoperability of systems.

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<sup>19</sup> <https://www.england.nhs.uk/wp-content/uploads/2020/11/diagnostics-recovery-and-renewal-independent-review-of-diagnostic-services-for-nhs-england-2.pdf>

<sup>20</sup> Representatives from all provider organisations in membership of the Community Network were invited to participate in an online survey during May 2021. Forty responses were received, comprising 34 trusts and six community interest companies.

## Conclusion

The eight asks outlined above represent important steps the government can take at the CSR to prioritise community health services and thereby help place the health and care sector on a more sustainable footing. As the pandemic has shown, an adequately resourced community sector improves outcomes for patients and their families and carers, as well as easing pressures on acute services and supporting the most effective and efficient operation of the health and care system.

Delivering more care in the community is a key ambition for the NHS and colleagues in the care sector which we must not lose sight of at this important juncture. But this will require sufficient capital investment, workforce training budgets and public health/local authority funding to become a reality. As the government focuses on 'levelling up' and on recovering care backlogs, it is more important than ever that we reap the demonstrable benefits of appropriate investment in resilient, sustainable community health services.