Briefing: Provision of community care: who, what, how much?

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Key points

- Increasing the use of community care – which currently accounts for about £1 in every £10 spent by health care commissioners in England – relative to acute care has been a policy priority for almost as long as there has been an NHS.
- In recent years, spending on community care delivered by non-NHS providers has increased substantially – and faster than in any other any area of NHS care. But surprisingly little is known about who is providing these services, or the size and scope of the contracts.
- Our analysis is based on August 2016 Freedom of Information (FOI) requests sent to all clinical commissioning groups (CCGs) in England. We asked for details on who was currently providing their community services, the type of provider providing these services, what services they were providing, how much the contract was worth and the length of the contract. We received details of 7,494 contracts from 161 CCGs (78% of all CCGs).
- We found that NHS providers hold over half (53%) of the total annual value of contracts awarded for community services. Contracts are also provided by organisations including general practices, local authorities, charities and private companies.
- Of the community care contracts in our sample, private providers held 5% of the total annual value, but 39% of the total number of contracts issued.
- Private providers tended to hold much smaller contracts, with 6 in 10 holding contracts with a combined value of less than £100,000. Additionally, most (7 in 10) held just one contract. The majority of very large contracts were held by the NHS.
- Much more will need to be done to understand this sector better – both to understand the capacity and capability of CCGs to successfully commission community care from such a large and varied group of providers, and to assess the quality of care. This is particularly important as the direction of policy encourages a shift of care out of hospitals and into the community.

The Health Foundation

Background

Moving care from hospitals into the community has been the direction of policy in England (and elsewhere[1]) for some time – at least since Sir Roy Griffiths' 1988 report *Community care: agenda for action*. The report famously describes community care as 'a poor relation; everybody's distant relative but nobody's baby'. It highlighted the fragmentation and lack of coordination in community care provision, and – citing the lack of progress in the previous 30 years – claimed that 'in few areas can the gap between political rhetoric and policy on one hand, or between policy and reality in the field on the other hand have been so great'.[2] More recently, investment in community provision has been central to the *Five year forward view*,[3] leading to 14 multispecialty community provider (MCP) vanguards testing new ways of delivering community care.

Community services account for about £1 of every £10 of clinical commissioning group (CCG) spending.[4] Primary care trust* (PCT) accounts show that between 2010/11 and 2012/13 spending on community services delivered by non-NHS providers grew from 20% of all spending to 31%.[5]

Analyses like this suggest that types of organisations providing community care are more diverse than those providing acute care, which is predominantly provided by the NHS. In the recent past, many community services were provided by commissioners of care (previously PCTs). In 2008, the Transforming Community Services programme began to move community care provision away from PCTs. By 2011 this split was completed, with most PCTs awarding three-year contracts to providers – the majority of which ran out in 2015.[7,8] The programme encouraged competition between providers to secure contracts, although it was largely neutral on what type of organisation should provide community services (eg NHS or non-NHS providers).

The 2012 Health and Social Care Act[9] and Any Qualified Provider (AQP) commissioning policy[10] aimed to encourage providers to compete both for contracts from commissioners and directly for patients, with the goal of increasing patient choice and improving care. In community services, AQP means that certain services (such as audiology, and podiatry) can be provided by a number of competing providers in an area, as long as they meet set quality criteria.

While often described by what it is not – hospital or traditional primary care – community care covers a broad range of activities, with almost 100 million contacts† with the public taking place in England each year.[11] In cost terms, the largest of these activities are district nursing and health visiting and midwifery care. However, this hides the diversity of care provided in the community, which includes targeted specialist interventions (such as treatment of musculoskeletal conditions) and some public health functions (such as sexual health services).

* Primary care trusts were administrative bodies responsible for commissioning primary, community and secondary health services from providers. They were abolished in March 2013.

† Such as discrete activities (eg, home assessments) or bundles of care.

Despite this volume of activity, very little is known about types of community care providers compared to those providing acute services.[6] More information is available about how much is spent on community care, although the measurement of total spending varies significantly between sources, largely due to how hard it is to delineate community services.

Given the changing market structure and increase in NHS-funded care from non-NHS providers, we wanted to investigate the number, value and length of community care contracts awarded by CCGs and the types of providers that hold the contracts. This briefing provides a snapshot in time rather than a trend – future analyses will be needed to better understand change and growth in the sector.

Methodology

In August 2016 we sent Freedom of Information (FOI) requests to all CCGs in England. We asked for details about:

- who was currently providing their community services
- the type of provider providing these services
- what services they were providing
- how much the contract was worth
- the length of the contract.

We received responses from 161 CCGs (78% of all CCGs). The responses provided information on a total of 7,494 contracts.

We sorted each contract into one of the following provider categories:

- private (including opticians and pharmacies, as well as broader services such as home care)
- NHS (mostly NHS trusts)
- general practice
- third sector (eg palliative and cancer care charities)
- 'other' (a diverse group including community interest companies, local authorities, social enterprises, as well as providers reported as 'non-NHS').

If a record did not include a provider type it was categorised as 'missing'.

We asked CCGs for the name of the provider. As this was a free text field, respondents may have used different names to refer to the same provider (for instance, if they were talking about the Health Foundation one CCG may have called it 'The Health Foundation', another 'health foundation', another 'the health foundation'). We used a method called cluster analysis to identify when this had occurred (by analysing similarities between answers) and then re-labelled responses based on a chosen cluster name (eg 'the Health Foundation').

Our analysis separates providers by name – and not ownership – and so when describing a provider as large or small these terms relate to the number/value of contracts they have with CCGs, according to our data. This is relative to the number/value of contracts other providers in our data have with CCGs. It does not relate to them as entire businesses.

Our figures should be viewed with some caution and we have not tried to define the level of uncertainty they might contain. They are intended to show broad patterns and proportions of spending at a particular moment in time, rather than precise values and long-term trends. The following factors may have caused inaccuracy in our reporting:

- Different CCGs may have interpreted 'community care' and 'NHS/private/third sector' differently.
- The 'other' provider type is quite large and may include providers that fit better into other types but we were not given sufficient information to assign them.
- CCGs may have made mistakes in the data they supplied.
- There are missing values.
- There may be some ways in which CCGs that didn't respond are different than those that did (non-response bias).

There is unlikely to be substantial non-response bias as organisations that respond to FOI requests are unlikely to have very different spending patterns to those that do not. However, there is a possibility that we may be missing some large contracts from CCGs who did not respond, which would have an impact on our results. Equally, while we have assumed that each contract is independent, it might be that some are formally or informally grouped together into a larger suite of services which has not been reflected in the way CCGs have reported them. This could have led to some double counting.

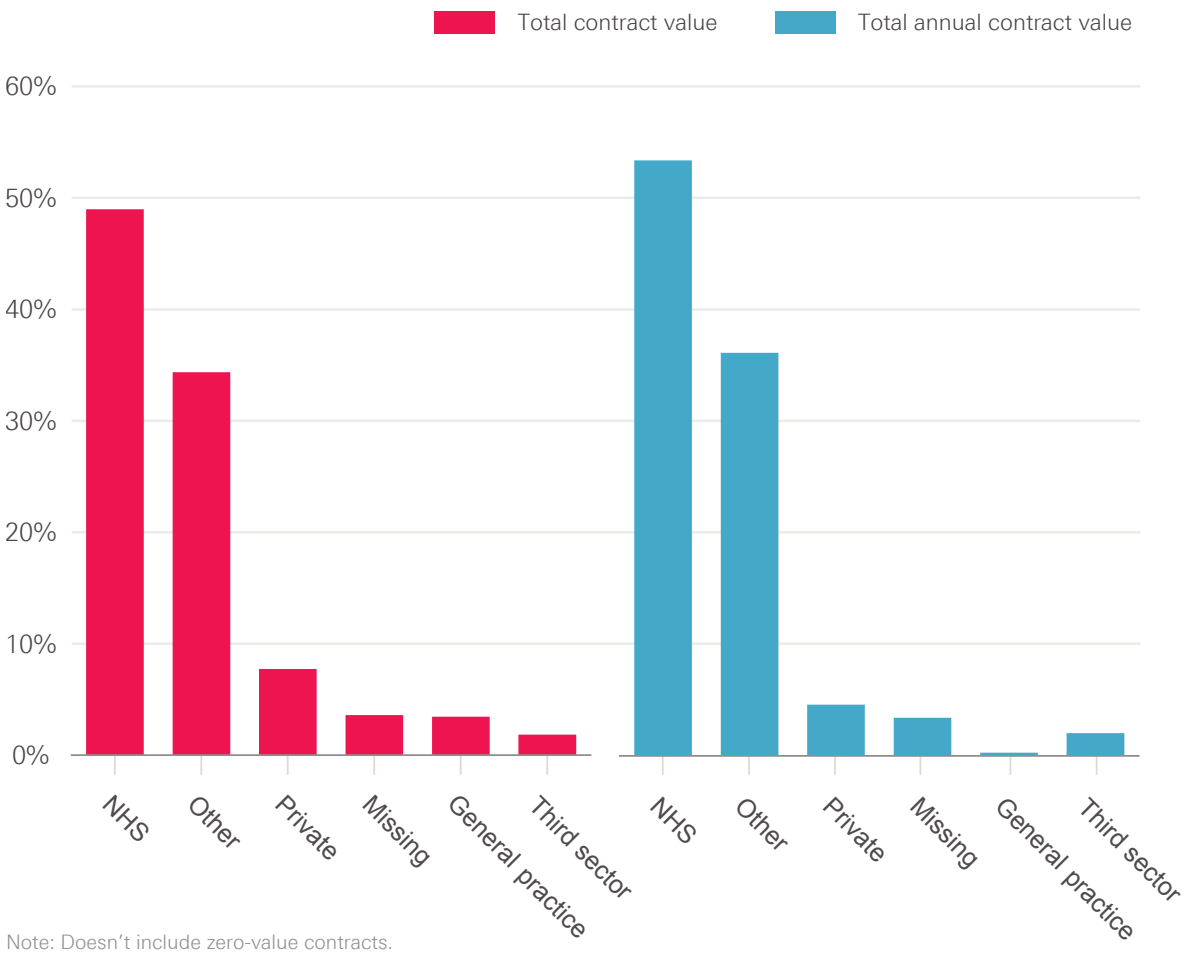
Findings

How much money goes to each type of provider?

We analysed the total value of contracts held by each provider category and found that NHS providers was the biggest provider type by total contract value. Contracts held by private companies, general practices, the third sector and those records for which a provider type was not reported had a combined value of less than £1bn – and they totalled just 17% of the overall value of the contracts in our sample.

However, it is also useful to compare provider types by annual value of contracts, which removes the additional value from longer contracts. When provider types are ranked by annual contract value, a similar pattern appears – NHS and 'other'* providers had the largest share of the contracts' value (53% and 36% of the total respectively). Combined, contracts held by general practices, private and third sector providers, and those for which a provider type was not available, were worth only 10% of the total annual contract value in our sample.

Figure 1: Share of total and annual contract values by provider category (%)

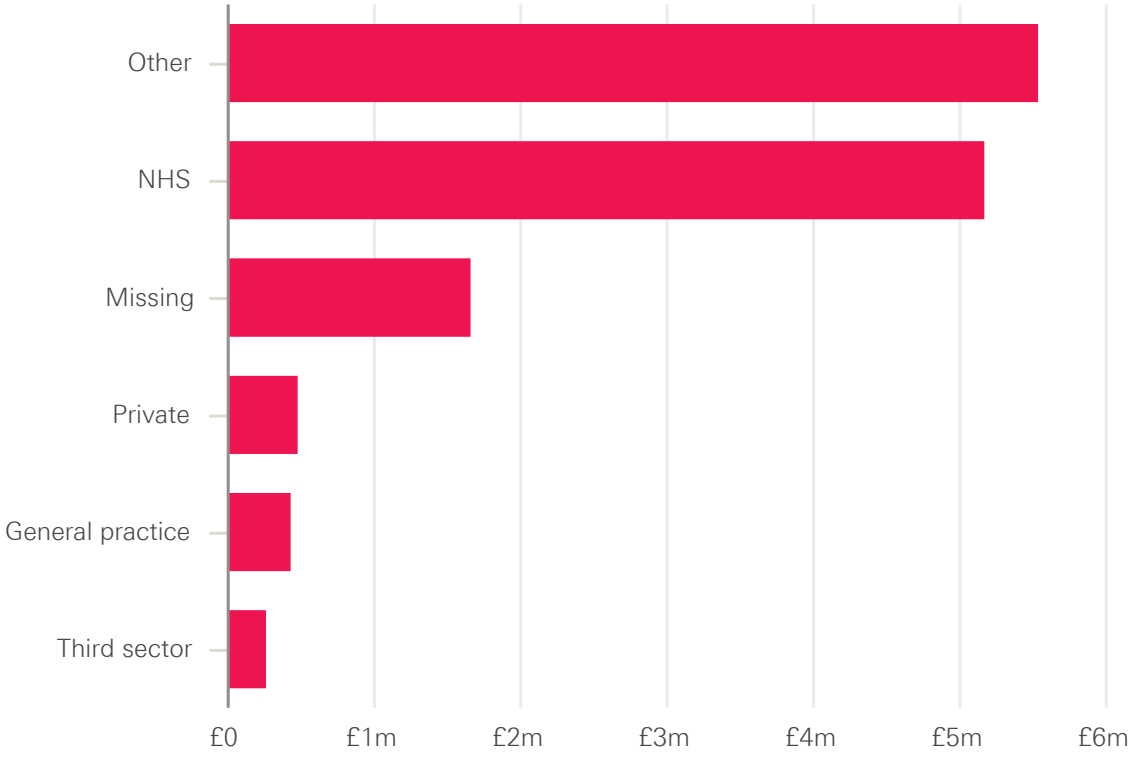


Note: Doesn't include zero-value contracts.

* The 'other' category is a diverse group including community interest companies, local authorities and social enterprises, as well as providers reported as non-NHS.

The average contract value was highest for 'other' and NHS providers, at over £5m each (Figure 2). General practices and private and third sectors providers each reported an average contract value below £500,000.

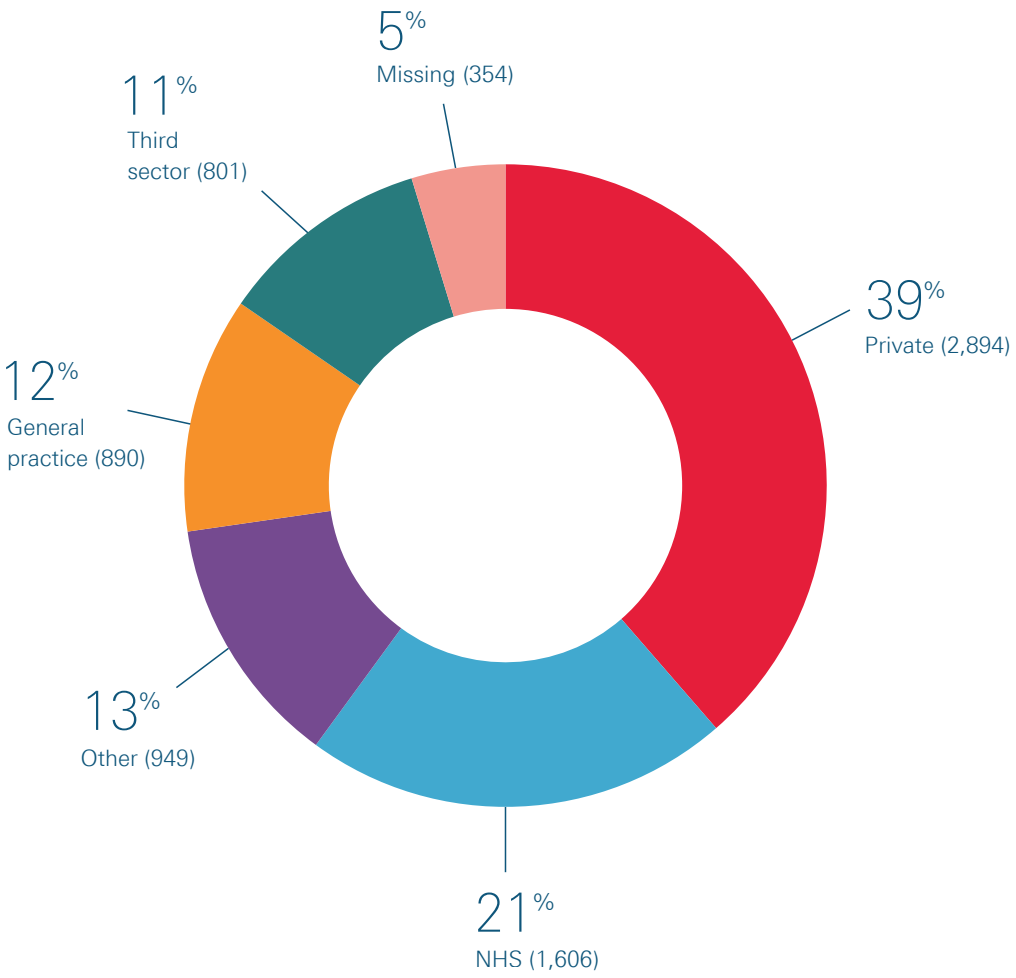
Figure 2: Average contract value (£m)



What types of providers provide community care?

Of the 7,494 contracts reported by CCGs, 39% (2,894) were provided by private companies and 21% (1,606) by NHS providers. General practices, third sector and 'other' providers each accounted for around 12% of contracts, while 5% of records were missing.

Figure 3: Share of contracts per provider category by volume



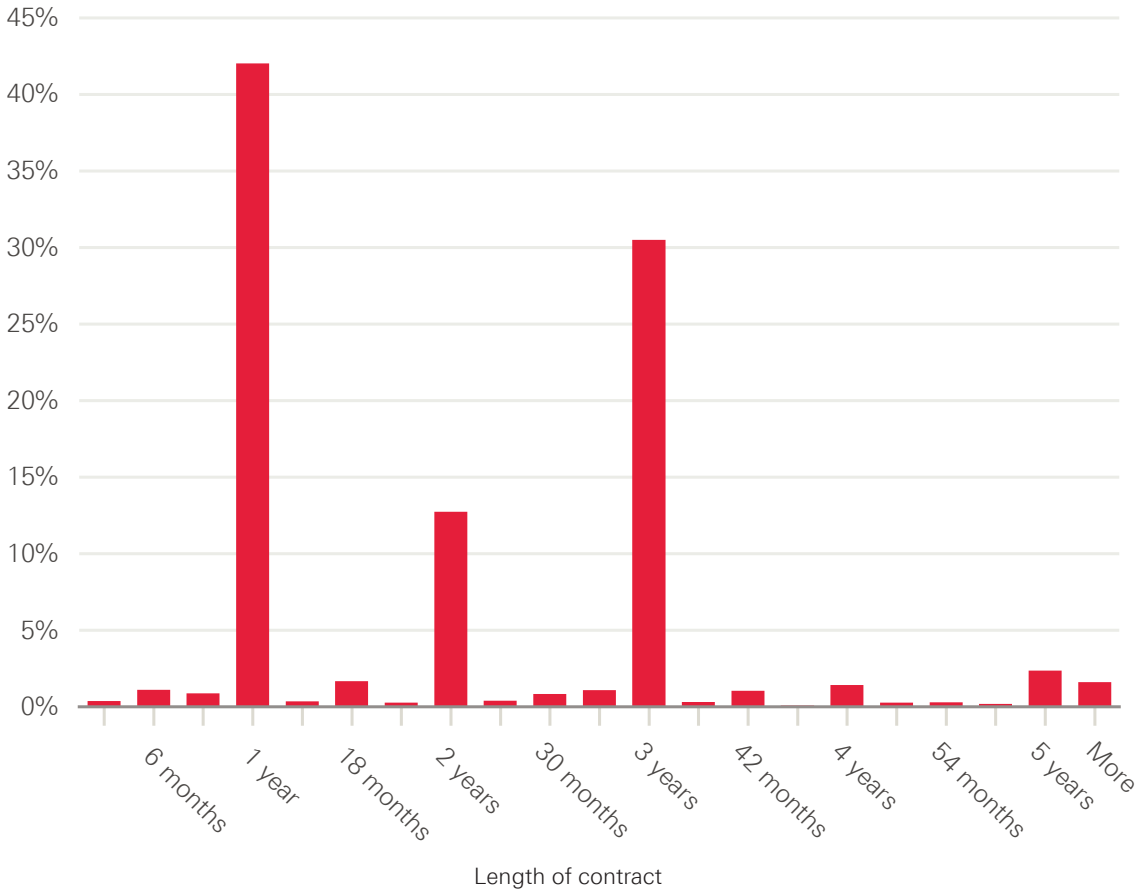
Note: N=161 CCGs with 7,494 contracts. Figures in brackets are number of contracts. Does not sum to 100 due to rounding.

When combined with the information outlined in the previous section, this shows that private providers (as a group) received a large number of low value contracts to provide community care. It also shows that the relatively small number of very high value contracts went to NHS providers.

How long are the contracts?

In the responses we received, the most common start date for contracts was 1 April 2016 (2,371 contracts) and the most common end date was on 31 March 2017 (2,025 contracts). This is consistent with findings from Monitor* in 2015 that CCGs mostly planned to extend or renew contracts expiring in 2015, in order to allow more time to review these contracts.[8] About half of all contracts reported were for less than two years.

Figure 4: Length of contracts with CCGs



* As of 1 April 2016 Monitor became part of NHS Improvement – the organisation responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

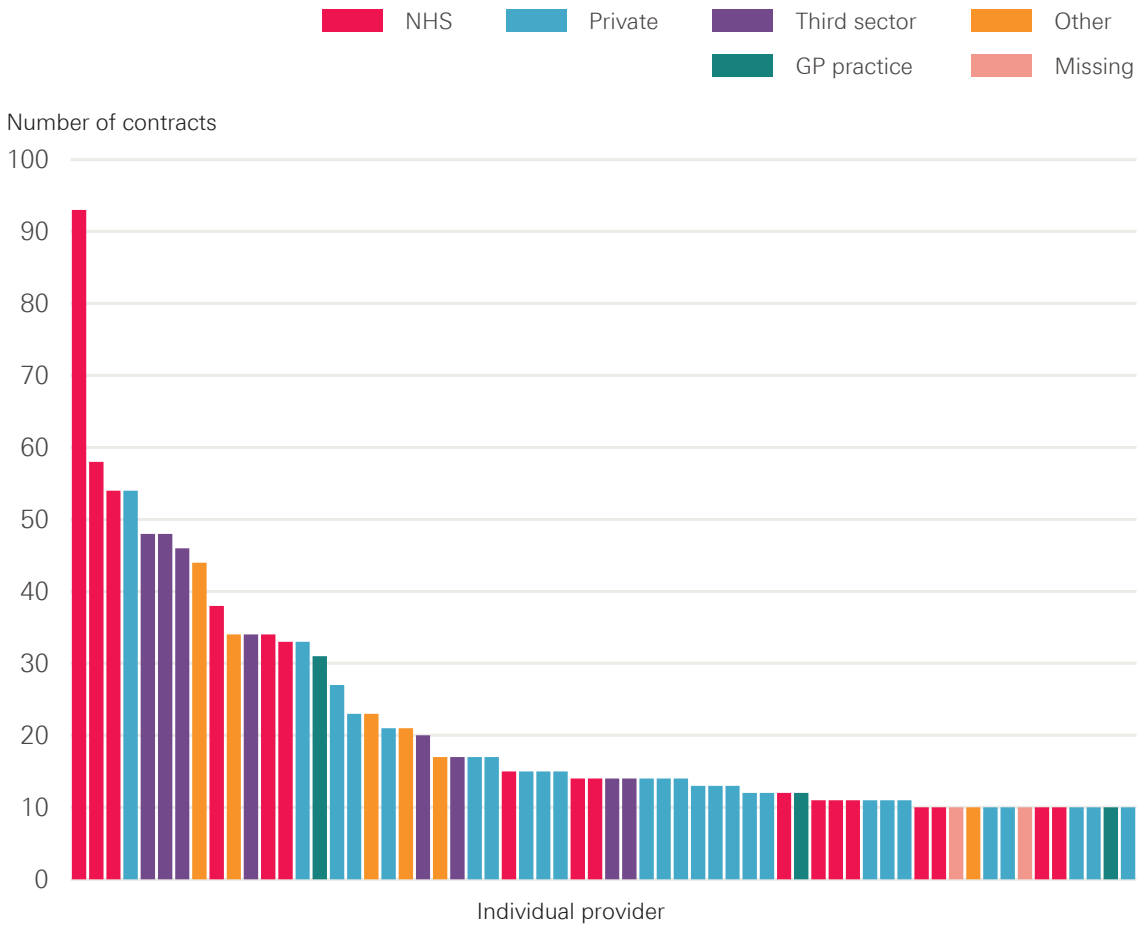
How concentrated are the contracts among providers?

As outlined in the methodology section, we used cluster analysis to identify providers that had multiple contracts with CCGs. This let us see if some providers had won a large number of contracts across the country, or received a large amount of CCG funds. However, we found relatively little concentration – over 3,500 providers accounted for the 7,494 contracts.

The data suggest that NHS providers tend to have the highest number of contracts – they account for four of the 10 providers with the most contracts, while only one private provider is in this top 10 (Figure 5). While there are a number of private providers with more than 10 contracts, 71% of private providers have just one contract. In fact, the average number of contracts per provider is lowest for private providers (1.9) and highest for third sector providers (2.4). This suggests that the large number of contracts held by the private sector is explained by the high number of private providers rather than the number of contracts each one holds.

It may be that the absolute number of contracts is skewed by the different ways CCGs categorise their contracts. However, looking at the annual value of the contracts suggests a similar story to that told by the number of contracts (see Figure 6).

Figure 5: Number of contracts provided to separate CCGs per provider



Note: Figures relate to providers with 10 or more contracts; each bar represents a different provider.

Figure 6: Concentration of funds by type of provider

Note: Doesn't include zero-value contracts.

When looking across all providers it is clear that most individual private providers held very few contracts. This is consistent with our other findings that contracts with private providers tend to be of lower value than those with NHS providers. It also indicates that private providers do not seem to be undertaking multiple small contracts in different areas.

Discussion

For the 78% of CCGs that responded to our FOI request, our findings show that most high value contracts for delivering community care across 2016 were held by NHS providers, although in absolute numbers the most contracts were held by the private sector. Data on individual providers support this: compared to private providers, NHS and third sector providers tended to have a greater number of high value contracts for community care.

The large number of small private providers compared to the relatively small number of large NHS and third sector providers suggests that private providers are principally undertaking single service contracts rather than whole area, multi-service contracts. This indicates a dispersed market, with many small volume, discrete services being commissioned. More work is needed to ascertain whether these small contracts are part of a larger, coordinated set of contracts. These are likely to be needed to offer multidisciplinary, whole person care, particularly for people with complex needs who are likely to be the biggest users of community services.[3] As the system attempts to adopt a more multidisciplinary approach to community care, it will be important to monitor how this impacts the incentives for different types of provider to undertake community contracts.

Commissioning and managing a large number of small discrete contracts may be costly and time consuming. This is particularly important if CCGs are aiming to undertake complex contracting arrangements that require substantial capacity and capability.[12] Our data are consistent with findings elsewhere[8] that, in addition to the sheer number of contracts – the CCGs that responded to our FOI request had an average of almost 50 contracts for community care, with some having many more – the bulk of community care is undertaken under rolling contracts or contracts with service providers chosen by previous PCTs. Given the current resource-constrained environment, CCGs clearly have a difficult task in managing all community contracts, tendering for new contracts and selecting the most appropriate provider that offers the best value.

Overall there is lack of data on activity undertaken by community care providers in England, as well as on the quality and costs of care. This, along with the piecemeal way the provider landscape has grown, suggests there is far more work to be done to assess care in this sector. This is particularly important as the direction of policy is to encourage a shift of care from hospitals into the community.

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Acknowledgements

A number of people contributed to the development of this briefing and the authors would like to thank them all for their comments and advice. Errors or omissions remain the responsibility of the authors alone.

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