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NHS Providers response: Liberal Democrat health and social care consultation paper 139

About NHS Providers

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in membership, collectively accounting for £84bn of annual expenditure and employing more than one million staff.

Our submission

We welcome the opportunity to submit to the Liberal Democrat health and social care consultation paper 139. We have not responded to all questions in the document and instead have focused our response on the most pressing concerns for the provider sector including: workforce, prevention, integrated care, funding for social care and mental health services.

Key messages

- Workforce is the number one concern for trusts, with over 100,000 vacancies across the sector. The interim NHS People Plan is welcome and is the first, clear, public recognition from our national system leaders of the severity of the workforce challenges the NHS faces. As we look ahead to the spending review and the publication of the final NHS People Plan in the autumn, we would like to see appropriate funding for education and training and issues around domestic supply addressed in more detail. We would also like to see additional funding for continued professional development; clarity over financial support and targets for international recruitment; and revisions to the apprenticeship levy.
- The funding shortfall for public health services needs to be addressed urgently. Local authorities have been forced to reduce spending and cut public health services, as well as other services that promote health and wellbeing – such as leisure facilities, libraries and access to green spaces – in order to fund other statutory duties, including adult social care. This means much has already been lost in the way of local authorities' financial capability to support a holistic and tailored approach to population health management.
- We welcome the move towards local system working and integrated health and care services. In developing approaches to system working – such as sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) – it will remain important to take into account the continuing

accountabilities of their constituent organisations, notably, trusts, clinical commissioning groups (CCGs) and local authorities.

- The NHS and social care are two sides of the same coin and we must invest appropriately in both if people are to access the support they need. Social care eligibility needs to be based on need and widened to make sure that those with unmet or under-met need have access to appropriate care and support. However, adult social care services are facing a funding gap of £3.6bn by 2025. There is a growing workforce gap due to low pay, working conditions and lack of job security. Addressing this situation means a new settlement is needed in order to provide secure, long-term, funding at a level to enable the social care system to operate effectively and deliver the care that people need.
- Mental health services continue to face significant challenges, including rising demand, enduring shortages in the workforce, constrained mental health funding and the impact of cuts to wider public services. Consequently there is a substantial care deficit in mental health that must be addressed, with unmet need for a number of conditions – particularly relating to community services for adults and children, gender identity services and crisis home treatment teams – and NHS commissioning decisions have often resulted in services being cut or reduced.

NHS and social care staff

Workforce issues are the number one concern for NHS foundation trusts and trusts. There are currently over 100,000 vacancies in the provider sector alone, a number which is predicted to grow in the coming years without urgent and significant policy reform.1 The impact of providers' difficulties in recruiting and retaining sufficient staff numbers is significant. Two thirds of nurses say they cannot do their job properly due to understaffing[2]. Safe and effective staffing levels are crucial to maintaining morale as well as safe and effective care. Data from the NHS staff survey and recent workforce statistics paint a picture of significant pressures on staff satisfaction compounded not only by rates of pay but also staffing levels, poor staff morale and work-related stress or poor work/life balance.

A long term workforce strategy

The interim NHS people plan (published in June 2019) is the first, clear, public recognition from our national leaders of the severity of the service's workforce challenge. It is a welcome statement, helpfully acknowledging that, alongside better workforce planning and increased funding, we need to look at culture and behaviours, with the government, arm's length bodies and the frontline having a key part to play here.

The interim plan makes clear that to ensure a sustainable workforce the NHS must:

- Become a better place to work, with the "new offer to staff" developed by the government providing the conditions for legitimate career flexibility and improved work-life balance.

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[1] NHS Improvement, *Performance of the NHS provider sector for the quarter ended 31 December 2018* (March 2019), https://improvement.nhs.uk/documents/4942/Performance_of_the_NHS_provider_sector_for_the_quarter_ended_31_Dec_2018.pdf

[2] https://www.unison.org.uk/content/uploads/2017/04/Rationotrationing.pdf

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- Be able to increase its recruitment of staff from abroad to plug gaps in the short-term given the considerable time it will take to expand the "home-grown" workforce.
- Receive significant investment from the spending review to expand clinical education and training budgets; and
- Receive support from HM Treasury, the Home Office and other departments across government to remove barriers to recruitment and retention, including addressing distortionary pension tax rules; apprenticeship levy limitations; and immigration restrictions.

A detailed framework and clear funding settlement are now needed in order to take these priorities forward.

Addressing recruitment and retention

Only 22% of respondents to the 2018 NHS staff survey reported they 'never' or 'rarely' suffered from unrealistic time pressures in their jobs. The interim people plan is correct in stating that "the culture of the NHS is being negatively impacted by the fact that our people are overstretched".

In the difficult environment facing NHS providers and their staff, trusts are innovating to seek to improve health, wellbeing and work-life balance. Examples include trusts:

- Employing a staff support chaplain to provide free pastoral care and counselling to those affected by stress, anxiety or depression.
- Collaborating with the local council to offer free housing to 24 junior doctors.
- Introducing flexible working schemes, including an option for some staff to take on term-time only working.
- Providing other additional benefits, such as annual leave on staff birthdays.

However, the only way to solve morale and retention issues in any meaningful way is a significant increase in the number of staff working in the NHS. Although our response focuses on the NHS workforce in particular, we are mindful that similar action needs to be taken to recruit and retain staff in social care roles. The primary short term solution to increasing supply would be to ensure immigration policy enables the health and social care sectors to recruit sufficient staff from the EEA and internationally. As well as adopting a positive approach to recruiting health and care staff within the UK immigration rules, a level of coordinated support from the national level could help those trusts who have been less successful or historically active in recruiting from abroad. It would also be helpful for any government to consider an offer of financial support for both trusts and prospective new staff who face a number of cost barriers to migration.

Alongside this, to increase supply, any government needs to work with trusts, universities and unions to ensure the planned 25% increase in nursing student places are filled, as well as fast-tracking development and regulation of new roles and remove trusts' barriers to apprenticeships funding. Removing return to work barriers would also be a positive step forward. Significant barriers remain in place where recent leavers might consider a return to working the NHS. More flexibility in re-training and appraisal for

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experienced staff would benefit both experienced nurses and hospital consultants, while changes to pension rules and other incentives should be considered to encourage early retirees back into practice.

Pay, terms and conditions also need to be addressed. The NHS is dependent on the efforts of clinical and non-clinical staff which frequently go above and beyond the call of duty as they respond to increasing service demand. Staff must be appropriately and fairly rewarded in order to support recruitment and retention and help create a motivated workforce. Prior to the latest Agenda for Change agreement, with a prolonged period of restraint, NHS pay had not kept pace with the wider economy and inflation.[3] This regression needs to be addressed, alongside reform to NHS pensions in order to retain NHS staff and ensure long-term scheme viability. Pension tax charges must be reformed as part of efforts to retain valued, experienced staff while protecting future benefits for all NHS workers. For this reason we welcome the cross government initiative to review pensions policy.

Starting well and keeping well

Good health is supported not just by health services and social care, but also by access to green spaces, leisure activities, libraries, education, and accessible public transport. Many local authorities have been forced to reduce spending and cut services across these areas in order to fund their statutory duties, including in respect of adult social care and social services. Much has already therefore been lost in the way of local authorities' financial capability to support a holistic and tailored approach to population health.

The central government public health grant has been reduced by £531 million between 2015/16 and 2019/20. This has a direct impact on how much local authorities spend on public health – 85% of councils reported reducing their spending on core public health services in 2017/18 and like-for-like spending on public health services was 8% lower in 2017/18 compared to in 2013/14.[4]

The shortfall local authorities are facing in funding public health services needs to be urgently addressed. In order for local authorities to continue to effectively deliver public health services, funding should be restored in order to support a long-term commitment to prevention.

Intensive users of services

Integration of health and social care

The NHS long term plan consolidates the national policy direction since 2014's Five year forward view in placing an emphasis on system working as the key driver of change and improvement in the NHS. The opportunity to increase collaboration and develop more integrated services is welcome, but in doing so it

[3] For example, the Health Foundation found that between 2008/09 and 2015/16 the basic pay of NHS staff fell by 6% in real terms. Health Foundation, *In short supply: Pay policy and nurse numbers* (April 2017) https://www.health.org.uk/sites/default/files/Workforce%20pressure%20points%202017%20FINAL_0.pdf

[4] https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/spending-public-health

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is important to ensure that any descriptions of the role and accountability of systems are clear and properly reflect the NHS legislative framework. This means being explicit about the fact that integrated care systems (ICSs) / sustainability and transformation partnerships (STPs) are the sum of their component, statutory, parts (clinical commissioning groups [CCGs], local authorities, NHS foundation trusts and trusts, and primary care colleagues and other local health and care organisations).

Each part of the system, given its decision-making powers, needs to be held answerable and accountable for those decisions. Without this recognition, in practice it means that responsibility may be confusingly dispersed and patients, service users and local communities lack routes of recourse. We would also note that evidence from the private and public sectors suggests that unitary boards –the governance mechanism within trusts – provide the best vehicle for good corporate governance because they combine an independent perspective with detailed knowledge of the organisation in setting strategy and culture, in oversight of the work of the executive and in being accountable to stakeholders.[5] The fact that the unitary board is responsible and accountable for everything that happens within the trust brings vital clarity in an environment which contains a significant amount of risk.

The ongoing consolidation of CCGs creates both challenges and opportunities for providers. NHS Providers welcomes the more strategic role this will allow CCGs to play and the potential for providers to take on some activities previously undertaken by CCGs. However, in some local systems, changes to commissioning structures will mean disruption and the need to quickly build new relationships. Trusts will also wish to ensure they have a full seat at the system partnership board, if the partnership board is hosted by the local CCG.

Increasing oversight of new emerging structures

As local systems develop their STPs and move towards gaining ICS status, there is a need for flexibility in the application of regulation and oversight during this transition. This is important because the consequence of contributing to a system-level plan may be that some individual organisations are disadvantaged or advantaged. The potential risks and gains need to be shared appropriately across organisations and monitored at a system level. Trusts which are facing performance issues will particularly need flexibility from the regulators to balance system responsibilities with requirements to improve organisational finance and performance.

As ICSs are not statutory bodies, it remains the case that any regulatory intervention or enforcement action can only be taken at individual organisation level. It is crucial that system oversight does not add an extra layer of performance management or burden, and that trusts and their local partners are not subject to multiple judgements.

It is also crucial that the national bodies and regulators agree a shared view of quality across a system and are aligned and coordinated in how they assess quality and offer support to local areas. There is much that

[5] See https://nhsproviders.org/we-still-need-to-talk-about-boards for further detail.

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the national bodies can learn from the CQC's programme of local system reviews – for example, some providers have noted that a benefit of the system reviews is the focus on improvement, as opposed to performance management or pleasing the regulator, because the CQC cannot take regulatory action against systems. Successful development of collective responsibility will depend in part on the relationships and trust developed between trusts, CCGs and the new regional directors. It is essential that there are clear lines of responsibility, accountability and decision making but this clarity seems unlikely given the transitional nature of current and proposed governance structures and legislation.

Funding for social care

The NHS and social care are two sides of the same coin and we must invest appropriately in both if people are to access the health and care support they need. The growing gap between the demand for social care services and the funding available needs to be closed.

There are a number of options for funding an increase in the adult social care budget, including changes to tax contributions, a social care premium, and changes to the self-funding model. The merits and drawbacks of these have been explored at length across numerous publications over the last five years. The choice of which option to pursue is ultimately a political decision for the government to take. However, the Health for Care coalition – of which NHS Providers is a member – has set out a number of principles which any settlement for adult social care should meet:

- Eligibility should be based on need and must be widened to make sure that those with unmet or under-met need have access to appropriate care and support
- Any settlement should provide secure, long-term funding at a local level to enable the social care system to operate effectively and deliver the outcomes that people want and need, addressing immediate needs from April 2020 as well as putting the sector on a sustainable path for the longer term.
- Social care funding would need to rise by 3.9% a year to meet the needs of an ageing population and increasing numbers of younger adults living with disabilities, and any additional funds must be accompanied by reform and improved service delivery.

Mental health

We support the general direction and aspirations of the Liberal Democrat's policy proposals around mental health. Despite the welcome progress that has been made in recent years, our research shows the sector continues to face significant challenges which are contributing to and maintaining a significant 'care deficit' across mental health services. These include rising demand, an enduring workforce shortage, constrained mental health funding and the impact of cuts to wider public services.

The mental health workforce

Action on workforce is a top priority and so the ambitions to increase mental health staffing and ensure GPs receive core mental health training are welcome. The success of other proposals, such as introducing

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24-hour services including mental health liaison teams in all hospitals, hinges on having the right workforce, with the right skills, in the right place.

Plans must be underpinned by a coherent and credible approach to national workforce planning that does not focus solely on numbers of staff, but also their skill mix and quality. Plans must also address geographic challenges; some parts of the country are harder to recruit to, which exacerbates issues of inequalities, deprivation and mental health.

Given training staff has a significant lead-in time, short-term solutions to address current shortages are also required, such as increasing the availability of clinical placement funding for undergraduate mental health students, and creating workforce development funding and offering more flexible working arrangements for existing staff. Reducing CPD for current staff has had a particularly negative impact and means that training time and specific skills development does not take place.

Waiting time standards

The ambitions around waiting time standards for all mental health services are welcome. More standards would bring greater transparency and parity of funding, along with better outcomes and experiences for service users. However, new standards would need to be introduced in a phased approach and coupled with adequate funding and resources. Our research suggests that providers are not yet receiving sufficient funding to ensure provision that meets current access targets.

It is also important to stress that access and waiting times are only a small part of the whole system; a focus on these standards should not come at the expense of resources and care for those receiving care in the community and those with severe and enduring mental ill health. A focus on waiting times risks skewing investment and focus away from certain parts of the care pathway. We need to consider the whole care pathway not just areas that lend themselves to measurement and thus waiting times. The general lack of IT support and information collection in mental health services is a key barrier that needs to be overcome.

Increasing hospital bed availability

We support ambitions to make more hospitals beds available and improve patient flow. Demand for community, mental health and hospital services is increasing which makes investment in both community based services, which enable people to receive support in their own homes, and in inpatient care, crucial. Careful demand and capacity planning needs to be undertaken, with input from trusts, commissioners and the national bodies, to ensure general and specialist beds are available where they are needed geographically across the country, and to close key gaps in provision for certain services – children and adolescent mental health for example .

Feedback from trusts shows pressure does not only come from demand and access, but also from an increasing severity and complexity of individuals' conditions, which may well be partly attributable to people having to wait longer to access the services they need. This is clearly the case for mental health services where the increasing use of Mental Health Act powers indicates the increasing severity of patients

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before admission. We have seen a reduction in lower severity mental health support services, particularly with local authority funding, which means patients only come to the attention of services when they are in crisis. This is particularly an issue for young men from the BAME population who do not have contact with other services.

Improving community based crisis services and alternatives to hospital admission should therefore also be developed alongside any consideration of increasing beds. Discharge from hospital is also an issue that leads to bed capacity being reduced. Better community support including accommodation for patients and service users that are homeless would make a more efficient use of the current bed stock.

Policy and funding for the sector needs to balance delivering on the ambitions for greater prevention, early intervention and community based care, whilst ensuring continued funding for, and access to, inpatient services which people with severe and enduring mental health conditions particularly rely on. Any increase in capacity within services, needs to be coupled with support for local training and placement opportunities to help providers overcome recruitment challenges, and ensure all services are appropriately staffed

Out of area placements

We welcome the focus on increasing the availability of local facilities to help tackle out of area placements. There are currently a range of factors contributing to providers' reliance on such placements. These include rising demand and the increasing severity of service users' conditions, as well as a lack of beds and specialist provision, alternatives to hospital and prevention support. As in other areas of the NHS, addressing the issue of out of area placements effectively will require sufficient workforce, the right investment, particularly in community mental health teams, and more investment in preventative services to help produce better outcomes for individuals and manage demand for more intensive services further down the line.

Commissioners hold a key responsibility for ensuring appropriate placements, and wrap around community care, are available within the local area, ensuring people can move closer to home as soon as possible. It should be remembered that out of area placements also mean that discharge becomes more difficult for providers as linking with local services to support discharge at a distance does not always take place, leading to readmissions. The impact on families and their ability to support patients at a distance is also a major impact on successful treatment and discharge.

Integration between mental health trusts, local authorities and hospitals

We support the ambition for greater integration and for a more holistic approach to mental health services, given the interdependence between mental health services and wider public health and prevention work undertaken by other parts of the local public sector.

However, there are a number of challenges inherent in taking a more integrated approach, including structural pressures in some health and care systems and the nature of local relationships, which can dictate the pace at which collaborative working progresses. Service redesign and integration takes time to

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deliver and may absorb significant leadership and management resources in the short term. It requires careful alignment of incentives and a shared understanding of priorities across the system. Moreover, resourcing greater integration and a more holistic approach will be particularly difficult given the challenges facing local authority finances.

Care needs to be taken to ensure workforce difficulties are not exacerbated by a well intentioned drive towards greater integration and efforts to take a more holistic approach. We already see pressure on the mental health workforce to also provide trained staff for police, ambulance, prisons, A&E and education. The staff required to deliver on our collective ambitions for the health and care sector are simply not available at the moment.

Commissioning

The complex and fragmented way in which mental health services are commissioned has a serious adverse impact on care. This is a longstanding issue which significantly impacts both the efficiency of service delivery and the continuity of care. Welcome work is already underway to foster less fragmented and burdensome approaches to commissioning, through new models of care as first set out in the five year forward view for mental health. Making further progress on data collection and data quality is also key to gaining a better understanding of mental health activity, access and outcomes which can consequently enable better commissioning.

The frequent tendering of services is an issue, particularly for community and mental health trusts. We have seen a number of services handed back to commissioners of late due to them being awarded on lowest funding basis that mean they are not sustainable and awarded to organisations that do not have the ability to provide the services. Providers have told us that reducing tendering activity would be one of the most effective ways of alleviating pressures on services.

Learning disability and autism services

The Care Quality Commission's recent interim report on the use of restraint, seclusion and segregation concluded that the pathway for people with a learning disability or autism is broken and we need to consider an alternative approach. The report's findings also highlighted the need for autism training for all current staff.

NHS services and the independent sector must work together with national policy makers and commissioners to determine the best route to the tailored care needs of every service user, and NHS providers are fully committed to learning the lessons from this report. Investment in workforce is crucial to overcome the severe shortage of specialist staff needed to deliver appropriate and personalised care in every setting, as is investment in facilities to improve the level and speed of access to appropriate support.

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