Written evidence from The Community Network (PCC0026)

HOUSE OF LORDS INTEGRATION OF PRIMARY AND COMMUNITY CARE SELECT COMMITTEE INQURY

House of Lords inquiry into integration of primary and community care
Community Network, April 2023

About the Community Network

The Community Network is the national voice of community providers. We support NHS trusts and not-for-profit organisations providing NHS community health services to deliver high-quality care by influencing national policy development, sharing good practice, and promoting a vision of integrated care in the community. The Network is hosted by the NHS Confederation and NHS Providers.

Key points:

We are responding to this submission on behalf of community provider leaders, referencing, where appropriate, the overlapping challenges that are also experienced by colleagues in primary care.

- Community provider leaders are optimistic about the potential for greater integration across primary and community services.
- At a local level, many community providers are working closely with primary care colleagues to explore ways to enhance integration, including by delivering care through integrated neighbourhood teams.
- Improved integration between community and primary care can bring significant benefits, including less duplication, more joined up services for patients and more opportunities to work and train in different care settings for staff.
- However, community provider leaders report some significant barriers to further integration. These include staff shortages in both community and primary care and challenges sharing data across sectors.
- Underlying this, there is a need for greater investment in, and prioritisation of, community health services. This would support a more preventative model of care, alleviating pressures on the acute hospital sector and importantly enable greater integration between community and primary care, in turn supporting more people to stay well and independent in the community.

Main challenges facing primary and community health services.

1. Staff shortages in the community sector. The community sector faces significant staff shortages, particularly in district nursing, health visiting, podiatry, speech and language therapy, and community dentistry. While there is no publicly available breakdown of NHS vacancy data for community roles, data from the Queens Nursing Institute shows the number of district nurses fell by almost 43 per cent between 2009 and 2019[1]. Furthermore, in a June 2022 survey of community provider leaders, 76% highlighted workforce recruitment and retention as the biggest challenge for their organisation. This is concerning given increasing demand for community services and acuity of care needs among patients. Without the right numbers and skill mix of community staff, service delivery is placed under increased pressure, limiting capacity to take forward wider strategic goals around integration with primary care.

2. Profile and visibility of community health services. There is scope to significantly improve the timeliness and reliability of national data on the community sector. This is a 'work in progress' and an aspiration the Community Network and its members strongly support. While new national programmes delivered in the community, including urgent community response services, have helped to improve the availability of nationally consistent data on provision, the vast majority of national targets and data collections continue to focus on acute services. While national targets are not always appropriate, they often drive leadership focus and can help create a more robust evidence base for the relative contribution and efficiency of different services. Without transparent and nationally consistent data of sufficient quality, it can be difficult to make the case for further investment in the community sector.

3. Insufficient funding, and funding flows to the community sector. The NHS Long Term Plan committed to investing an additional £4.5bn in primary and community care by 2023/24. However, this has followed years of underinvestment in community services, and this combined funding commitment for both community and primary care makes funding flows and investment difficult to track for each sector respectively. Unlike other sectors, including acute and mental health, there is no ringfenced investment for community providers, leading to concerns about a financial squeeze on the sector given existing national targets and competing demands.

4. The knock-on impact of pressures facing social care. Social care providers also face severe staff shortages, with approximately

[1] https://qni.org.uk/news-and-events/news/urgent-need-for-more-investment-in-the-district-nursing-service/

165,000 vacancies[2], at a time of soaring demand and acuity of need. The lack of sustainable investment and meaningful reform means the sector struggles to support everyone who requires social care, leaving thousands of people with unmet needs. This in turn can shift additional pressure onto community and primary care providers as people present at alternative settings to receive care or present with greater acuity of need because they haven't been able to access the right support.

Barriers preventing improved integration, and how these might be overcome. Examples of innovative models of integration between primary and community care.

5. Community provider leaders are optimistic about the ambition for greater integration with primary care as outlined in the Fuller stocktake report[3]. However, there are still several barriers to further integration.

6. Sharing data (often described as interoperability) between community and primary care is a significant challenge. It is important that community providers and primary care colleagues build trust to enable the sharing and use of cross-organisational data.

7. Integrated care systems (ICSs) can also play a key role in helping teams to align how they are working and how data is captured and shared. However, further national support and resource is required to give providers and ICSs a clear view of local population health needs.

8. Workforce pressures across primary and community health services also impact on the time and resource available to take forward integration. Community providers report that staff shortages can limit the capacity for frontline staff and leaders in both sectors to work towards developing integrated teams. In a context of rising demand, operational pressure and industrial action, leadership 'headspace' has unfortunately become curtailed. On top of this, even when progress is made, high staff turnover rates in primary care can mean that it is difficult to retain expertise and relationships across organisations.

9. Despite the level of operational challenge, there are examples of good work underway. To address workforce challenges, and to

[2] https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx

[3] https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

reinforce integration between community and primary care, some areas have invested in cross-organisational training to support the work of integrated, multi-disciplinary teams. Others report offering rotations in both community services and primary care for newly qualified nurses. Community providers are uniquely placed to employ staff under national terms and conditions, and to support their continuing professional development to enable them to work across organisational and sector boundaries.

10. Community providers are also developing innovative models of integration between primary and community care. For example, North Tees and Hartlepool NHS Foundation Trust is working closely with the GP federation, and local authorities, to deliver a virtual frailty ward and explore ways to further integrate services for the benefit of patients. To support this way of working, the trust has developed a memorandum of understanding with the local GP federation, with primary care staff providing urgent care for patients as part of the virtual frailty ward multi-disciplinary team. Improved integration between primary and community care is also supported through an integrated single point of access which is convened by the trust and acts as a coordinator for all community services. Primary care colleagues are able to dial into the single point of access team to determine whether a patient would benefit from a GP visit. This multi-disciplinary approach ensures the trust can take a system wide view of managing patient needs, reducing the risk of multiple referrals to different teams and ensuring patients receive the right support at the right time in the community.

Implications of the government's long-term workforce plan for the NHS on primary and community care staffing.

11. The community sector faces some significant challenges with recruitment and retention. This should be carefully considered in the long-term workforce plan (LTWP) to ensure the sector can sustainably recruit and retain staff.

12. Although the LTWP is yet to be published, community provider leaders have been engaging with national policy makers in NHS England to support its development. As part of this, community providers have recommended that the sector would benefit from the development of new roles and alternative training routes for staff, more funding for training and development, and the promotion of roles and careers in the community sector.

13. Within the LTWP, community provider leaders also want to see strengthened national workforce planning which better supports the development of integrated career pathways. Adopting a 'one

workforce' approach to the health and care workforce planning can support greater flexibility and development opportunities for staff, which in turn aids recruitment and retention. It can also encourage a more collaborative approach to workforce challenges between system partners, and particularly across primary and community care.

14. Critically, the LTWP must be fully costed and fully funded. It must also be iterative and updated at regular intervals for it to remain fit for purpose.

How successful have Primary Care Networks been in facilitating joined up working between primary and community care provision, and other parts of the system?

15. Primary care networks (PCNs) play an important role in bringing together multi-disciplinary teams and enhancing general practice access to a range of specialist staff through the additional roles reimbursement scheme (ARRS). However, we are aware of the challenges this scheme faces in some areas, as a result of regional variation in the supply of particular roles, lack of sufficient flexibility to respond to local need and difficulties in attracting candidates based on the pay scales primary care can offer. We also hear of instances where trust leaders feel that ARRS roles have disrupted local recruitment markets, offering paramedics and other professionals more competitive terms than they would otherwise receive on agenda for change. The key here may be for primary care colleagues to work together with community, acute, mental health and ambulance colleagues to co-ordinate workforce planning within their local ICSs.

16. Joint working at scale offers benefits including spreading good practice and supporting the workforce. In particular it can bring expertise in back office functions and support rapid-access clinical care. PCNs represent one model by which this can be achieved. It is worth noting that various models of delivery exist across the country including structural integration with trusts, partnerships with federations, and at-scale partnerships or corporate bodies. There is merit in supporting practices to collaborate using a range of models that create access to expertise and investment.

17. For example, Hampshire and Isle of Wight ICS, in collaboration with the National Association of Primary Care and NHS Providers have piloted a project[4] to promote closer working between primary, secondary and community services and shift focus towards

[4] https://napc.co.uk/hampshire-new-frontiers-group/

neighbourhood care to improve the health and wellbeing of local populations.

18. The scheme demonstrates the ways in which systems can support innovative forms of integration and promote effective collaboration between professionals to reduce systemic pressures and reduce inequalities through community-focused approaches.

The benefits of improved access to out of hours and 24/7 services.

19. Timely access to community services helps people to access the right care at the right time in the right setting. It can also alleviate pressure on other parts of the health and care system. The provision of regular out of hours services such as urgent community response are vital to preventing unnecessary A&E attendances[5] and hospital admissions by delivering care quickly in people's homes.

20. Without access to such care, people often present on urgent and emergency care pathways. This adds pressure to this part of the health and care system and can have detrimental outcomes for patients where this is not the most appropriate setting. This is particularly true of frail patients and people receiving palliative care[6] , who often require urgent out of hours care, but can be best cared for at home or in the community.

21. Improved access to out of hours and 24/7 services can therefore contribute to improved patient flow through the whole health and care system and help to tackle wider capacity challenges such as discharging patients from hospital.

22. National guidance[7] requires the provision of 2-hour crisis response services from 8am to 8pm, seven days a week (at a minimum). However, many systems are going beyond the minimum, with some delivering these services 24/7.

23. Although there are examples of areas where care out of hours care is delivered, is it not consistent across the country and could be improved to ensure everyone can receive timely care at home.

24. However, this requires capacity, resource and investment at a national level to ensure there are the appropriate levels of staff to deliver these services.

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[5] https://www.nhsconfed.org/publications/making-most-urgent-community-response-services

[6] https://www.mariecurie.org.uk/policy/better-end-of-life-2022

[7] https://www.england.nhs.uk/publication/community-health-services-two-hour-urgent-community-response-standard-guidance/

To what extent have ICSs been able to deliver the aims they were set up to achieve?

25. Trust leaders are working incredibly hard to drive forward the ambitions of system working. ICSs are still relatively new as statutory bodies. Each system is developing from a different starting point with considerable variation in levels of deprivation and local need as well as the make up of providers. It will therefore take time to determine the extent to which ICSs are delivering on their four core purposes[8] to: improve outcomes in population health and health care; tackle inequalities in outcomes, experience and access; enhance productivity and value for money; help the NHS support broader social and economic development. Furthermore, there are 42 ICSs, each of which have distinct local contexts, opportunities and challenges. The pace at which ICSs make progress on each of the four core purposes will differ.

26. ICSs must have a realistic 'ask' and the necessary resources to deliver that ask. At present, operational, workforce and financial pressures pose a significant risk to the ability of ICSs to focus on their core aims. Without national to support to address existing challenges, including through a fully funded and costed LTWP and increased funding for the public health grant allocation[9], ICSs face reduced capacity to deliver on the aims they have been created to achieve

27. For community providers, there are considerable opportunities to help deliver more integrated care via 'place' based footprints and at neighbourhood level within an ICS. Community providers are however also forming into 'provider collaborations' offering some of their services at scale across a larger patch within an ICS.

28. It is also essential that NHS community services, primary care, and social care, has a voice within the ICS – ideally within the integrated care board governance structure as well as within the integrated care partnership. Trusts and community interest companies which provide NHS community services describe a mixed picture, with some feeling plugged into the system infrastructure and others less so. It remains challenging for primary care colleagues to ensure representation on system level bodies.

How existing infrastructure could be enhanced to improve the use of health technologies and possible benefits for patients.

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[8] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

[9] https://www.health.org.uk/news-and-comment/news/health-foundation-response-to-the-announcement-of-the-public-health-grant-allocation-in-england

29. Community providers have often been overlooked in national digital policy priorities and funding streams. While funding and support for the community sector has increased in recent years, a history of insufficient and patchy access to national funding has led to varied in digital maturity across the community provider sector. This has had a significant impact on non-NHS providers delivering community services.

30. The community provider landscape is complex, and with varied digital maturity across the sector, it can be difficult to share data between providers and with different system partners, including primary care colleagues.

31. The lack of interoperability between different IT systems is a key barrier to improved integration between primary and community care. Without shared data, it can be difficult to develop a holistic view of a person's health and care needs, and deliver integrated care through multi-disciplinary teams. This can lead to duplication and increased clinical risk for patients.

32. Increased revenue and capital funding for digital infrastructure, including interoperability and virtual wards, is a key enabler to improving the use of health technologies in the community sector. This bring benefits for patients by offering joined-up services that better support them to stay well and independent at home and in the community.

One key recommendation to enable effective and efficient integration in the delivery of primary and community care services.

33. Both community and primary care leaders are clear that workforce pressures across the sectors are the key barrier to integration that must be urgently addressed to enable providers to deliver more joined up services.

34. This could be supported by giving greater flexibility for staff to work across organisational and sector boundaries through multi-disciplinary teams to promote recruitment and retention by offering new development opportunities for staff, and boost organisational resilience.

35. For example, the introduction of a rotational model between primary care and ambulance-based settings by Yorkshire Ambulance Service[10], working with the county's ICSs, has allowed

[10] https://www.yas.nhs.uk/news/campaigns-and-events/campaigns-and-events-2021/paramedics-in-primary-

them to provide additional support to primary care colleagues, enabled staff to develop new skills, and allowed the organisation to maintain staff capacity.

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