STRATEGIC POLICY UPDATE

GOVERNOR FOCUS CONFERENCE

9 May 2019

Chris Hopson
Chief Executive
<table>
<thead>
<tr>
<th>What we will cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political and external environment</td>
</tr>
<tr>
<td>The NHS long term plan and system working</td>
</tr>
<tr>
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</tr>
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</tr>
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What we will cover

Political and external environment

The NHS long term plan and system working
Funding
Quality and performance
Workforce
How providers are responding to a challenging environment
The governor role
Government focused on Brexit...with huge turmoil

Politically:
• Conservative and Labour deeply divided over Brexit
• Government negotiating with Labour to try and reach a compromise
• UK will take part in European Parliament elections, but the government hopes to pass Brexit legislation in time to avoid UK MEPs taking up their seats

Clear impact nationally and locally:
• Ministerial and civil service time diverted to Brexit issues and leadership campaign politicking
• Unprecedented ongoing turmoil with little time, focus or appetite for domestic policy issues
• NHS mandate and social care green paper both delayed...with spending review at risk

NHS Providers focus:
• Helping trusts to navigate Brexit – influencing policy and keeping trusts informed
• Reinforcing where Government attention needed – e.g. workforce, capital, social care
A twist of the kaleidoscope

- NHS England and NHS Improvement coming together to act as one organisation under Simon Stevens as Chief Executive
- Seven new NHSE/I regional teams
- Moving from a commissioner / provider and NHS England / NHS Improvement split to a single, more collaborative and managed system
Where will the pendulum come to rest?

- Devolution to FTs and trusts with appropriate autonomy for unitary boards
- A return to a more centralist approach via stronger joint NHSE/I regions and central team
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</tr>
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High level direction of travel to help the NHS respond to the future needs of the population. Direction now underpinned by the **5-year funding settlement** and the **NHS Long Term Plan**.
NHS Long term Plan: worthy ambitions.....

- Investment in primary medical and community services to grow faster over the next 5 years than NHS budget; additional £4.5bn a year in real terms by 2023/24; GP practices required to join primary care networks
- Sustaining and better tracking of MH investment
- Preventative focus on the causes of early mortality
- Improving outcomes for children and disease groups: cancer, diabetes, cardiovascular, respiratory, stroke, MH
- Ambitions to back and grow the workforce and tackle the implications of Brexit and immigration policy
- Ambitions to mainstream digital access to care
- Balancing the NHS books, including for providers, and delivering efficiencies
- Roll out of Integrated Care Systems (ICSs) across the country by 2021.
but some crucial missing pieces

- A sustainable solution for social care. Much promised social care green paper delayed again
- The much delayed national workforce implementation plan including funding for training, and development, due later this year
- Capital expenditure, awaiting the spending review
- A credible focus on addressing the wider determinants of health in the context of cuts to public health budgets
- Trajectory for recovery of performance targets awaiting outcome of Clinical Review of Standards
- Prioritised, implementation plan for 300+ LTP commitments that fits available workforce & money
System working – a core pillar of the Long Term Plan

• Major transition under way:
  o from a system focused on competition between individual providers with a clear purchaser / provider split to
  o an additional (or replacement?) focus on integrated local health and care systems with providers & commissioners coming together
• All STPs are meant to become ICSs by 2021
• Commissioning evolving at pace – move to one strategic commissioner per STP/ICS level, better aligned to local government
• Every ICS will have:
  o a partnership board
  o a non-executive chair
  o full engagement with primary care
• All providers will be required to contribute to ICS performance
• Targeted legislative proposals (2020/21?) to speed up transition

Major implications for governance, accountability, financial management, regulation and oversight...and your role as governors
Managing ambiguity and uncertainty

- How to manage speedy transition from individual institution focus to an integrated local health and care system focus (replace or additional?)
- Particularly given massive variation in maturity between systems
- Strategic direction of travel misaligned with legislative framework:
  - 2012 Act: purchaser/provider split; competing providers
  - LTP: integrated local health and care systems
- Little chance of an imminent major legislative overhaul. We are therefore looking for imperfect practical workarounds
- Insufficient thinking on how to marry local system integration with an ongoing legal and governance framework focused on FTs/trusts...
  - ...And misalignment isn’t just legislative, the way the NHS is run, structured and measured and its underlying culture are misaligned too
- So whilst strategic direction of travel makes sense, the transition:
  - Will take time to deliver
  - Brings risk, ambiguity and potential for confusion
  - Will depend on good relationships that don’t exist in many places
  - Requires leaders and managers to behave very differently
- Even less thought on what this transition means for FT governors!
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</tr>
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Funding: only a return to the long run average

- NHS demand/cost risen by c3.5% to 4.5% p.a. since NHS founded in 1948
- NHS funding rose, on average by 4% real terms 1948-2010
- Exception is last 8 years of 1.4% funding growth, not next 5 years of 3.4% growth
- Latest financial settlement:
  - better than last 8 years
  - better than other public services
  - below long term NHS average
  - below what’s needed to recover performance, cope with growing demand and transform the NHS

Average Annual NHS funding increases

- Blair and Brown 1997-2010: 6.0%
- Minimum to recover and transform: 5.0%
- Minimum to recover performance: 4.0%
- Long run NHS average 1948-2018: 3.7%
- This settlement: 3.4%
- Minimum to keep pace w demand/cost: 3.3%
- Cameron/May Governments 2015-17: 2.3%
- 2010-2018 funding rise: 1.4%
- Coalition Government 2010-2015: 1.1%

- = time series
- = this settlement
- = vs forecast demands
Current financial position for providers

**Year end**
- Planned deficit: £394m
- Forecast deficit: £661m
- Adjustments: +£256m

**Some key statistics....**
- 134 out of 230 in deficit
- £3.2bn savings forecast
- 1.6% productivity gain

Our guess: end of 2018/19 provider deficit to be around £1bn before adjustments
Signs of unsustainability wherever you look...

- Persistent ongoing provider sector deficit
- Number of trusts in deficit
- Scale of annual savings required
- “All kinds of wheezes” needed to hit provider control totals
- Restrictions on capital and size of capital / revenue switches
- Growing backlog maintenance
- And financial pressure growing on commissioning side as well
Financial outlook and questions going forward

Clear LTP commitment
• Return provider sector and as many providers as possible to surplus

Tough financial climate continues
• 2019/20 task looks easier for most ...but planning still in flight
• Keeping to 2019/20 capital limit looks difficult
• Too many priorities chasing too little money:
  o How to cope with settlement when we need to recover, meet extra demand and transform
  o How to match inflated LTP expectations to financial reality

Move to systems
• NHSE/I want to manage finances at STP/ICS level: how realistic is this?

Overspending systems / trusts
• How realistic is it for “heavily overspending” systems or trusts / FTs to return to surplus quickly?
What we will cover

- Political and external environment
- The NHS long term plan and system working
- Funding
- Quality and performance
- Workforce
- How providers are responding to a challenging environment
- The governor role
Quality and performance is under huge pressure

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<td><strong>Ambulance red 1 calls</strong> Standard: 75% responded to within eight minutes</td>
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<td>76%</td>
<td>72%</td>
<td>73%</td>
<td>69%</td>
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<td><strong>Ambulance category 1 calls</strong> Mean response time of seven minutes</td>
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<td><strong>A&amp;E</strong> Standard: 95% treated, admitted or discharged within four hours, all units</td>
<td>96%</td>
<td>96%</td>
<td>94%</td>
<td>92%</td>
<td>89%</td>
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<td>90%</td>
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<td><strong>Elective treatment</strong> Standard: 90% begin treatment within 18 weeks</td>
<td>94%</td>
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<td><strong>Cancer waiting time</strong> Standard: 85% of patients receive first treatment within 62 days following urgent referral from GP</td>
<td>87%</td>
<td>86%</td>
<td>83%</td>
<td>82%</td>
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<td>80%</td>
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<td><strong>Cancer waiting time</strong> Standard: 93% of patients to wait two weeks between an urgent GP referral and seeing a specialist</td>
<td>96%</td>
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Source: NHS England performance data

**Satisfaction with NHS 'hits 11-year low'**

By Nick Triggle
Health correspondent

7 March 2019

**A&E waits at worst level for 15 years in England**

By Nick Triggle
Health correspondent

14 February 2019

A&E waits in England have reached their worst level since the four-hour target was introduced in 2004.

Public satisfaction with the NHS has fallen to its lowest level for over a decade, a long-running survey suggests.

**Winter hits elective waiting times**

By Bob Ewing
14 February 2019

However, national waiting times policy has now reached the point where the NHS Constitution right to treatment within 18 week waits is simply unachievable, and attention has turned to stopping things
Winter, the real story?

• Many fewer negative media stories, less sense of crisis
• Bed occupancy high but not at same levels as last year
• Ambulance arrivals extremely high
• Efforts to improve patient flow appears to be having some effect (handover delays and length of stay considerably better than last year)
• Many report that better system working definitely having a positive impact
• But was the lack of media crisis due to Brexit focus or better performance: danger of false comfort?
• Do we really think these levels of performance are satisfactory or appropriate: what becomes new normal?
Overall, the quality of health and social care has been maintained or improved

Some providers coping better than others with pressures, and safety still at risk

Hospital & mental health pressures caused by struggling local system/social care. Quality is now an ‘integration lottery’

Five factors: 1) access; 2) quality; 3) workforce; 4) capacity; 5) funding & commissioning

NHS Long Term Plan funding will be wasted without long-term social care funding

Ratings: more good or outstanding than 16/17, moving from RI to Good getting more difficult
Reflections on CQC’s approach

• Cycle of member views on CQC approach
• Concerns about behaviours and attitudes of some inspection teams, and experience/seniority of some inspectors
• Worry about inconsistency in judgements
• Data returns continue to be burdensome
• Coordination with NHSE/I changes
• Is CQC’s sector-based approach keeping up with integration and new models of care?
• Narrative of a tougher stance e.g. prosecutions

• New chief inspectors of primary care and integration, and social care
  • Member roundtables and dinners
  • NHSP regulation survey coming soon
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</tbody>
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We now have a major workforce problem...

Vacancies
100,000 (8.5%) vacancies across the workforce; 39,000 (11%) nurse; 9,000 (7%) medical; and 52,000 (7%) other staff vacancies. Two recent acute trust visits: 20% nurse and 27% medical vacancy rates
LTP makes problem much bigger

Pressure, morale and retention
Latest (2018) staff survey shows over half worked unpaid hours; 28% report harassment/abuse from patients, 13% from managers and 19% from colleagues; 30% often think about leaving their organisation

Complex national architecture
Responsibility for workforce split between Ministers, DHSC, HEE, NHSE, NHSI etc. Several failed attempts to produce an honest, realistic, national workforce strategy

Domestic/international supply in doubt
Unclear how 25% nursing student increase delivered given placement funding uncertainty & lower # applicant. Mature student # down; smaller courses in doubt.
Ongoing uncertainty with impact of Brexit. New Government migration policy and £30k annual “skilled” salary cap.
Solving it will take time....

• National workforce plan being produced:
  - Inclusive of all major national workforce stakeholders
  - Focus on the nursing and midwifery workforce
  - Quick wins for 2019/20 and long term
  - Emphasis on leadership and workforce architecture

• Some encouraging signs:
  - Focus on NHS as “great place to work”
  - Emphasis on improving leadership
  - Recognition that we have start with nursing crisis
  - Welcome recognition that this isn’t just about more staff and more money...important though these are
  - Devolving more to STPs/ICSs and trusts...but with money and resource
  - But we must be realistic about speed of getting into a deep hole and long term
An overall RAG rated current NHS report card

| Vision | • Good, clear, forward vision that entire NHS can align with…
|        | • …Though needs prioritised delivery framework, and then delivery at scale and pace |
| System working | • Sensible vision to move to integrated local health and care systems
|        | • But we haven’t yet fully thought through how we align this with existing law which gives responsibility and accountability to FTs/trusts – work arounds means risk |
| Funding | • Recent NHS funding settlement just returns NHS to long term trend growth…insufficient to meet demand, recover performance & transform
|        | • Long term plan ambitions look misaligned with financial settlement envelope |
| Quality and performance | • Patient experience is holding up thanks to staff commitment and there is evidence of improved outcomes for some services
|        | • But performance on access is a long way behind constitutional standards…and will take significant time, extra workforce & funding to recover |
| Workforce | • We have a major workforce problem we’ve been slow to address …
<p>|        | • …It will take significant time to solve and the scale is so great and the context so challenging it’s unlikely to be soluble using existing approaches |</p>
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Working beyond the immediate organisational boundaries

**Collaborating horizontally with neighbours (often of a similar type)**

- Trusts clubbing together on procurement / back office services (West Yorks acutes)
- Mergers (Birmingham), Groups (Essex and Royal Free), and now crossing sector boundaries (Somerset and Cumbria)
- Reconfiguring and / or sharing services to eliminate inefficient duplication (Manchester, Black Country and South London Mental Health)

**Collaborating vertically on the immediate patch with the rest of health and social care**

- Primary care: acquiring GPs (Wolverhampton) or supporting networks/federations (Yeovil & Northumbria)
- Commissioning social care and taking responsibility for Council social care services (Salford)
- Seeking new integrated structural models (Dudley)

**Horizontal integration**

**Vertical integration**
Many trusts have given up waiting for central solutions...

...and are now seeking to do a lot more for themselves. The more difficult the trust’s problems, the more innovation and effort in play.

Short term: overseas recruitment; agency/collaborative bank use; innovative use of new roles; aggressive marketing to attract; thinking harder about retention; flexible working; thinking laterally e.g. part roles.

Long term: rethinking the employment offer especially for younger staff; links with local universities / colleges; sweat the Apprenticeship Levy;

Very long term: promoting careers in local schools to grow your own long term workforce.

Risks: zero sum poaching game with the neighbours; loss of potential economies of scale by not working together; effort / distraction involved; denuding the social care workforce.

Taking more local action on workforce issues....
Supporting improvement internally...

• Investment in better use of technology for patients, staff and the trust (Global Digital Exemplars)

• Ongoing efficiency programmes (Get It Right First Time – GIRFT)

• Dedicated staff driven improvement programmes (Virginia Mason Institute and Western Sussex approaches to introducing quality improvement methodology trust wide)

• Close engagement with patients and service users, the public and the council of governors

• Focussing on improving culture and building leadership capacity and capability
## Ten Things We Are Learning From All This Change

| 1. New, exciting and different things are starting to happen at scale and pace |
| 2. At local level we are moving from a cookie cutter NHS to a variegated one |
| 3. This is more complicated and difficult than we thought |
| 4. It will take much longer than we thought: 5 to 15 years, not 3 to 5 years |
| 5. Clear evidence on ability to rapidly improve patient outcomes |
| 6. Little evidence on rapid and significant efficiency savings |
| 7. Work needed on enablers: data; contracting; funding; governance models etc |
| 8. Amount that needs to change is much larger than anticipated |
| 9. Existing system framework - money, regulation, perf. mgmt. - prevents change |
| 10. Alignment across currently separate institutions is key but challenging |
The challenge of the current context

The size and number of current challenges and the current lack of leadership bandwidth are strong pressures impelling trusts to run harder and harder within the existing model. This is unsustainable. Though it may take some time to realise that!

BUT...

Change is difficult, particularly if...you are under huge operational pressure, you have to work with others in a local system, there are lots of different possible changes to pursue, and leadership bandwidth is at a real premium.
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The governor role in today’s climate

- Getting the governor support / challenge balance right
- Help engage the public in transforming care, while providing assurance
- Assure yourself that the Board has right balance between operational and strategic
- Running harder within existing model vs heading for a new one
- Being cognisant of balance between institutional versus system focus for Boards
- Maintaining positivity and optimism in face of growing challenge – continue to act as an advocate
Q&A

THANK YOU

chris.hopson@nhsproviders.org
Refreshments, Showcase and networking
Introduction to the Governor Advisory Committee

• Mark Price, Member Development Manager, NHS Providers
Governor Support Programme

- Governor focus conference
- GovernWell training – open and bespoke courses
- Regional workshops
- Governor focus newsletter
- Website information
- Signposting
- Ad hoc telephone/email enquiries
Governor Advisory Committee

• Elected 2018 for 3 years
• Membership
• Chair/Deputy Chair
• Serving governor
• Representative roles
• Frequency of meetings
• ...but not just about meetings!
Governor Advisory Committee

• Guides the governor support programme

• Advises on our support offer to ensure it meets the needs of our members

• Provides intelligence on governor issues
Governor Advisory Committee

• Peter Abell, Chair
Governor Advisory Committee

- **Peter Abell**, Doncaster and Bassetlaw Teaching Hospitals NHS FT – acute services constituency
- **Robert Alabaster**, North East Ambulance Service NHS FT – ambulance services constituency
- **Alison Fisher**, Dorset Healthcare University NHS FT - public governor constituency
- **Maurice Alston**, Hampshire Hospitals NHS FT – any category constituency
- **John Jones**, Essex Partnership University NHS FT – mental health services constituency
- **Anne Carlile**, Northumberland, Tyne and Wear NHS FT – patient/carer/service user constituency (and **Deputy Chair**)
Governor Advisory Committee

- **Pauline Garnett**, Bradford Teaching Hospital NHS FT – staff governor constituency
- **Chris Roberts**, Oxford Health NHS FT – community services constituency
- **Suzy Brain England OBE**, chair, Doncaster and Bassetlaw Teaching Hospitals NHS FT – chair representative
- **Dean Fathers**, chair, Nottinghamshire Healthcare NHS FT – chair representative
- **Saffron Cordery**, deputy chief executive, NHS Providers (non voting member)
Roundtable discussion

- What sources of information and evidence do you use in your current role as a governor?
- What is the future role of the governor?
Lunch, Showcase and networking
Roundtable feedback

What sources of information and evidence do you use in your current role as a governor?

- Council of Governors and board papers
- Press and social media - websites/intranet
- Talking to trust staff – formal and informal
- Attendance at committees/public meetings
- Inductions & buddying
- Partnerships eg Healthwatch
- Trust constitution
- Patient and member meetings
- Survey data eg Friends and Family Test
Roundtable feedback

What is the future role of the governor?
• Partnership working
• Understanding the local health and care system and balance with own trust. Potential conflict.
• Working with non FT trusts that don’t have Governors and CCG lay reps
• Recruiting Governors from varied backgrounds, and younger Governors
• Getting messages out to the public
• Governor involvement in change
• More training, strengthening holding to account
• Ensuring parity of care
The NHS Providers Governor Focus Conference
9th May 2019
Imelda Redmond, National Director, Healthwatch England
Healthwatch England
Established by 2012 Health and Social Care Act

- Our role is to ensure that the voice of the public is heard in the planning, design and delivery of health and care services

- We listen to public feedback and use this to help the system make good decisions

- We work right across all of health and all of social care services
There are 152 Healthwatch - 1 in every local authority area in the country

Statutory place on Health and Wellbeing Boards

Carry out incredible work

We have over 6000 volunteers
Primary Care

Our contribution to the development of the Long Term Plan:

- We contributed to most workstreams and have a place on the Engagement and the Clinical Priorities workstreams - both continue to meet regularly

- Tight timescale to produce the plan and so we concentrated on the insight we already had from the public to inform the plan

- We fed in 85,000 people experiences of using services
45,000 people’s views on primary care services including GPs, dentists and community pharmacies

Main themes

- Improving access
- Continuity of Care
- Technological solutions that work for people
Main themes

- Struggling to find information about the support available
- Mental and physical health needs being treated in isolation
- Waiting too long to access mental health services and receive diagnosis
- Professionals who are not specialists in mental health not always having the awareness, information or training they need to recognise and respond to people’s mental health challenges
- Not feeling listened to or involved in decisions that affect them
- People expressed desire for more peer to peer support
Main themes

- The most common issue is dissatisfaction with the quality of care and treatment.
- Poor staff attitudes and issues with communication comes second with people noting that the staff are under pressure.
  - How they were triaged really matters more than the 4 hour wait.
  - Those who are triaged on arrival and have the next steps explained to them are more positive, even if they face a long wait.
  - Whether or not they were then told how long they might have to wait.
- Local Healthwatch work suggests anywhere between a third and two-thirds of those attending A&E are not given any indication of how long they may have to wait. This causes understandable frustration.
- Whether they were kept updated if things changed due to other circumstances – e.g. more urgent cases arriving.
Main themes

- A lack of access to services
- A lack of holistic support
- Struggling to find information about the support available
- Generally, the insight showed that access to health services is impeded by solvable bureaucratic factors around homelessness such as:
  - Lack of address
  - Lack of identification
  - Lack of phone credit
  - Primary care - particularly problems registering
  - Poor treatment in hospitals
  - Lack of joined up physical and mental health services

Homeless People
766 homeless people’s experiences of the NHS
Main themes

- Many people don’t know how care is funded and expect it will be free at the point of use.
- Most people have given 'little thought' to their future care needs.
- Individuals want to know if a care service is safe, will meet their needs and the comparative cost.
- Many people don’t know where to go for information to help them plan.
- People want a reliable and trustworthy source for advice on social care.
- Great difficulty in finding services even if you pay for them.
Main themes

- So does the plan respond to these priorities?
- Good on:
  - Increase funding for primary and community care services by £4.5bn so more people have access to high quality care closer to your home.
  - Focus on prevention, health inequalities and population health
  - Public health is under funded: £700m removed from their budget
  - Focus on personalisation and the publication of “Getting Serious About Personalisation in the NHS”
- Expansion of personal health budgets
- Growth in social prescribing
- Focus on people and communities as assets
- Prevent crisis
- Greater support for preventative measures - focus on selfcare e.g. diabetes, asthma
✓ Tech agenda

➢ helping more people to access advice and care in a timely way
➢ Reduction in outpatient attendance
➢ Digital first - will be great for many
✘ But we must plan for the public who are heavy users of services but are not able to access services digitally
➢ Personal Health Records - allowing better sharing of information and greater ownership by the patient and carer
✓ Primary Care Networks
  ➢ Will make a range of services more accessible with pharmacacies, community nurses, physios, social care and the voluntary sector joining up

✓ Carers’ Support
  ➢ Better recognition of the role and support needs of carers
  ➢ Identification of carers and plans to support their health needs

✗ Much of carers’ support comes through local government and cash-strapped councils have had to cut support
✓ **Mental Health**
  - Good focus on maternity and mental health
  - Children and young people’s mental health needs recognised with a commitment to supporting 345,000 children and young people by 2023/4 via CAMHS with a commitment to supporting 100% of young people with mental health needs
  - Flexibility in age range now up to 25
  - Target for mental health to have parity with physical health

✓ **Care Homes**
  - Care homes to be supported by a consistent team of healthcare professionals with a named GP
  - People will be helped to have good oral health and stay well hydrated and nourished
Supporting Homeless People
- Extra £30 million for mental health support

Children and Young People’s Health
- Much greater emphasis on CYP health than previously with a focus on autism, learning difficulties
- Children with complex needs will be assigned a key worker
Greater Support for Older people - Ageing Well

- Professionals to work together and provide tailored support to help people live well and independently at home for longer
- Give older people and family more say about the care and support we choose and receive, particularly towards the end of our lives
- Develop more rapid community response teams which provide timely care to prevent unnecessary admissions to hospital, help people leave hospital sooner and recover better and faster with support in their communities
- Further improve care for people with dementia, or delirium, whether they are in hospital or at home

Workforce - to be published later

- We will need a different type of workforce to deliver on these ambitions; flexible, person centred, community based with different skill sets
What Next?

Healthwatch across the country are contributing to the development of next steps

- Every Healthwatch in the country is running engagement events and working closely in partnership with the regional Integrated Care System/organisations
- We have so far received over 18,000 responses to surveys asking people what would help them engage with services
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National Director
Healthwatch England

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Workforce race equality in the NHS

Yvonne Coghill and Habib Naqvi
NHS England

9 May 2019
The NHS Constitution

The NHS belongs to the people.

It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.
The 1st Principle of the NHS Constitution

The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to diagnose, treat and improve both physical and mental health. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.
Race inequality: a global challenge

There is irrefutable evidence globally that people from black and minority ethnic backgrounds (BME) that live in white majority countries like the US, UK, Canada, Australia and New Zealand have poorer life chances and experiences compared to their white counterparts.

Across all indicators BME folk, in general, are more likely to:

- Health – get chronic diseases and die sooner
- Wealth – make less money over their life course
- Housing – live in poorer areas and accommodation
- Judiciary – to be convicted and imprisoned
- Employment – have poorer experiences and opportunities in the workplace
Black and Minority Ethnic (BME) staff in the NHS – scale of the challenge

- 1.4 million people work in the NHS
- 20% staff from BME backgrounds
- 28% GPs from BME backgrounds
- 40% of Hospital Doctors are from BME backgrounds
- 21% Nurses and Midwives (qualified and unqualified) rising to more than 50% in London

But...

- 8 BME CEOs (from ~231 Trusts)
- 9 Chairs
- 10 Directors of Nursing
- 37 Medical Directors
- Less than 6% very senior managers from BME backgrounds
- 7% BME board representation

This is a significantly improved position from 3 years ago.
Discrimination by protected characteristic

In the 2017 survey there were 55,535 staff who reported experiencing discrimination at work.

Ethnicity has consistently been the most commonly reported reason for discrimination across the last five years.
Biological Weathering – Arline Geronimous

• Chronological age captures duration of exposure to risks for groups living in adverse living conditions

• Blacks are experiencing greater physiological wear and tear, and are aging, biologically, more rapidly than whites

• It is driven by the cumulative impact of repeated exposures to psychological, social, physical and chemical stressors in their residential, occupational and other environments, and coping with these stressors

• Compared to whites, blacks experience higher levels of stressors, greater clustering of stressors, and probably greater duration and intensity of stressors
Micro assaults, stressors or aggressions

Being the only BME person in a room

Not being able to readily get the products for your hair and skin

Not seeing many people that look like you on billboards, magazines and Journals or on TV, few role models

Feeling ‘other’ as your cultural norms are different

Receiving a reduced service in healthcare and in society generally

Knowing that you have to be twice as good to go half as far

People not believing you or your lived experience
The consequences for people

- Disillusionment
- Unhappiness
- Depression
- Lack of confidence
- Anger/Rage
- Lack of belief in the system
- Lack of engagement and buy in
- Resentment
- Influences performance

**Impact on patient care…!**
More BME staff are unsatisfied with the outcome of workplace investigations than white staff (40%:27%)
BME staff are more likely to be victimised by management than white staff (21%:12.5%)
BME staff are less likely to be praised by management after raising a concern than white staff (3%:7.2%)
BME staff are more likely than white staff to not raise a concern for fear of victimisation (24%:13%)

Impact on patient care...!
The reasons for tackling workforce race inequality in the NHS

MORAL CASES
• Treating everyone regardless of background with respect and fairness is the right thing to do

THE LEGAL
• The Equality Act 2010 states that all public sector bodies have a duty to promote equality and inclusion

THE FINANCIAL CASE
• Equality and inclusion saves money

THE QUALITY CASE
• Helps ensure high quality care, patient satisfaction and patient safety
• Link between staff satisfaction and patient outcomes
NHS boss Simon Stevens criticises lack of diversity in management

New chief executive says there is a lack of managers from black and ethnic minority backgrounds involved in running hospitals

"It can't be right that 10 years after the launch of the NHS race-equality plan, while 41% of NHS staff in London are from black and ethnic minority backgrounds, similar in proportion to the Londoners they serve, only 8% of trust board directors are, with two-fifths of London trust boards having no BME directors at all.

"Similar patterns apply elsewhere, and have actually been going backwards," Stevens."
# WRES indicators

<table>
<thead>
<tr>
<th>Indicator 1</th>
<th>Indicator 2</th>
<th>Indicator 3</th>
<th>Indicator 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM compared with the percentage of staff in the overall workforce</td>
<td>• Relative likelihood of BME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts</td>
<td>• Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process</td>
<td>• Relative likelihood of BME staff accessing non mandatory training and CPD as compared to white staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator 5</th>
<th>Indicator 6</th>
<th>Indicator 7</th>
<th>Indicator 8</th>
<th>Indicator 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>• KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>• KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>• KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion</td>
<td>• Q17.. In the last 12 months have you personally experienced discrimination at work?</td>
<td>• Percentage difference between the organisations’ Board membership and its overall workforce</td>
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</tbody>
</table>
## WRES data for all NHS trusts in England: 2016 to 2018 comparison

<table>
<thead>
<tr>
<th>Indicator Type</th>
<th>WRES Indicator</th>
<th>Metric Description</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Direction</th>
<th>2018 National</th>
</tr>
</thead>
<tbody>
<tr>
<td>WORKFORCE</td>
<td>2</td>
<td>Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts</td>
<td>1.66</td>
<td>1.69</td>
<td>0.87</td>
<td>↓</td>
<td>1.45</td>
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<tr>
<td></td>
<td>3</td>
<td>Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process.</td>
<td>1.57</td>
<td>3.41</td>
<td>1.92</td>
<td>↓</td>
<td>1.25</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff</td>
<td>1.07</td>
<td>0.75</td>
<td>1.01</td>
<td>↑</td>
<td>1.15</td>
</tr>
<tr>
<td>STAFFS URVEY</td>
<td>5</td>
<td>KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.</td>
<td>25.2%</td>
<td>25.4%</td>
<td>31.0%</td>
<td>↑</td>
<td>28.7%</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.</td>
<td>23.9%</td>
<td>14.6%</td>
<td>20.7%</td>
<td>↑</td>
<td>27.8%</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.</td>
<td>80.0%</td>
<td>78.0%</td>
<td>73.2%</td>
<td>↓</td>
<td>71.4%</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Q17. In the last 12 months have you personally experienced discrimination at work?</td>
<td>12.1%</td>
<td>8.9%</td>
<td>12.2%</td>
<td>↑</td>
<td>15.0%</td>
</tr>
<tr>
<td>BOARD</td>
<td>9</td>
<td>Percentage of BME Board membership</td>
<td>-</td>
<td>0.0%</td>
<td>0.0%</td>
<td>↓</td>
<td>7.0%</td>
</tr>
</tbody>
</table>
WRES strategic approach towards workforce representation

Exclusive: Regulator tells trusts to set diversity targets

By Annabelle Collins

NHS organisations will have to set their own targets for black and minority ethnic representation across leadership teams and the broader workforce in NHS Improvement’s new workforce equality strategy.
The NHS Long Term Plan and WRES

- Respect, equality and diversity will be central to changing the culture and will be at the heart of the workforce implementation plan.

- Through the WRES, we are making progress in addressing these issues from the perspective of BME staff.

- Working with the WRES team, each NHS organisation will set its own target for BME representation across its leadership team and broader workforce.

- This will help ensure senior teams and boards more closely represent the diversity of the workforce and local communities they serve.
WRES support for delivery of the aspirational goals

- Leadership and cultural transformation
- Positive action and practical support
- Accountability and assurance
- Monitoring progress and benchmarking

Representative workforce at all levels across the NHS
NELFT Ethnic Minority Staff Network 2020 strategy – Stronger together.

- BME staff representation on interview panels for all Band 8a and above.
- Management and leadership training for BME staff at Band 6 and 7.
- Anti – discriminatory training for interviewers.
- Support non BME managers when dealing with grievances and disciplinary cases.
- Embed equality and celebration of diversity in the Trust - include equality in appraisals (not just race).
- Mentoring/reverse mentoring – all board members to mentor a BME staff member.
- Pledge to have an Associate BME board member until there is an executive BME board member.
- Recommend/bring a friend to NELFT.
### NELFT BME Staff compared to white staff

<table>
<thead>
<tr>
<th>Organisations name</th>
<th>Indicator 5</th>
<th>Indicator 6</th>
<th>Indicator 7</th>
<th>Indicator 8</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
<td>BME</td>
<td>White</td>
<td>BME</td>
</tr>
<tr>
<td>NORTH EAST LONDON NHS FOUNDATION TRUST</td>
<td>24.2%</td>
<td>29.8%</td>
<td>16.3%</td>
<td>19.5%</td>
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<tr>
<td>BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST</td>
<td>30.1%</td>
<td>37.8%</td>
<td>24.4%</td>
<td>30.5%</td>
</tr>
<tr>
<td>CAMDEN AND ISLINGTON NHS FOUNDATION TRUST</td>
<td>34.2%</td>
<td>41.1%</td>
<td>19.0%</td>
<td>27.3%</td>
</tr>
<tr>
<td>CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST</td>
<td>29.4%</td>
<td>31.9%</td>
<td>23.3%</td>
<td>26.5%</td>
</tr>
<tr>
<td>EAST LONDON NHS FOUNDATION TRUST</td>
<td>28.9%</td>
<td>32.6%</td>
<td>23.2%</td>
<td>22.6%</td>
</tr>
<tr>
<td>OXLEAS NHS FOUNDATION TRUST</td>
<td>29.8%</td>
<td>41.2%</td>
<td>17.0%</td>
<td>26.5%</td>
</tr>
<tr>
<td>SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST</td>
<td>32.6%</td>
<td>34.5%</td>
<td>22.6%</td>
<td>26.5%</td>
</tr>
<tr>
<td>SOUTH WEST LONDON AND ST GEORGE’S MENTAL HEALTH NHS TRUST</td>
<td>30.3%</td>
<td>32.9%</td>
<td>22.6%</td>
<td>30.2%</td>
</tr>
<tr>
<td>TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST</td>
<td>21.8%</td>
<td>24.3%</td>
<td>15.9%</td>
<td>31.5%</td>
</tr>
<tr>
<td>WEST LONDON MENTAL HEALTH NHS TRUST</td>
<td>29.6%</td>
<td>36.1%</td>
<td>27.2%</td>
<td>30.4%</td>
</tr>
<tr>
<td>Peer Trusts Median</td>
<td>29.7%</td>
<td>33.7%</td>
<td>22.6%</td>
<td>26.9%</td>
</tr>
</tbody>
</table>

**NELFT white staff have a better experience than white staff at peer Trusts.**
Compassionate leadership: being comfortable with the uncomfortable...
Resources and further information

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Closing remarks

Please fill in our evaluation form:
https://www.smartsurvey.co.uk/s/GF2019/