The King's Fund

Ideas that change health care

Written submission

The King's Fund submission to the Special Inquiry Committee on the Integration of Primary and Community Care

The King's Fund is an independent charitable organisation working to improve health and care in England. We have a long championed the development of integrated care to support the increasing number of people who access support from multiple health and care services. We also have a longstanding interest in primary and community care. Alongside a growing body of research and policy work, we also provide organisational and leadership development support to systems, primary care networks and work with GPs across the health system.

This evidence submission draws on our experience of working closely with local system leaders, as well as our research on primary care, community health services and integrated care in England and internationally. It will focus on community health services, such as district nursing, physiotherapy, occupational therapy and falls services, rather than primary care. This is because we believe the area of community health services is particularly poorly understood. We are, of course, also happy to speak separately about primary care.

The main challenges facing community services

The profile and understanding of the sector

1. Community health services are poorly understood compared to other parts of the NHS, due, in part, to the complexity of collecting and aggregating data in disparate settings and services, services being delivered 'behind closed doors', the diversity of services, and complex patterns of provision and commissioning.

2. Robust national data is vital as without this it is difficult to understand not only activity, but also the workforce, spend and quality in community health services, and to

understand where improvements are needed. While significant steps forward have been made on national data through the community services dataset, there is still more to do to improve it, especially when compared to the mandated data collection on activity in hospital, where every patient episode has been recorded and nationally collated since the development of hospital episode statistics (HES) in the late 1980s (NHS Digital 2023; Charles *et al* 2018).

3. In comparison to the HES dataset, the community-level data is patchy, as currently only a proportion of providers are submitting data returns, and when they do submit data there are very few mandatory fields, leading to incomplete returns (Scobie and Kumpunen 2023). The issues with the data are particularly serious for activity as, despite providers reporting on numerous key performance indicators (KPIs), there is little standardisation and definitions vary, which means the national datasets are less useful than they could be (Charles *et al* 2018). This, of course, in turn means there is limited comparable data available to local services too.

Funding

4. Gaps and inconsistencies in national data also make it difficult to accurately quantify spending on community health services but there are indications that budgets have fallen in recent years while demand for services is increasing. This demand has been driven by growing numbers of older people and people living with multiple long-term conditions and by the NHS seeking to strengthen community services and shift care from hospitals into community settings.

5. Before the Covid-19 pandemic, spend on community activity was £5.44 billion in 2018/19 but fell to £5.43 billion in 2020/21 (Scobie and Kumpunen 2023). This was around 7.4 per cent of the £72.5 billion total spend by NHS providers on identified and costed forms of patient care in 2020/21 (Scobie and Kumpunen 2023). Spend increased to £6.4 billion in 2021/22, including Covid-related costs (NHS England 2022). While this is an increase, it may only be a temporary trend due to specific and time-limited funding for Covid-19 costs. Community services have long had budgets that have remained static or been reduced (NHS Providers 2018).

6. These services are particularly vulnerable to financial pressures as their funding has historically been primarily via block contracts, which is not linked to activity and so care is less visible than in other settings. This means that, compared with acute services, it is 'easier to squeeze funding but more difficult to see the consequences of doing so' (Robertson *et al* 2017). The absence of routine comparable data on activity further compounds this funding challenge as it makes it more difficult to make the case for increased funding to respond to demand.

7. While the NHS Long Term Plan (NHS England 2019) set out ambitions to 'boost "out-of-hospital" care' and committed to increasing the share of the NHS budget going to community and primary care services, it is difficult to see that this has happened in practice. Increasing the budget allocation to community services has often also been predicated on expectations that this could be financed by savings from a reduction in

acute hospital capacity which would then be redirected toward spending on services in the community. This is not realistic at a time when hospitals are working under intense pressure. Instead, a more realistic aim is that the proportion of the NHS budget being spent on services in the community would increase over time by prioritising this area for any growth available.

Reorganisation

8. Successive governments have attempted to transform community health services through multiple reorganisations but have done so without evaluation of the impact of successive changes. This means that services have undergone frequent structural reforms resulting in the organisation and delivery of community health services being varied and complex (Charles 2019).

9. It has been estimated that NHS providers, including standalone NHS community trusts and combined community and acute or mental health trusts, hold around half of the total value of community service contracts (NHS Providers 2018). The rest are held by a range of providers including community interest companies, local authorities, social enterprises, private providers, GP practices and pharmacies (Gershlick and Firth 2017). A focus on competition and using 'any qualified provider' approaches from 2010 led to community health services being re-tendered on a more regular basis than those in other parts of the NHS, as they were seen to be more amenable to competition than services in acute hospitals. This led to further disruption and uncertainty for service providers. However, the changes introduced by the Health and Care Act 2022 to tendering processes and the forthcoming provider selection regime could address this, although this will largely depend on how the new framework is applied by local budget holders.

10. The repeated reorganisations of community services have led to a complex pattern of provision and major changes to their relationship to other parts of the service.

    - Arguably, having community health services as part of primary care trusts (PCTs), which were also responsible for primary care, may have helped with the integration of these two major parts of out-of-hospital care. The progressive separation of community services from PCTs and into different provider models was never evaluated.
    - The pattern of organisational provision of community services is both complex and changing. Some services were taken into acute trusts, some into mental health trusts, some into standalone providers, and some left the NHS to become social enterprises. Since 2012, mergers have continued to occur, generally increasing the size of providers along with some changes of ownership.
    - Overlaid on top of this already relatively complex model have been series of competitive tenders and these have created (in some geographies) a patchwork of different providers, sometimes working on non-geographical contiguous basis. However, the evidence suggests that the development of integration relies partly on the quality of relationships developed across a geography and this approach is

unlikely to provide a supportive environment for such relationships (Timmins *et al* 2022).

Workforce shortages

11. Combined community staff make up an estimated one-fifth of the total NHS workforce. However, there are severe shortages in the community workforce, leaving providers struggling to meet current demand, let alone make a reality of plans to deliver more care in the community (Charles 2019). In contrast to the increases recently seen in the acute sector, key staff groups in the community, such as district nurses and health visitors, have seen declining numbers (Warner and Zaranko 2022). There were 10,424 district nurses in 2022 compared to 11,209 in 2020 and similarly, health visitor numbers have dropped to 6,766 in 2022 compared to 7,094 in 2020 (NHS Digital 2022). These falls come on the back of many years of decline, with the number of qualified district nurses falling sharply by 42 per cent between 2010 and 2018 and the number of health visitors falling by almost 40 per cent since 2015. The fall in district nurses for part of that period, in 2012/13, is likely to reflect some community services moving out of the NHS (Dayan and Palmer 2018). However, this is unlikely to explain the continued decline in numbers.

12. The reasons behind the declining numbers of staff in community services can be difficult to pinpoint. However, unmanageable caseloads, insufficient time to provide care, regular unpaid overtime and a lack of training and development have been cited as reasons (The Queen's Nursing Institute 2019). There were also changes to nursing training over the past decade which had an impact on the number of new recruits into this profession. The two main changes were a reduction in the number of places funded by the government in 2011, which was intended to prevent an oversupply of nurses, but ironically contributed to the shortages we see now, followed by the removal of the nursing bursary in 2017, a move intended to remove the cap on the total number of nursing placements (Maguire 2021). However, these changes initially led to a reduction in the overall number of nursing students in training in the context of an existing nursing shortage (Maguire 2018).

13. Many of these factors also apply to acute sector nurses. However, in the acute sector it has proved significantly easier to supplement domestic supply with large-scale international recruitment and this has been missing in the community sector. Work is needed to assess whether this lack of international recruitment is due to a lack of comparable roles in other, exporting countries or merely due to an initial focus on traditional acute roles. It does appear international recruitment can work for allied health profession roles (eg, in occupational therapy and physiotherapy, which are also key roles in community services as well as in acutes). While international recruitment is not (and should not) be the long-term answer to workforce shortages it may play an important role in the near-term.

14. Workforce issues are all the more significant given the staff-intensive nature of services in the community. This creates a gap between capacity and demand which means the availability and quality of care is compromised in some cases, however the lack of robust data means these issues are less well documented than those for elective care.

15. Workforce shortages are likely to be a major limiting factor to plans for improving and expanding community care (The King's Fund 2023). Addressing the shortfall will require local systems to draw on the skills of the full range of community-based professionals – nurses, pharmacists, allied health professionals and others – as well as make efforts to improve retention of current staff and attract new staff by increasing exposure to community settings during training (Beech *et al* 2019). International recruitment may provide a short-term boost to these longer-term measures.

Primary care networks and community services

16. The NHS Long Term Plan sets out a requirement for community services to be configured around primary care networks' (PCNs) footprints with expanded community multidisciplinary teams that would provide services to people with more complex needs, providing proactive and anticipatory care (Beech and Baird 2020; Charles 2019; NHS England 2019). This also chimes with the intent set out in the Fuller stocktake review of next steps for integrating primary care, which recommended that PCNs develop neighbourhood teams which work with community health services (Fuller 2022).

17. Despite this intention, the reality has been that, initially, PCNs have been focused on building their relationships within general practice, rather than focusing on connections with community-based services more broadly (Beech and Baird 2020). In our experience it has been harder for PCNs to engage with community trusts for a number of reasons. Most PCNs lack the managerial or change management infrastructure needed to further their ambitions for integration with community services and much of their funding is narrowly focused on delivering a set of defined service specifications set out in the GP contract extension. While the ambition is for community health services to be aligned around PCN footprints, the scale of many NHS community services providers means that they do not have the capacity to engage with multiple PCNs (up to 90 in some cases) and indeed, are likely to continue to struggle to do so.

Learning from the new models of care programme

18. In 2015 the NHS England new models of care programme set out to test new approaches to delivering services. There is learning to be derived from the new models of care in the NHS England primary and acute care system (PACS) vanguard sites. They are examples of a future in which primary care teams, integrated community teams and others work together to meet the needs of patients and service users. These care models aimed to promote service integration and benefited from relatively modest transformation funding and the ability to release staff to work on service improvement (Naylor and Charles 2018). Our research showed that the vanguard sites

made some progress and catalysed significant amounts of innovation in terms of both frontline services and wider structures supporting system-wide collaboration (Naylor and Charles 2018).

19. Bringing about this system-wide change required strong relationships, trust and an ethos of mutual interest. Building this takes time, and in many vanguard sites efforts to develop system leadership and a shared local vision began several years before the new care models programme commenced (Naylor and Charles 2018). Relationships were strengthened in vanguard sites through regular communication, creating joint posts across organisations, co-locating teams, and fostering a culture of openness and transparency between partners.

20. This kind of relationship-building or 'reshaping the overall organisational relationships' needs to happen before making more formal changes to contractual arrangements or organisational structures (Naylor and Charles 2018). Previous reforms of community services have often relied on these more formal changes to structures or organisational forms, rather than relationship building, which didn't achieve the desired changes and led to significant disruption and the complex provider landscape we have now. Integrated care systems (ICSs) and place-based partnerships now have an opportunity to take forward this learning from the vanguards.

Conclusion

21. There is a need to learn the lessons from decades of repeated failures to make the step change required to move care into the community. Changes to structures or contracts, which have been the lever most often pulled in the past, are unlikely to be successful unless equal attention is paid to complex and interrelated issues such as staff training, financial rules and cultural change. If these are not addressed, it is hard to see how the ambition to shift care to the community will become a reality. Primary care and community services will need a greater share of resource, both in terms of money, workforce and improvement capability, and more attention from policy-makers. Strong, coherent leadership for community and primary care services should be a priority within national bodies and for local ICSs.

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