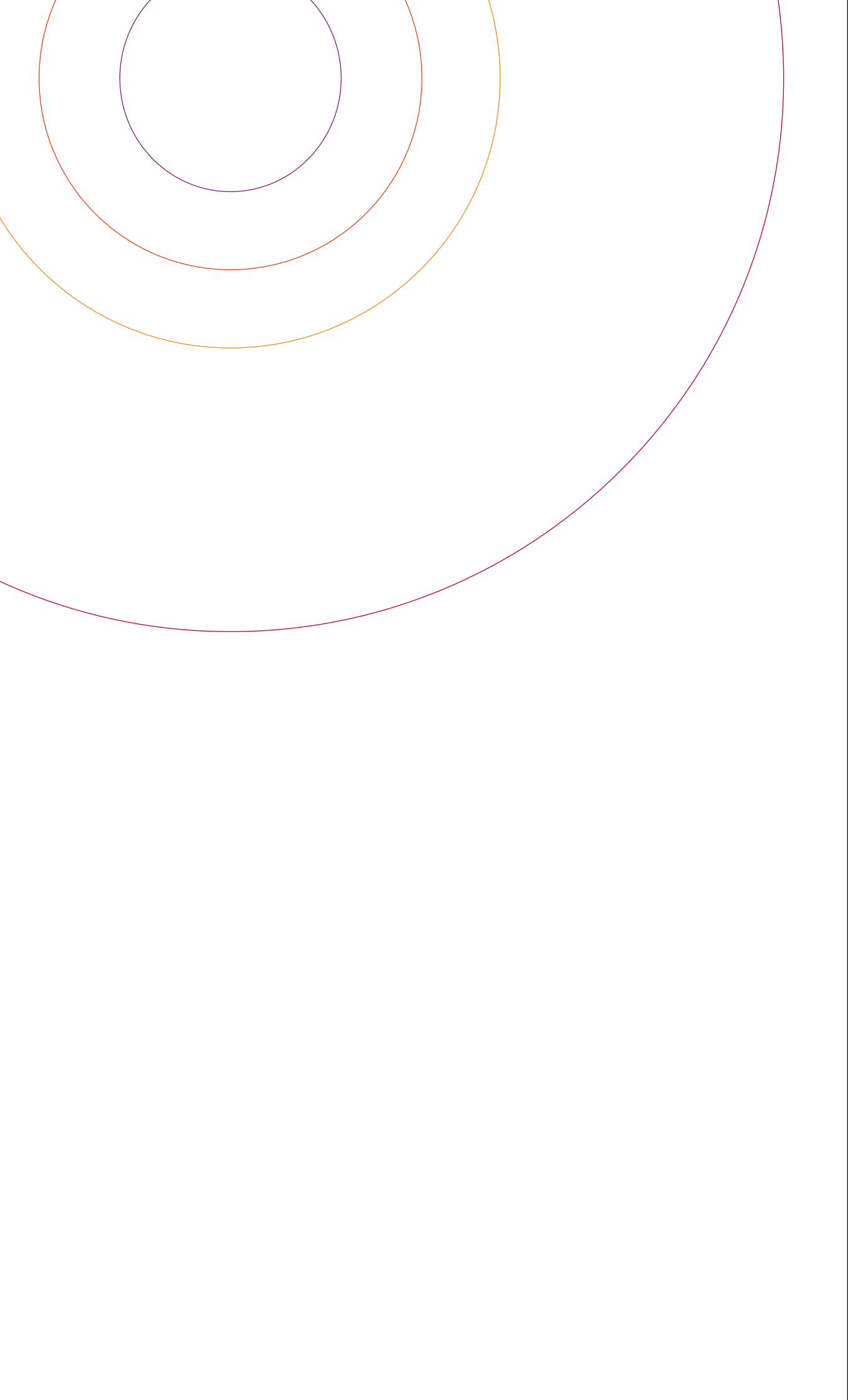


# THE STATE OF THE NHS PROVIDER SECTOR

JULY 2017



## FOREWORD



Welcome to the second in our series of reports that examines the state of the NHS provider sector. The timing of the report comes just weeks after the general election, with attention now turning to the key issues and challenges that need to be resolved over the course of this parliament.

Our latest assessment sets out to provide a valuable commentary on how the provider sector is performing, the challenges that trusts are facing, and the support they need as we head into another five years of what seems likely to be constrained funding increases and rapidly rising demand.

The report is a unique combination of our own policy analysis and commentary, published data and, most importantly, the views of the chairs and chief executives who run hospital, mental health, community and ambulance services in England. It is they who are responsible for ensuring their trusts provide outstanding patient care 24 hours a day, 365 days a year, and they who are best placed to identify key trends.

The centrepiece of this report is mental health. This is a critical area of care for the NHS, working in collaboration with a range of other public services, as well as now being a growing concern for wider society. There is a strong and welcome commitment from the top of government to address long-standing inequalities in care for people with mental health needs. We wanted to test progress with trust leaders on what was happening in the NHS mental health sector. The key finding – that core mental health services on the ground are under increasing pressure and at risk of deteriorating – should make compelling reading for politicians, system leaders and all those engaged in improving outcomes for people with mental health needs.

Alongside this, our report again covers key issues in the wider provider sector such as performance on quality, waiting times and finances; ensuring trusts have the right number, quality and mix of staff to deliver high-quality care; and how trusts are delivering much needed transformation. We are deliberately tracking the views of trust leaders on these key issues over time.

We are, once again, grateful to the trust chairs and chief executives who took the time to complete the survey and provide their views. The report would not be possible without them.

*Chris Hopson*

**Chris Hopson**  
Chief Executive, NHS Providers

# OVERVIEW

## KEY POINTS

- **Mental health** – there is a welcome commitment at the very top of government and among NHS system leaders to address long-standing inequalities in care for people with mental health needs. The accompanying increased funding is starting to enable better service provision in the targeted areas. But there is an increasing divergence between this new commitment and the deteriorating state of core mental health services. Rapidly rising demand is overwhelming those core services; extra funding is not reaching the NHS trust frontline; trusts are facing major workforce shortages; and mental health does not feature strongly enough in sustainability and transformation partnership (STP) plans and thinking.
- **Access and quality** – trusts are experiencing record demand, and many are running at capacity levels that are starting to risk patient safety. As we saw last winter, local services are becoming less resilient and some are increasingly unable to cope with surges in demand. Despite the best efforts of staff last year, for the first time, the NHS missed all four key ambulance, A&E, elective surgery and cancer 62 day targets. The evidence on quality is mixed: while patient satisfaction remains high and some trusts are improving, the NHS faces serious challenges in maintaining standards of care.
- **Finances** – thanks to a clear plan, financial support and a lot of hard work at the frontline, NHS trusts made significant progress in reducing the provider sector deficit in 2016/17. But the underlying financial position is unsustainable and trusts remain heavily dependent on one-off and non-recurrent savings. The NHS still needs a credible medium-term plan to match what is required of the NHS to the funding available.
- **Workforce** – workforce challenges are now the top concern for trusts. There are not enough staff to meet the rising demand for services. Staff shortages are increasing as Brexit uncertainties persist and more staff leave due to seven years of pay restraint and their jobs becoming more pressured, stressful and difficult. The NHS needs a realistic long-term workforce strategy that ensures the NHS has the right number of people, with the right skills, in the right place, within the funding available. This needs to include a clear plan to end pay restraint.
- **Transformation** – trusts recognise the need to transform to deliver the vision set out in the NHS *Five year forward view*. While we need to be realistic about how quickly such a wide-ranging and complex set of changes will take to deliver, the required transformation is taking too long. Trusts need more leadership capacity, more support and less regulation from NHS arm's length bodies, appropriate investment and clarity on the future of STPs.

## INTRODUCTION

This report examines the state of the NHS provider sector – the 233 hospital, mental health, community and ambulance trusts in England. It examines how they are performing, the challenges they face, how they are responding and the support they need to consistently deliver outstanding patient care. It combines our own analysis and commentary, published data and the views of 158 chairs and chief executives from 125 NHS trusts that responded to our survey in April 2017. The responses cover more than half (54%) of all trusts with all regions and trust types well represented.

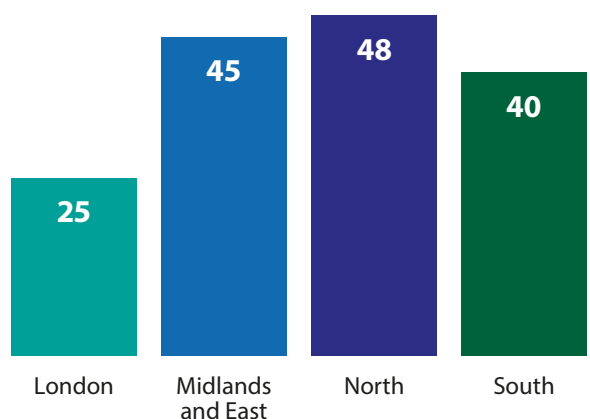
As with our first report from this series, published in November 2016, the report covers four key issues:

- quality and patient access
- finance
- workforce
- transformation.

However, the centrepiece of this latest report is a survey of NHS mental health provision. Our aim is to ascertain how commitments from government to address long-standing inequalities in care for people with mental health needs are actually translating into action on the frontline. Our mental health analysis is informed by the views of all trust leaders that responded to the survey with particular emphasis on the 43 chairs and chief executives from 37 mental health trusts that responded. This represents almost two thirds (62%) of the foundation trusts and trusts that provide mental health services.

**Figure 0.1**  
**Number of survey respondents overall**  
**(chairs and chief executives) by region.**

(n=158)



## THE PROVIDER CHALLENGE

Rapidly rising demand, constrained funding and a set of increasing workforce challenges are leading to mounting pressures across all NHS services. The following summarises the key findings from our report, starting with our analysis of the state of mental health services.

### 1 Mental health

There is a welcome commitment at the very top of government and from NHS system leaders to address long-standing inequalities in care for people with mental health needs. This has been accompanied by increased funding which, in turn, is starting to enable better service provision in the targeted areas. However, the clear view of trust leaders that responded to our survey is that there is an increasing divergence between this top-level commitment and the deteriorating state of core mental health service delivery on the ground.

Seven key areas of concern have emerged from our analysis:

#### **Rising demand outstripping capacity**

Rapidly rising demand is overwhelming core mental health services and outstripping their capacity to provide effective care. There are two underlying reasons for these increases: increasing public focus on mental health uncovering unmet demand, and broader societal pressures, such as rising unemployment, leading to a greater need for services. Demand for mental health services is rising at a rate that matches and in many cases exceeds the available capacity. This is the case for services for adults, as well as children and young people. Bed occupancy rates for inpatient units are now regularly exceeding 100% in many trusts. This not only means negative experience for service users, but also creates consequential pressures on emergency services provided by acute hospital and ambulance services. Of particular concern is the growth in the numbers of children attending A&E departments for psychiatric reasons and the growth in referrals for child and adolescent mental health services (CAMHS). These have increased by 44% over the last three years.

This reported growth in demand is borne out by our survey. The majority of mental health trust chairs and chief executives – over 70% – expect demand for services to ‘increase’ or ‘substantially increase’ this year. Other providers beyond mental health trusts also noted the rise in mental health demand, with two-thirds of respondents indicating that they have seen an increase in demand for mental health services for patients seen within their trusts.

## **Funding not getting through to the frontline**

The publication of the *Five year forward view for mental health* and its delivery plan set out the scale of collective ambition for mental health services.<sup>1</sup> These have been translated into a set of provisions in the Department of Health's NHS Mandate. New funding has been allocated to a range of specific areas and this is starting to drive improved services in these areas. However, as with physical health, and indeed social care, the level of financial investment in core mental health services – against a backdrop of rising demand and costs – is failing to keep up with rapidly rising demand.

This is compounded by mental health trusts largely having to operate on block contracts which, unlike the acute sector, do not account for rising demand. At the same time, these trusts are having to make very significant annual cost improvement plan (CIP) savings often in the range of 4-6% per year. This is putting huge pressure on core frontline services.

There is also a lack of transparency in how funding is allocated from clinical commissioning groups (CCGs) to NHS mental health trusts, with CCGs also facing inevitable pressure to use any 'new' funding to prop up core services whose funding has been cut or is static.

Our survey indicates that the extra money intended for mental health at a national level is still not getting through to NHS mental health trusts operating frontline services. Eight in 10 respondents from mental health trusts are 'worried' or 'very worried' about whether the national commitment to increase investment in mental health and transparency on CCG spending will result in adequate investment in their trust to meet the ambitions set out in the NHS Mandate for 2017/18. In addition, the majority (54%) of respondents from trusts not delivering mental health services felt that access to mental health services in their local area would not improve – they felt it would only stay the same – despite national commitments to increase investment.

## **Persistent gaps in the mental health workforce**

The ambition to improve mental health service services will only be met if we have the right workforce with the right skills in the right place. However, as with other parts of the NHS, our survey shows that mental health trusts are struggling to find enough staff with the right skills to deliver existing services to the right quality, let alone being able to find new staff to extend services to new users or create new services. Across all staff roles in all specialties, less than a third of chairs and chief executives were 'very confident' or 'confident' that national workforce planning will deliver appropriate numbers of staff. Respondents generally had higher levels of confidence for recruiting psychologists and therapists and other allied health professionals than for nurses and psychiatrists.

If the government's mental health ambitions are to be realised, these shortfalls will need to be addressed rapidly and effectively. However, given the lag to recruit and train new staff, there is an argument that the timescale for delivering the ambition already now looks far too optimistic.

## **Deteriorating access to and quality of some mental health services**

The speed at which service users are able to access treatments, and the quality of their experience once using them, is being hampered by rapidly rising levels of demand and the capacity of mental health trusts to meet this demand. Resourcing pressures are resulting in higher thresholds for referrals into mental health services from GPs, and there is also a direct correlation between timely treatment and outcomes, particularly for conditions such as psychosis or those related to drug and alcohol misuse.

Our survey reveals wide discrepancies in the services where trusts feel they are effectively able to manage demand. Two-thirds of mental health trust chairs and chief executives believe they are managing demand for perinatal, elderly care specialist support and police and crime services effectively. However, this drops significantly for CAMHS and A&E services, with over half of chairs and chief executives from providers of mental health services saying they were not able to meet demand for these services.

## **Insufficient support for liaison between mental health and other NHS services**

One of the key issues in mental health care is the need for effective liaison between mental health and other NHS services, particularly acute care. Liaison psychiatry features heavily in the *Five year forward view for mental health*, which states that "by 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50% of acute hospitals should be meeting the 'core 24' service standard as a minimum". We wanted to use the survey to test the extent of provision in this area. Three-quarters of chairs and chief executives from providers of mental health services noted that they deliver 24/7 liaison services for A&E, but only just over 40% of respondents from other providers indicated that they have 24/7 liaison services in place for urgent care. The most prevalent provision of 24/7 liaison psychiatry is for urgent care in A&E and for police and crime services, but this drops for CAMHS and perinatal liaison psychiatry.



## **Lack of priority for mental health in sustainability and transformation partnerships**

The NHS is changing and moving to new ways of providing care. It is using sustainability and transformation partnerships (STPs) – a key part of the new NHS landscape – to plan for this transformation. If mental health services are to flourish and we are to realise the new ambition, then it is vital that mental health is at the centre of the STP process.

However, feedback from mental health trust leaders strongly suggests that mental health services are not being given enough priority in STPs up and down the country, with only 11% of respondents confident that their local STP will lead to improvements in access and quality of services. Almost half of respondents (45%) were either 'worried' or 'very worried' that STPs will not improve capacity to enable more timely access to mental health services for people in their local areas. Another 45% were neutral on the issue. Respondents from other parts of the NHS were also concerned about the priority given to mental health in the STPs, with only 8% confident that STPs will result in improvements in capacity to provide more timely access to services.

## **Fractured commissioning leading to uncoordinated care for service users**

The challenges facing mental health services are being compounded by the fractured nature of commissioning arrangements in mental health, with the 2012 Health and Social Care Act resulting in a split between NHS England (for specialist commissioning), local CCGs and councils which in turn leads to uncoordinated care. This means patients are often treated in expensive, inappropriate care settings, or it means that patients are unable to access a service at all. In particular, a number of those wider services supporting mental health service users, such as substance misuse or public health more generally, are now commissioned by local authorities which has introduced delays and inefficiencies into the coordination of care. It has also meant lower levels of investment as local authority funding pressures have increased.

These seven key issues point to a growing gap between the government's welcome ambition for the care of people with mental health needs and the reality of the core services these service users are receiving on the frontline. In some cases, the reality is that core mental health service provision by mental health trusts is actually getting worse, not improving. Unless action is taken to address these areas of concern, then the government's overall ambitions for transforming mental health care will not be met.

# OVERVIEW

The challenges facing mental health services, including from rapidly rising demand, constrained funding, an increasingly scarce workforce and barriers to delivering transformation, are mirrored in the wider health service. Our survey and report shows, for the wider NHS:

- continuing pressure on quality, waiting times and access
- an approach to NHS finances that remains unsustainable
- a rapidly rising set of workforce challenges
- a transformation process that, while it is gathering pace, remains too slow.

## 2 Access and quality

NHS trusts are experiencing record levels of demand for their services. At the same time, patients have higher and more complex needs. These increases in demand are a long way beyond the levels predicted in the NHS *Five year forward view*. Many trusts are now running at capacity levels beyond the recommended norm and levels in other advanced western health systems. This is contributing to local health systems being less resilient and some being unable to cope with surges in demand. This was exemplified by NHS performance levels last winter, with performance against waiting time targets dropping sharply despite the best efforts of staff operating under intense pressure.

Other performance targets across the system are under similar pressure. For the first time, the NHS is now missing all four of its key targets: 75% ambulance response, 95% A&E four hour, 92% 18-week elective surgery and 85% seen within 62 days of GP referral for cancer.

The evidence on quality is mixed. While patient satisfaction with the NHS remains high and some trusts, despite the unprecedented pressures, are improving, the NHS faces serious challenges in maintaining standards of care. Responses to our survey reinforce this mixed picture, with 61% of chairs and chief executives saying they are confident their trusts are currently able to provide high-quality care (this was 64% when we last surveyed them in November 2016).

## 3 Finances

The NHS is in the middle of the longest and deepest funding squeeze in its history. While the extra funding promised in the Conservative manifesto is welcome, spending on health will still significantly fall as a percentage of our national wealth until 2022/23.

# OVERVIEW

NHS trusts made significant progress in reducing the provider sector deficit in 2016/17 as a result of a clear plan, financial support and a lot of hard work from trusts on the frontline. The provider sector ended 2016/17 with a -£790m deficit, just under 70% less than the -£2.45bn deficit recorded in 2015/16. One of the key areas of success has been reducing spending on agency and temporary staff: in 2016/17 trusts reduced these costs by more than £770m (20%). The stronger performance seen in 2016/17 is reflected in our survey of chairs and chief executives. When asked how they expect their trust's finances to develop over the next six months, a quarter predicted they would improve while most (41%) expect their finances to stay the same. A third expects their trust's finances to deteriorate.

However, although trusts delivered a good financial result in 2016/17, the underlying financial position remains unsustainable. Trusts remain heavily dependent on one-off and non-recurrent savings, such as land sales to deliver their year end targets. We estimate these account for at least £1bn of 2016/17's savings. Given the significantly lower funding increases the NHS is due to receive this year, and for the next three years, this suggests trusts will struggle to eradicate the provider sector deficit. The National Audit Office is right to argue the NHS still does not have a clear, credible plan to match what is required of the NHS to the funding available.

## 4 Workforce

Workforce is a top concern for trusts up and down the country, and the workforce challenge is now equal in scale to the NHS financial challenge. Although different trusts face different pressures, the sector as a whole is finding it increasingly difficult to recruit and retain sufficient staff with the skills and experience needed to meet the rising demand for services. Trusts are also struggling to match the staffing levels they require with the finances available. Even if money were not a constraining factor, insufficient staff have been trained within the UK to meet current and projected demand. These shortages impact directly on the safe and sustainable delivery of high-quality care, with trusts finding they are increasingly having to close or suspend services for short periods of time or altogether.

Our survey showed that well over half of chairs and chief executives (57%) are 'worried' or 'very worried' about their ability to maintain the right numbers of staff – clinical and non-clinical – to deliver high-quality care. When asked what the picture would look like in six months' time, their level of confidence decreased and 61% were 'worried' or 'very worried'.

## 5 Transformation

The existing fragmented NHS pattern of service delivery is no longer fit for purpose and trusts recognise the need for transformation. Trust leaders support the idea of system-based planning and the vision outlined in the NHS *Five year forward view* of moving to new ways of providing care, including accountable care systems. They see the integration of health and care as a potential means of addressing the challenges of rising demand, responding to the growing number of individuals with more complex health needs and improving health outcomes. New care models are making good progress in transforming care and are gathering pace across the country, but they still only cover small areas and are limited in scope. And there is no compelling evidence that they will deliver long-term financial savings or reduced hospital activity. There is support for the concept of STPs as a means of delivering these changes but there are some key barriers to overcome. We also need transformation to move faster while also being realistic about how long it will take to deliver these changes.

Our survey reinforces these concerns by revealing there is little confidence that local transformation is happening quickly enough. Almost two thirds (62%) of chairs and chief executives are worried their local area is not transforming quickly enough. Fewer than two in 10 (17%) are confident that this is happening.

## WHAT PROVIDERS NEED

- To meet the challenges and realise the ambition for mental health, providers need:
  - realism about rising demand and what's needed to meet it, recognising that increased focus on mental health and current societal pressures will generate more demand
  - better ways to guarantee that mental health funding reaches frontline services provided by trusts
  - a robust workforce strategy combined with support at local level to ensure the strategy actually gets delivered
  - for STPs to give enhanced mental health service delivery greater priority in their plans
  - for commissioning to be overhauled to deliver more coherent pathways of care and to maintain the level of financial investment in mental health services.

## OVERVIEW

- More generally, NHS trusts need a smaller number of priorities, with a realistic delivery trajectory for each. The government has the opportunity, at the start of a new parliament, to review what is being asked of the NHS given the proposed spending levels. We then need a new plan which honestly sets out what can be achieved for the funding available. This needs to include a realistic plan and achievable trajectory to recover financial balance in the provider sector.
- We need to ensure the NHS is appropriately resourced to manage the increased patient safety risk we will face next winter. The government's strategy of creating NHS capacity through the extra £1bn social care funding allocated in the budget only offers a partial solution. More capacity within the NHS and the wider health and care sector are needed to manage next winter safely and we need a longer-term approach which avoids a recurrent sense of crisis each winter.
- A new longer-term financial regulatory framework, to replace what was always intended to be a short-term sustainability and transformation funding/control total regime, is required. Provider autonomy must sit at the heart of this framework. As part of this, we also need to decide how the £1.8bn sustainability and transformation funding will be mainstreamed in future.
- The NHS needs a realistic, joined up, long-term workforce strategy which ensures trusts have the right number of staff with the right skills in the right place to deliver high-quality care within the allocated funding. This strategy needs to include a short-term plan to address immediate gaps in staffing. This plan will also need to outline how we move away from seven years of pay restraint to ensure NHS roles are appropriately rewarded and remain attractive. We also need clarity on the status of EU nationals working in the NHS and an immigration system that allows the NHS to recruit the staff it needs.
- Trusts recognise the need for rapid transformation as set out in the NHS *Five year forward view*. To speed up the current pace of change, trusts need:
  - much enhanced leadership capacity at the frontline to deliver the required transformation alongside outstanding day to day care in an increasingly unstable context where demand is rising rapidly
  - a capital plan that reflects the fact that no other sector has ever attempted transformation on this scale without proper funding
  - some risks will need to be taken, including turning the arm's length body model on its head – from an approach based on assurance and regulation to one that supports and enables change and transformation

## OVERVIEW

- continued funding for the vanguards given their job is only three-quarters complete. The vanguards are still creating key transformational building blocks such as new contracting and funding models; new information governance approaches to enable joined up care records and new workforce models. They need targeted funding for at least one more year to ensure the task of creating these key building blocks for others to use is completed
- clarity on where we are headed with STPs. If they are to be our main vehicle for transformation, we need much greater clarity on their longer-term status as the current picture is confused.

## THE MENTAL HEALTH PROVIDER CHALLENGE

Mental health and wellbeing have rightly risen up the NHS agenda in recent years and we are witnessing a steady and welcome change in attitudes to mental ill health. After a decade of campaigning *Time to Change* and *Heads Together*, alongside wide range of other charities and organisations, have finally broken into the public consciousness to highlight the stigma of mental ill health and the importance of access to the right support and services in a timely way.

Politicians have also expressed their ambition to transform mental health care, create equity between the treatment of physical and mental health and enhance the priority given to mental health within the NHS. The *Five year forward view for mental health* and the introduction of new access standards for key mental health conditions are two key new initiatives designed to turn these ambitions into reality.

But delivering these ambitions is dependent on the quality of mental health service delivery on the ground. NHS mental health trusts are the mainstay of provision in England so analysing how well they are doing is a good way to assess whether the new ambitions we have for mental health provision are actually being delivered.

This chapter focuses on the state of the NHS mental health provider sector. We start by setting the context in the form of a snapshot of mental health provision in England and the NHS mental health provider sector's place within it. We then analyse the state of core service provision on the ground through the results of our survey of trust leaders.

over  
**70%**

of mental health trust  
chairs/CEOs expect  
demand for mental  
health services to  
increase this  
year

## MENTAL HEALTH SECTOR SNAPSHOT

What does mental health provision in England look like and what is the case for investing in that provision? This context-setting snapshot looks at:

- current activity levels
- current level of investment
- the shape of services
- the shape of the provider sector
- the case for investing in mental health provision
- the historic structural disadvantages mental health has suffered from
- the new commitments to mental health that have recently been made.

### Activity

In February 2017 over 1.2 million people accessed NHS mental health services:

- 86% accessed adult mental health services
- 12% children and young people's mental health services
- 6% accessed learning disabilities and autism services, some of whom will have also accessed adult or children's mental health services.

These figures include:

- 114,000 new referrals to talking and psychological therapies
- over 13,000 open ward stays in adult acute and specialised services
- over 314,000 active referrals for under 19s, including 42,000 new referrals.

And, between 1 January and 31 March 2017 there were:

- nearly 3,000 referrals with suspected first episode psychosis started treatment
- 1,600 new referrals for people aged under 19 with eating disorders
- over 16,000 admissions to crisis resolution home treatment team adult wards.

### Investment

In 2013/14 £9bn was spent by the NHS on mental health support and services, of which:

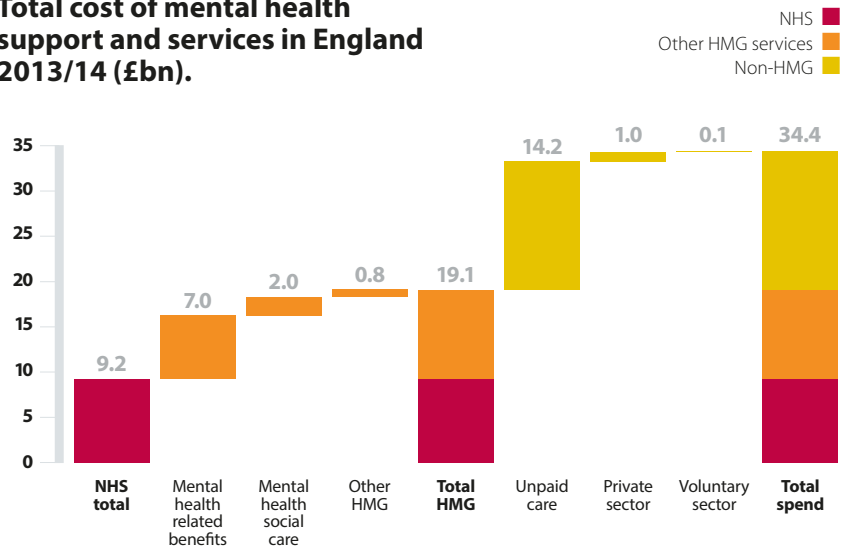
- £1bn was invested in children and young people
- £2.4bn in common mental health problems
- £4.8bn in severe mental illness.



Figure 1.0 below, taken from the mental health taskforce report, shows how money is spent on services to treat mental health conditions and gives a good sense of both the diversity of the sector and how much is spent on those with mental health issues beyond the NHS and beyond the government.

Figure 1.0<sup>2</sup>

### Total cost of mental health support and services in England 2013/14 (£bn).



## Shape of services

Given the diversity of mental health need, NHS mental health trusts provide a complex mix of services. These can be delivered on a standalone basis or in partnership with other sectors (acute, ambulance, community trusts), other agencies (housing, police, prison services), or other organisations, in particular voluntary/social enterprises.

Care is provided across three settings:

- care provided in the community (where a service user accesses services from home, or another domestic setting, including a crisis house)
- inpatient care, usually an inpatient ward
- secure care, in a locked setting.

Services can broadly be categorised as:

- adult services (which would include services for older people, and also be subdivided for women's services)
- children and young people's services
- urgent and crisis care – including liaison psychiatry, work as part of the

Crisis Care Concordat, initiatives such as street triage and homelessness outreach services

- forensic services, in locked settings, usually subdivided into low, medium and high secure settings.

Mental health trusts treat, and seek to prevent, a host of mental health conditions. A simplified list is set out below:

- addiction
- anxiety and depression
- dementia and memory
- eating disorders
- gender reassignment
- perinatal mental health
- personality disorders
- psychosis and schizophrenia
- sexual problems
- traumatic stress.

## Shape of providers

There are 55 NHS mental health trusts focusing predominantly on delivering mental health services, and a further 20 which deliver combined mental health and community services.

Although NHS mental health trusts make up the largest single type, there are other providers:

- over 80 independent providers of mental health inpatient services
- over 100 independent and social care organisations providing community-based mental health care and/or learning disability services.

The market value for mental health hospital services (as opposed to wider community mental health services) was £4.3bn in 2014/15, with the independent sector responsible for £1.3bn of this revenue, a 29% market share. NHS mental health trusts have a collective annual turnover, across all types of mental health provision, of £11bn and they make up a quarter (24%) of the NHS provider sector by number of providers.

## The economic case for investment in mental health

There is a strong economic case for investment in mental health services, as a number of studies clearly demonstrate. Work by the London School of Economics and the Centre for Mental Health calculated the economic and social costs of mental health problems in England in 2009/10 at £105bn; with indirect costs due to unemployment, absenteeism and presentee-ism at £30bn, compared to a direct health and social care cost of intervening of £21bn and a human cost of £53.6bn.<sup>3</sup>

Looking at more specific, but relatively common, conditions such as psychosis, a 2014 study has shown that intervening early in psychosis can mean that, over 10 years, for every £1 invested a possible £15 cost can be avoided.<sup>4</sup> At a time of financial constraint these arguments are compelling, although the length of time for the return could be regarded as a challenge. This economic case was also clearly brought out in the NHS *Five year forward view*, with its focus on employability and helping people with enduring mental health conditions gain or stay in employment.<sup>5</sup>

## Structural disadvantages

Mental health provision and NHS mental health trusts have suffered an historical, structural disadvantage compared to physical health provision and other NHS trusts such as acute hospitals trusts, for a number of reasons:

- stigma – the stigma associated with mental health in society, reflected politically and institutionally, has meant that only a significant minority of those in need seek help at all or at the right time, meaning that provision of services has not been a priority for the NHS as a whole
- funding and payment systems – alongside the need to boost funding overall, the sustained use of block contracts<sup>6</sup> has not resourced providers sufficiently for escalating demand or enabled wider service investment. Although this is changing through the introduction of different payment systems, it is a significant legacy issue
- commissioning – following the 2012 Health and Social Care Act the commissioning of mental health care by local and national commissioners has been fractured, impacting on the efficiency and continuity of care. On top of that, a number of those wider services supporting mental health service users, such as substance misuse or public health more generally, are now commissioned by local authorities. This has introduced delays and inefficiencies into the coordination of care and has meant that investment in those services has decreased as financial pressures on local authorities have risen.

## New commitment

The *Five year forward view for mental health implementation plan* sets out how the welcome new commitment to transforming mental health services should be delivered. The key elements of the plan focus on:

- children and young people's mental health
- perinatal mental health
- adult mental health – common problems; community, acute and crisis care; secure care
- health and justice
- suicide prevention
- sustaining transformation with new models of care; a healthy NHS workforce; infrastructure
- support from the centre.

The NHS mandate sets out two key provisions:

- 24/7 access to mental health crisis care in both community and A&E settings
- People with mental health problems should receive better quality care at all times, accessing the right support and treatment throughout all stages of life... This will require great strides in improving care and outcomes through prevention, early intervention and improved access to integrated services to ensure physical health needs are addressed too... To close the health gap for people of all ages, we want to see a system-wide focus on prevention and early intervention, as well as improvements to perinatal mental health. Central to this approach... the delivery of, the *Five year forward view implementation plan*. Overall there should be measurable progress towards the parity of esteem for mental health enshrined in the NHS Constitution, particularly for those in vulnerable situations.<sup>7</sup>

**80%**

of mental health trust chairs/CEOs worried funding is not getting through to the frontline

## THE SURVEY – WHAT THE MENTAL HEALTH FRONTLINE IS TELLING US

While there are signs that the new commitment to increase support for specific mental health services is starting to bear fruit, it is important to judge the quality of mental health service provision in the round.

Our survey reveals a concerning picture of core NHS mental health service delivery on the ground in seven key areas, each of which is set out in more detail below:

- demand for service is rising rapidly
- the extra financial investment is not running the NHS mental health frontline
- workforce challenges are increasing
- taken together, these are impacting adversely on access to and quality of service delivery
- commissioning is fractured
- support between different parts of the NHS, as embodied by liaison psychiatry, still needs to be improved
- the new sustainability and transformation partnerships (STPs) are not giving sufficient priority to improving mental health provision.

### Demand for services is rising

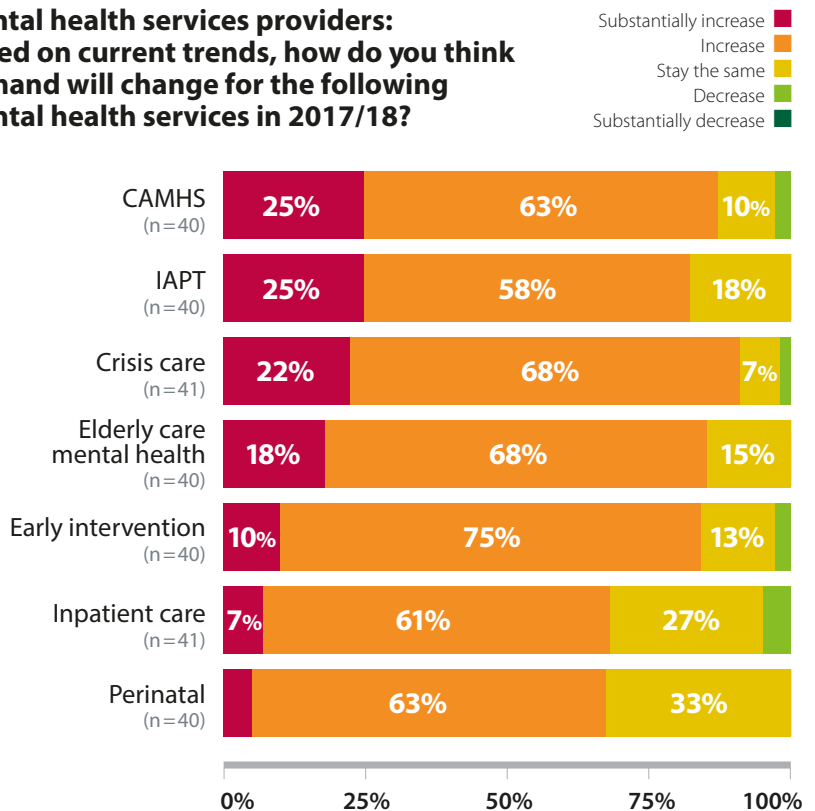
Demand for mental health services is rising at a rate that matches and in many cases exceeds that experienced by the acute sector. This is the case for services for adults, and children and young people. Bed occupancy rates for inpatient units are regularly exceeding 100% in many trusts, which, as well as leading to a negative experience for service users, also creates consequential pressures on emergency services provided by acute and ambulance trusts.

Particularly concerning is the growth in children attending A&E departments for psychiatric reasons<sup>8</sup> and the growth for referrals in child and adolescent mental health services (CAMHS) which have increased nationally by 44% over the last three years.<sup>9</sup>

This reported growth in demand is reflected in our survey. The majority of mental health trusts leaders – over 70% – expect demand for health services to ‘increase’ or ‘substantially increase’.

As figure 1.1 shows, mental health trust leaders expected demand increases across all seven areas listed – the key mental health delivery areas: CAMHS, talking therapies, crisis care, elderly care, early intervention, inpatient care and perinatal mental health.

**Figure 1.1**  
**Mental health services providers:**  
**Based on current trends, how do you think**  
**demand will change for the following**  
**mental health services in 2017/18?**



Particularly concerning is the fact that 90% expected an increase in demand for crisis care, and that the two areas where trusts were anticipating a ‘substantial increase’ were CAMHS and access to psychological therapies (such as CBT or talking therapies). The demand increases in these fields are not matched by an increase in the available workforce or by commissioning or funding intentions. A trust leader gave this insight: “We deliver CAMHS... we need universal coverage of intensive home treatment teams way more than we need more inpatient beds.” Another said: “Demand is rising as the other safety nets [are] removed as a result of local government cuts.”

The survey shows two underlying reasons for increases in demand. First is the growing public focus on mental health which is uncovering unmet demand. Campaigns such as *Time to Change* and *Heads Together*, which seek to tackle the stigma surrounding mental health and encourage people to treatment, are somewhat understandably leading to a higher

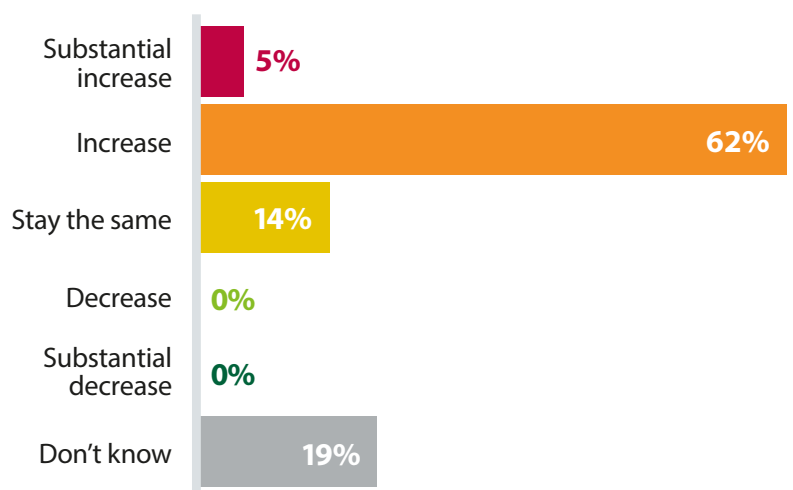
demand for services. Second are broader societal pressures – such as societal expectations, workplace pressures and the overall pressures of a faster pace of life – leading to a greater need for mental health support. This is particularly noticeable among children and young people.

As one trust leader put it: “The increased attention being paid to mental health requirements, quite rightly, will probably lead to more people being willing to seek care.” Another commented: “More people of all ages are becoming ill as a result of the pressures of modern life.”

However, although the numbers are very small at the moment, there is some levelling out or decreases in demand for inpatient care and early intervention. This could be the start of the recently introduced access standards for mental health making an impact, and the changing shape of mental health provision, moving care from inpatient to community settings. One trust leader commented: “[Our] decrease in inpatients [is] due to transformation and strengthening of community services.” Importantly the overall rise in demand is not only being experienced by mental health trusts. Leaders from other trusts – hospital, community, and ambulance – echo this position. Two-thirds had seen an increase in demand for mental health services for patients in their trusts, with none seeing any decrease, as figure 1.2 demonstrates. The impact of the rise in demand for mental health services is felt across the whole system.

**Figure 1.2**  
**Providers not delivering mental health services:**  
**Are you aware of changing demand for mental health services for patients seen within your trust?**

(n = 111)



## Financial investment is not reaching the NHS mental health frontline

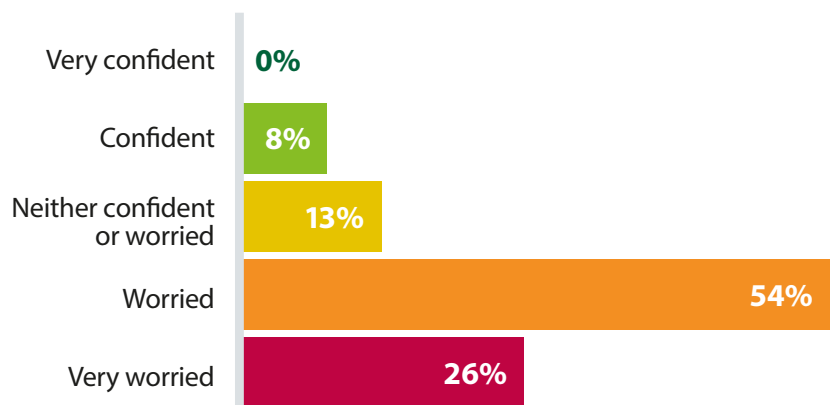
The publication of the *Five year forward view for mental health*<sup>10</sup> and its delivery plan<sup>11</sup> set out the scale of collective ambition for mental health provision. These have been translated into a set of provisions in the NHS Mandate.<sup>12</sup> The additional funding to support delivery of the *Five year forward view for mental health* is £1.4bn over five years and for the Future in Mind programme (for CAMHS) it is £1.25bn.<sup>13</sup> There is early evidence that the overall level of money spent in mental health in the NHS is rising, as intended.

NHS Providers understands that last year mental health services saw a total increase of more than 7% nationally. However, NHS mental health trusts received on average only 1%. A mixed economy in services – across third sector and independent organisations – is part of the current model of provision. However, the system as a whole must recognise that the majority of transformation initiatives, management of urgent and emergency care pathways, whole population healthcare approaches, are driven by NHS mental health trusts. They need support to maintain these core services.

Is this extra funding reaching the NHS mental health trust frontline, where the majority of key mental health support is delivered? As figure 1.3 shows, 80% of mental health trust leaders were not confident that the overall investment for the ambitions in the NHS Mandate was adequate or that it would reach the frontline.

**Figure 1.3**  
**Mental health services providers:**  
**How confident are you that national commitment to increase investment in mental health and transparency on CCG spending will result in adequate investment to meet mandate ambitions in 2017/18?**

(n=39)





There are number of reasons for funding failing to meet the NHS mental health frontline and keep up with rising demand including:<sup>14</sup>

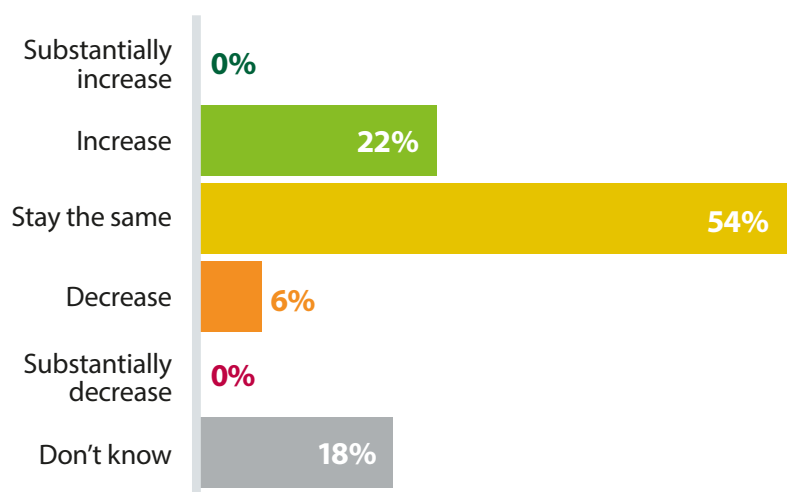
- the new funding for mental health has not been ring-fenced. Trust leaders highlight that earmarked mental health funds are used for other priorities, compensating for wider pressures in the system, such as population and inflationary pressures. Respondent comments included: "The money is not passed on, it is used to bail out the CCGs and the acute sector" and "No investment at all to deliver transformed services. Real terms disinvestment with some CCGs investing significantly less than their growth"
- where new mental health funding is flowing, it is either being targeted at new services or is allocated to non-NHS mental health trusts. This does nothing to alleviate the growing pressure on core services, many of which are facing significant demand increases
- many providers are experiencing significant pressures as a result of cuts in local authority and social care funding. These have increased demand for both adult and children's services, with higher numbers presenting at secondary services who would usually have been supported by local authority funded third sector services, and also increases in delayed transfers of care due to a lack of community support services. As one trust leader indicated: "Extra mental health spend is not going into mental health five year forward view standards due to growth in Section 117 packages of care post discharge"
- NHS mental health trusts are still paid largely via block contracts which do not take account of rising demand, and have been asked over each of the last five to seven years to realise significant annual cost improvement programme (CIP) savings of 3-6%. This has had a major impact on the provision of the core services, particularly since the National Audit Office (NAO) pointed out that the costs of improving mental health services may be higher than current estimates<sup>15</sup>
- there is a lack of transparency in how mental health funding allocated from clinical commissioning groups (CCGs) to mental health trusts is accounted for. This makes it difficult to track which of the following reasons is responsible:
  - funding not reaching the CCG
  - funding reaching the CCG but not being spent on mental health
  - funding being spent on mental health but not in the NHS mental health provider sector
  - funding being spent on the NHS mental health provider sector but on new as opposed to core services
  - funding being spent on core services, but spend not keeping up with demand increases.

There have been welcome moves to increase transparency, driven by the NHS England mental health director and her team, but more is needed.

These concerns about the failure of increased mental health investment to reach the NHS mental health frontline are shared across the wider NHS provider sector. As figure 1.4 shows, only one in five leaders from other (non-mental health) provider trusts thought that increased investment would change access to mental health services for their patients, with nearly two-thirds believing access would stay the same or decrease. However, even those expressing confidence also express a degree of caution: "hopefully. But we'll see how it gets delivered in practice."

**Figure 1.4**  
**Providers not delivering mental health services:**  
**Following national commitments to increase investment**  
**in mental health, do you think local investment will**  
**change accessibility to mental health services for**  
**patients in your area in 2017/18?**

(n=112)



## Workforce challenges are growing

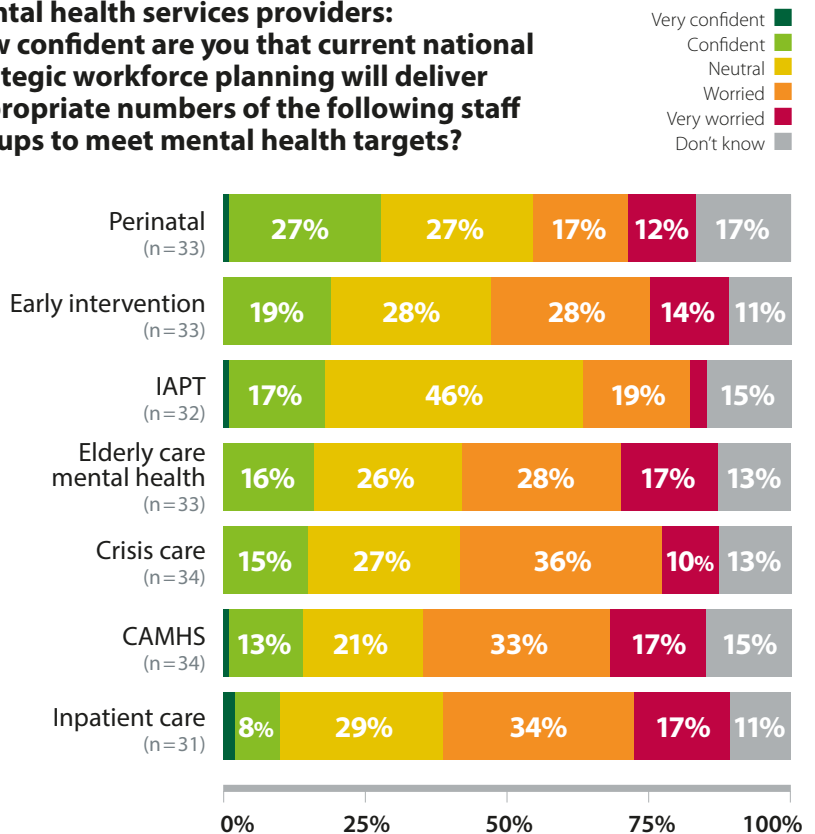
Having the right workforce, with the right skills in the right place, is central to meeting the shared ambition to improve mental health service provision on the ground. Our survey shows that NHS providers are struggling to find enough staff to deliver existing services to the right quality let alone being able to find new staff to extend services to new users or create new services. These issues must be tackled speedily. Given the lag to recruit and train staff, there is an argument that the timescale for delivering the new ambition now looks far too optimistic.

The lack of staff in specific roles in some specialties, coupled with rising demand in these areas, is causing particular concern.

Health Education England has indicated that at least an additional 19,000 staff are needed by 2020/21 to deliver the mental health ambitions set out in the *Five year forward view for mental health*.<sup>16</sup> Their national level strategy for delivery is only now emerging, with a huge amount to be done locally to ensure effective delivery.

Across the mental health sector, levels of confidence in national workforce planning are low. As figure 1.5 shows, no more than a third of respondents were confident that national strategic workforce planning will deliver appropriate numbers of staff to meet mental health targets.

**Figure 1.5**  
**Mental health services providers:**  
**How confident are you that current national strategic workforce planning will deliver appropriate numbers of the following staff groups to meet mental health targets?**



One trust leader summed up the approach being taken in their area: “Local solutions are being developed as the national workforce plans are not sufficient in most areas.”

Figure 1.1 outlined the areas where demand for services is rising, including talking therapies, crisis care and CAMHS. Matching that data to the areas of concern in terms of workforce supply, paints a particularly

challenging picture for both crisis care and CAMHS where 46% and 50% of mental health trust leaders are 'worried' or 'very worried' that the right numbers of staff will be delivered. Only for talking therapies is the picture marginally improved, with 46% neutral on the issue and 18% 'confident' or 'very confident'.

Other issues also need to be taken into account that impact on mental health workforce supply:

- changes to nursing bursaries – it is not yet clear what impact the change to bursaries will have on the ability of the mental health sector to attract new enrolments. However, the profile of the mental health workforce is more mature and better educated (in terms of first degrees) than the general NHS workforce, and it is possible that the loss of financial support could have a particularly adverse impact, although we are awaiting firm data here
- attrition rates – the mental health student cohort experiences higher attrition rates (ie the conversion from training place to staff member) than the general NHS workforce<sup>17</sup> which will further reduce the actual numbers in the workforce compared to projections
- training placements – without a published strategy from Health Education England on the delivery of the workforce in mental health on which funding allocations from other national bodies will be based, it is unclear how training placements will be made available to NHS mental health providers
- lack of funding certainty – NHS mental health trusts require certainty of recurrent funding increases if they are to commit to increase their permanent workforce. As already illustrated, extra mental health funding is not currently flowing to the NHS mental health trust frontline as intended/anticipated. This makes it much less likely NHS mental health trusts will commit to the planned and desired increase in their permanent workforce.

A key and enduring challenge for all providers and for the quality of mental health services overall is staff health and wellbeing. Recent research by Royal College of Physicians<sup>18</sup> is highlighting burnout as an increasingly significant problem. This will have a knock-on effect on quality of care and increased risk of harm. A total of 41% of staff from mental health and learning disability trusts reported feeling unwell due to work related stress in previous 12 months. Only staff from ambulance trusts reported higher rates.<sup>19</sup>

## Impact on access to and quality of services

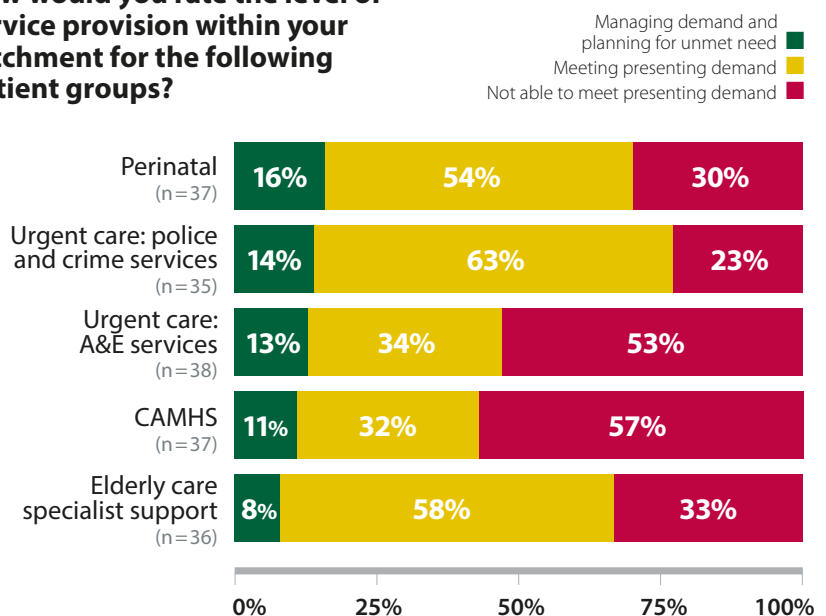
Rising levels of demand and the lack of financial and staff resources to manage them adversely impacts both access to and the quality of

frontline services. Resourcing pressures are resulting in higher thresholds for referrals into secondary services from GPs, and there is also a direct correlation between timely treatment and outcomes, particularly for conditions such as psychosis or those related to drug and alcohol misuse.<sup>20</sup>

Our survey showed concern at trusts' ability to meet demand across the range of services. Although two-thirds of trust leaders believe they are managing demand for perinatal, elderly care specialist support and police and crime services, this drops to less than half managing demand for CAMHS and A&E services (see figure 1.6). These figures are particularly concerning when one compares these levels of access to what might be regarded as access to similar services in physical health:

- 92% of patients receiving elective surgery with 18 weeks of referral
- 85% of cancer patients being seen within 62 days of GP referral.

**Figure 1.6**  
**Mental health services providers:**  
**How would you rate the level of**  
**service provision within your**  
**catchment for the following**  
**patient groups?**



As figure 1.6 shows, only a little over 10% of respondents felt their trusts were both managing demand and planning for unmet need. Taken together with other evidence, these results paint a concerning picture for the future quality of mental health services:

- responsiveness – the survey shows a worrying inability to respond as effectively as desired in a crisis situation; a worrying inability to meet spiralling demand in CAMHS which will impact on future demand for services; and a worrying inability in the vast majority of trusts to make inroads into those needing, but not yet receiving, services

- right capacity in the right place – a resourcing shortfall is leading to local bed capacity shortage, which is pushing up out of area placements in both CAMHS and adult inpatient care, as well as driving inappropriately early discharges. This can mean unnecessary readmissions or the same service user re-presenting for support at a later date. Work by NHS Benchmarking, and a review of provision of acute inpatient psychiatric care pointed out that, in aggregate, there are enough inpatient beds in CAMHS and adult services, but they are not in the right place to meet local demand<sup>21</sup>
- older people’s mental health – currently, older people’s mental health needs are too often inappropriately co-located with dementia care despite the needs, and treatment/support required, being very different. Given demographic trends, this is a major concern which will put additional strain on services as providers see increasing numbers of frail elderly people with severe mental health needs, where the appropriate facilities are not available
- community provision – the decommissioning of community support services funded locally by both CCGs and councils adds to the capacity issues trusts face, as patients and service users are trapped in the expensive end of the specialist pathway, as there is nowhere else to provide treatment. Alongside this, the NAO has raised concerns about community provision, and its ability to meet the needs of service users, following the Transforming Care for Learning Disabilities committed CCGs to repatriating LD service users into community settings rather than receiving inpatient care.<sup>22</sup>

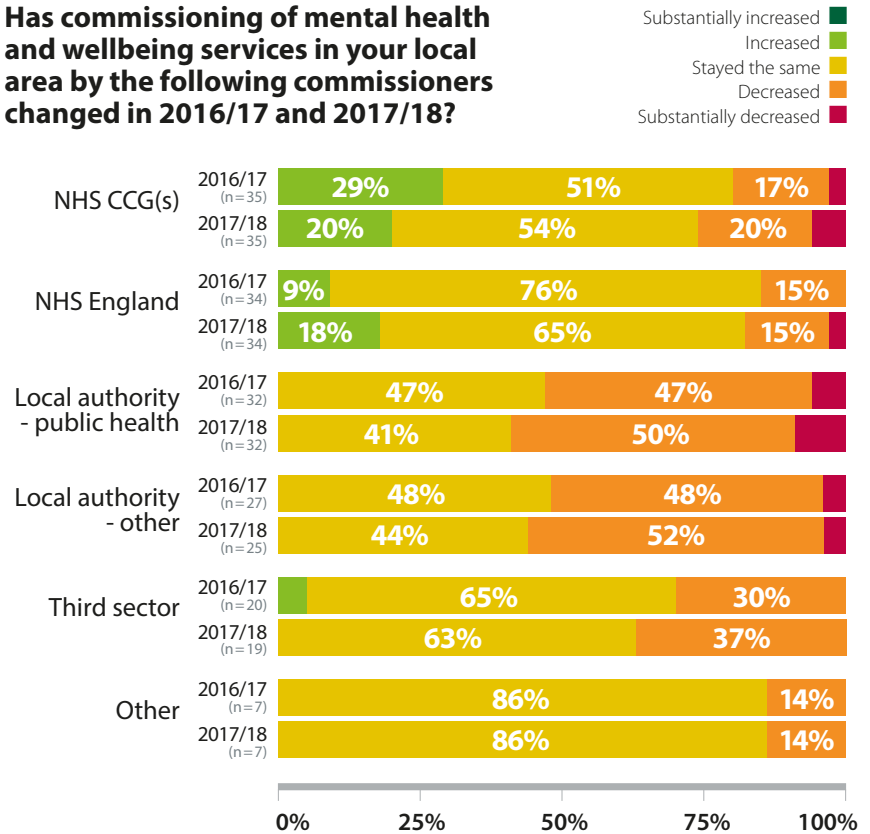
## Fractured commissioning

The impact of commissioning structures and decisions on managing demand, financial investment and both access to and quality of services emerges strongly in the survey.

The fractured nature of commissioning in mental health – split between NHS England for specialist commissioning, local CCGs and councils – too often leads to an uncoordinated care pathway. This is less efficient, with patients often treated in expensive, inappropriate care, or it means that patients are unable to access a service at all.

However, the most direct consequence of the changes to commissioning since 2012 is financial. Mental health services are commissioned by CCGs, NHS England, council public health functions, other council functions and the third sector. Across all of these groups mental health trusts saw a decrease in the levels of services commissioned for 2017/18 compared to 2016/17 (figure 1.7).

**Figure 1.7**  
**Has commissioning of mental health and wellbeing services in your local area by the following commissioners changed in 2016/17 and 2017/18?**



The most notable change is in the area of council commissioning of all types, where no trusts saw an increase on the previous year, 59% saw a decrease in public health commissioning, and 56% saw a decrease in other types of council commissioning. Also, given that councils are often the main financial supporters of third sector organisations it is not surprising that 37% of trusts believed that commissions from this source had decreased this year, against 30% last year.

Financial pressures on councils mean that mental health trusts are in a position where services are decommissioned altogether or severely restricted. This leaves them to either fill the gap directly by providing services themselves, without payment, or needing to provide much more expensive treatment for service users, who present much later.

Trust leaders reported the impact this is having: "[A] decrease in local authority funding has led to a reduced service." "Services are under significant pressure particularly in patient and home treatment but this is knocking on to other services." "The impact is increasing levels of unmet need and increasing pressure on our staff trying to deliver increased demand on less resources."

## Inadequate priority for mental health in STPs

Over the past 30 years the mental health sector has demonstrated its ability to deliver significant transformation – moving services out from asylums into the community, creating bespoke mental health trusts and designing and delivering more patient-centred care pathways. This experience and learning means the sector has much to contribute to the current NHS transformation agenda.

The NHS as a whole is seeking to transform. It is using STPs – a key part of the new NHS landscape – to lead the transformation process. If mental health services are to flourish and we are to realise our new ambitions, it is vital that mental health is at the centre of the STP process. A recent report by The King's Fund and the Royal College of Psychiatrists on mental health services in the new care model vanguards,<sup>23</sup> which are now part of STP delivery, throws important light on to the extent to which these test beds are working to the benefit of patients and service users in mental health. The report does not paint a positive picture. The mental health offer is often not core to enhanced service models and too often they are under-using the beneficial contribution that mental health professionals can make.

This is echoed by our survey which asked how confident respondents were that STPs would improve timely access for local populations to mental health services. There are 44 STPs across the country. Feedback from mental health trust leaders strongly suggests that mental health services are not sitting centrally in these planning processes with only 11% confident that their local STP will lead to improvements in access and quality of services. (see figure 1.8). Over 40% were worried or very worried, and 45% were neutral on the issue.

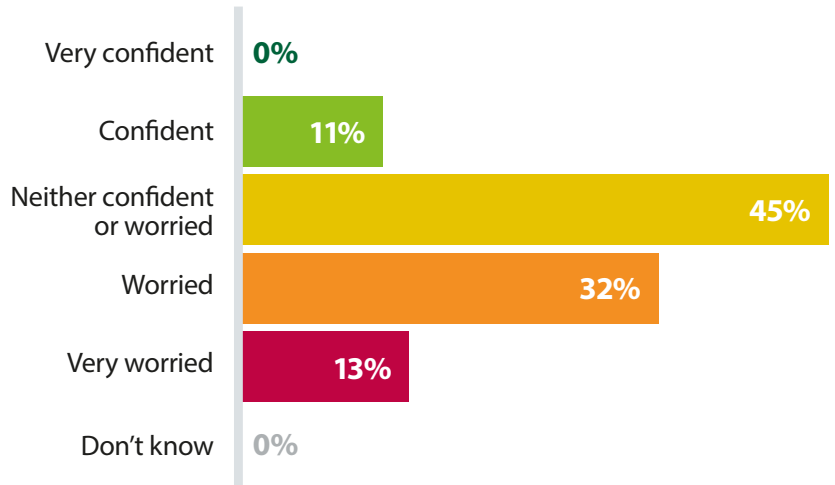
Two themes emerge from trust leaders' feedback:

- acute focus – the STP is focusing on acute services, or mental health is not sitting in the mainstream of the STP's plan, process and thinking: "too acute focused", "All the focus and STF funding has gone to the acute trusts. The mental health investment letter remains unsigned." "...in the other [area] it is yet to be mainstreamed in the way I would wish."
- lack of investment – the STP is not or is no longer investing in plans for mental health provision. "While our submission in November led to increased investment planned for mental health, CCGs locally now wish to change this as they report they can no longer afford the commitment in the plan. The commitments in the plan were not evidenced in contracts for 2017/19." "The mental health component of the STP was very good and would support delivery of improved services however the required investment is no longer available."



**Figure 1.8**  
**Mental health services providers:**  
**How confident are you the local STP process will lead to improvement in capacity to provide timely access to mental health services to your local population?**

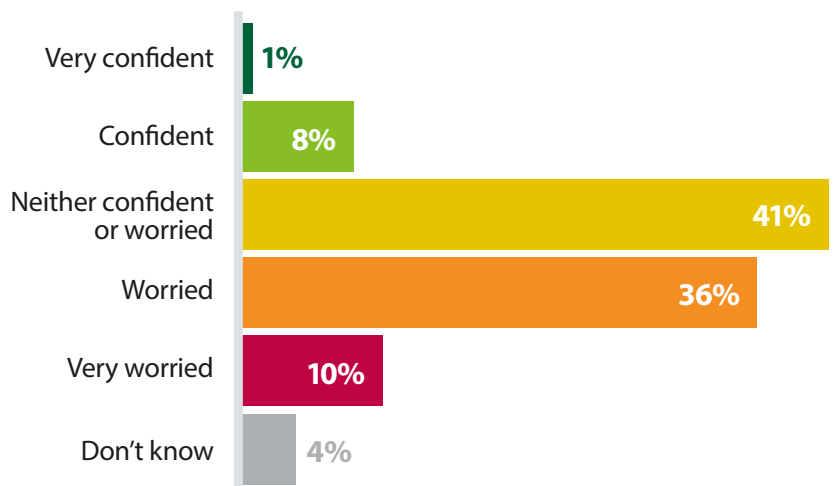
(n=38)



Interestingly the perspective from other trusts – acute, community and ambulance – on mental health involvement is even less positive. As figure 1.9 shows, only 8% were confident that STPs would deliver improvements and 46% were 'worried' or 'very worried' about the role of mental health. They commented: "mental health has not been an issue to date" and "priority is acute, primary care and urgent care."

**Figure 1.9**  
**Providers not delivering mental health services:**  
**How confident are you the local STP process will lead to improvement in capacity to provide timely access to mental health services to your local population?**

(n=112)



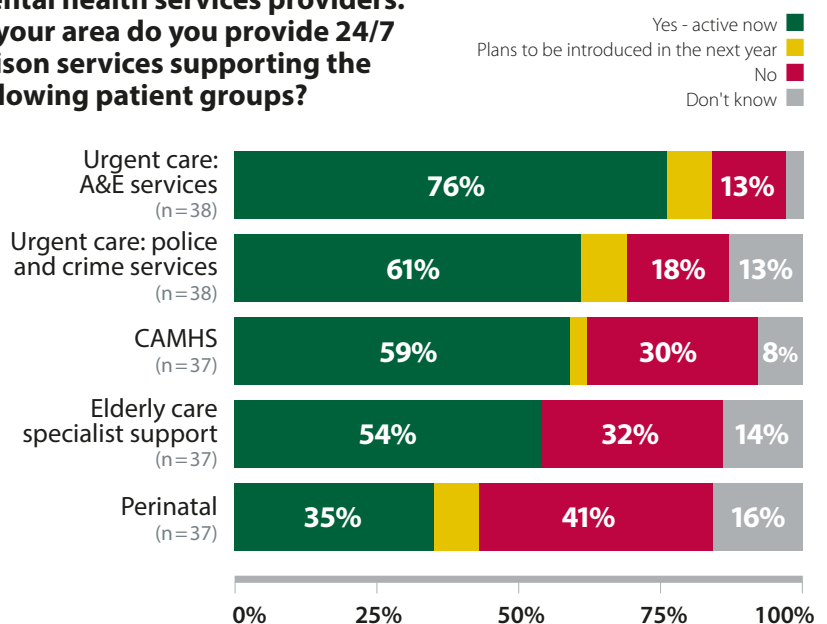
## More needed to improve working across NHS sectors: liaison psychiatry

Effective liaison between mental health and other NHS services, particularly acute care is vital. The survey therefore looked in detail at liaison psychiatry as an example of an important cross-sector service. Liaison psychiatry features heavily in the *Five year forward view for mental health*, and the aim is for 50% of all trusts to have in place 24/7 all-age liaison psychiatry services by 2020/21. We wanted to use the survey to test what progress was being made to meet these ambitions.

As the data in figure 1.10 shows, the most prevalent provision of 24/7 liaison psychiatry is for urgent care in A&E and for police and crime services, at 76% and 61% respectively (84% and 69% if including those planning to introduce from 2018/19). For CAMHS this drops to 62%, and currently only 35% of trusts deliver 24/7 perinatal liaison psychiatry.

**Figure 1.10**

**Mental health services providers:  
In your area do you provide 24/7  
liaison services supporting the  
following patient groups?**

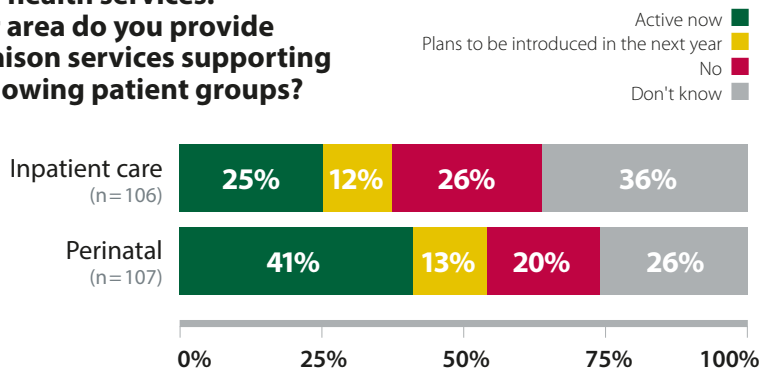


The responses to the survey in this area once again bring the impact of commissioning decisions on provision to the fore. One trust leader commented: "Though we are not the CAMHS provider... commissioners have not ensured appropriate services for under 25s and we cover the gap." Another said: "The 24/7 liaison service was decommissioned by CCGs a few years ago. There is an extended daytime liaison service, crisis team and CAMHS on call at night but not a comprehensive 24/7 service."

For acute trusts, the picture is less clear, as figure 1.11 sets out. Although over half have 24/7 liaison services in place or due to be introduced in the next year for urgent care, and just over a third had them for inpatient care, they commented that even when it was technically in place delivery could be “patchy” particularly at evenings or weekends. Over one in four did not have 24/7 liaison services in place at all for inpatient care, and one in five for urgent care.

**Figure 1.11**

**Providers not delivering mental health services: In your area do you provide 24/7 liaison services supporting the following patient groups?**



This comment from a trust leader shows how resourcing is impacting on delivery plans: “Currently plans [are] being worked up to develop liaison service but will be dependent on funding being released from other services to fund this.”

Liaison psychiatry is one of the areas of service provision subject to the new access standards for mental health services, introduced to improve quality and access.<sup>24</sup> Mental health trusts are working hard to meet these new standards but the picture is mixed. Figures 1.7 and 1.8 show the picture for liaison psychiatry, where 24/7 liaison psychiatry is a minimum requirement. The standard for talking therapies is being met in aggregate but drilling down to local figures shows that 83 out of 211 CCGs had not achieved the required standard. Although crisis care has improved dramatically through the Crisis Care Concordat,<sup>25</sup> crisis mental health services are still struggling to meet demand. Yet again the message is consistent – timely access to and the right quality of core services can only be achieved through effective resourcing and commissioning.

## WHAT PROVIDERS NEED

Our survey sets out challenges to frontline core mental health service delivery, which, despite some progress with the mental health access standards, stand in the way of realising the shared new ambition to transform mental health services.

Providers need:

- realism about demand and what's needed to meet it, recognising that increased focus on mental health and current societal pressures will generate more demand
- better ways to guarantee that mental health funding reaches the NHS mental health trust frontline
- a robust workforce strategy and, critically, support at local level to make it happen. We need to ensure that we match the ambition to expand services with a realistic view of how quickly we can grow the workforce to deliver this
- STPs to give enhanced mental health service delivery greater priority in their plans, processes and thinking
- commissioning to be overhauled to support the delivery of more coherent care and to maintain the level of financial investment in both core and new priority mental health services.

Support for mental health services at the most senior level is very important. It keeps mental health challenges on the agenda but real change will come about through local action and engagement. It is critical that there is a central/local dialogue to:

- maintain transparent monitoring and reporting of what is actually happening on the frontline, involving local providers to provide a true picture
- ensure a balance between maintaining core services and extending new services
- reach a shared understanding that this the start of a long journey.

The new commitment to improve the quality and breadth of mental health provision is welcome. But it also needs to be sustained, with the current level of energy and vigour, over the long term.

## NHS MENTAL HEALTH TRUST PROVIDERS

**NHS mental health care in England is delivered by...**

- **55 NHS mental health provider trusts**, a quarter of all NHS trusts and foundation trusts
- who employ over **180,000 staff**, including 9,000 doctors and 57,000 nurses
- and have a collective annual **turnover of £11bn**

**1.2m people a month use NHS mental health services, with...**

- **114,000 new referrals** to talking and psychological therapies
- **over 13,000 open ward stays** in adult acute and specialised mental health services
- around **314,000 active referrals for under 19s**, including over 42,000 new referrals

## THE STATE OF THE MENTAL HEALTH SECTOR

Over 50% felt they were not able to meet current demand for CAMHS and A&E services

Only 11% of mental health providers and 8% of other NHS trust leaders were confident that local STPs will help local people with better access to mental health services

Not even a third of mental health providers were confident that national workforce planning will deliver appropriate numbers of clinical staff to deliver services

80% chairs and chief executives from mental health providers are worried that funding to meet 2017/18 mandate ambitions will not be adequate

In 2017/18, 57% saw a decrease in the number of services commissioned by local authorities, 37% a decrease in third sector funding, and 22% a drop in NHS commissioning for mental health and wellbeing

Over 70% of chairs and chief executives from mental health providers expect demand for services to increase in the next six months

## FIVE KEY ACTIONS



**1**  
Realistic ambitions for what can be delivered and how within existing funding



**2**  
Dedicated mental health funds which reach frontline services



**3**  
A workforce strategy for mental health that is fit for purpose



**4**  
STPs that put mental health provision front and centre



**5**  
Commissioning approaches which support delivery of high quality services

NHS trusts are experiencing record levels of demand for their services. Many trusts are now running at capacity levels beyond the recommended norm and levels in other western systems. This is contributing to local health systems being less resilient and some being unable to cope with surges in demand. This was exemplified by one of the toughest winters the NHS has faced, with performance against waiting time targets dropping sharply despite the best efforts of staff operating under intense pressure. Other performance targets across the system are under similar pressure. For the first time, the NHS is now missing all four of its key targets: 75% ambulance response, 95% A&E four-hour, 92% 18-week elective surgery and 85% seen within 62 days of GP referral for cancer. The evidence on quality is mixed – while patient satisfaction with the NHS remains high and some trusts, despite the unprecedented pressures, are improving, the NHS faces serious challenges in maintaining standards of care.

## THE PROVIDER CHALLENGE

### Rapidly rising demand and pressure on access to services

The NHS continues to experience sharp increases in demand for hospital, community, mental health and ambulance services. Increasing demand is being matched by increasing acuity. Although there are early signs of new care models starting to make an impact, these are at a small scale, so system level demand continues to increase rapidly.

For example, in total, A&E departments in 2016/17 saw attendances increase by 3%, and 3% more patients were admitted to hospital.<sup>26</sup> These levels of demand are beyond the assumptions made in the NHS *Five year forward view*.

NHS provider capacity, including staffing levels, is broadly fixed. Despite their best efforts, trusts are therefore struggling to meet this extra demand and data from the winter period shows that performance against key targets has slipped further and more sharply as a result.

In December 2016, only three out of 139 trusts with a major type 1 A&E department met the standard of admitting, transferring or discharging patients within the four-hour target. Performance reached the lowest on record in January 2017 – down to 85% for all types of A&E and to 78% for the largest A&E departments. The last time the standard was consistently met for all types of A&E was in 2013/14. There have also been significant increases in the number of patients waiting longer than four hours before

being admitted from A&E to hospital – so-called trolley waits. Between October and December 2016, 164,555 patients waited more than four hours for a bed – this is 66% more than the same period in 2015. This is a good indication of increasing patient safety risk.

Performance across all targets is under pressure. The target for 92% of patients to start consultant-led treatment within 18 weeks dropped to 90% at the end of March 2017 – the lowest end of year performance since the standard was introduced in April 2012.<sup>27</sup>

**52%**

of trust chairs/CEOs  
say they are confident  
their trusts are able  
to provide high  
quality care

Ambulance response times are also on a downward trend. There has been a steady decline in the proportion of calls attended within the eight-minute target for Red 1 and 2 calls (67% and 59% in January 2017 against a target of 75%). The target for Red 1 calls was last met in May 2015.

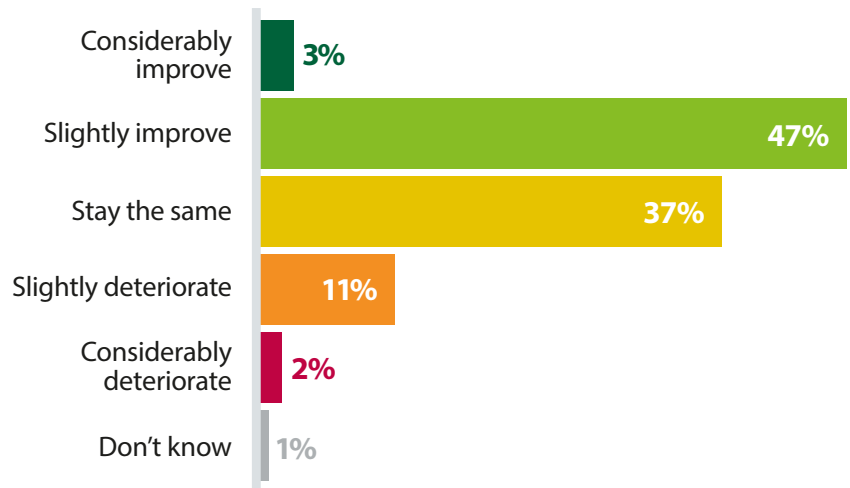
The recent decisions to relax the performance trajectories for the four-hour A&E and 18-week elective surgery targets in 2017/18<sup>28</sup> are therefore a simple recognition of reality. However, even the new A&E performance trajectory will be stretching and difficult to achieve, as The King's Fund survey of frontline NHS leaders recently concluded. In its latest survey, almost half (49%) of trust finance directors and 60% of clinical commissioning group (CCG) finance leads were either fairly or very concerned that the NHS will not be able to deliver the revised performance trajectory (from 95% to 90%) by September 2017.<sup>29</sup>

Our survey found that almost half of chairs and chief executives (47%) expect their trust's performance on waiting time targets to improve over the next six months. More than a third (37%) thought performance would stay the same; while just over one in 10 (13%) said they would deteriorate.

All of this will impact patient care. As we said in our report earlier this year, *Mission impossible? The task for NHS providers in 2017/18*,<sup>30</sup> not meeting the 95% four-hour A&E target means that patient experience and safety in urgent and emergency care will be adversely affected. Not meeting the 18-week elective surgery standard means that more patients will have to wait longer for elective surgery. And in other critical areas, such as cancer care, despite their best efforts, trusts have been unable to meet the standard of 85% of patients having a first treatment within 62 days of an urgent GP referral. Clearly this also carries patient safety risk.

**Figure 2.1**  
**Over the next six months, do you think your trust's performance against key access targets is likely to:**

(n=158)



## Increasing risk from higher occupancy levels and lower resilience

As the mismatch between rising levels of demand and the NHS's relatively fixed capacity grows, two major issues emerge: unsustainable bed occupancy levels and growth in the number of local health systems that are less resilient.

First, bed occupancy levels are now regularly well above the recommended safe level of 85% for all weeks during the winter period, peaking at 96%.<sup>31</sup> Bed occupancy figures reached 88% for the October-December period – this is the highest ever recorded levels since quarterly data began in 2010/11.<sup>32</sup> Exceeding the 85% recommended level is associated with much greater levels of patient safety risk. As the National Audit Office has noted, regular bed shortages, periodic bed crises and increased numbers of healthcare-acquired infections are all more likely to occur in hospitals with average bed occupancy levels above 85%.<sup>33</sup>

One key driver of increased occupancy levels is the rising number of delayed discharges the NHS is experiencing. In January 2017 there were 197,100 total delayed days, up 23% from 159,600 a year earlier.<sup>34</sup> This affected more than 7,000 patients who were medically fit for discharge but were delayed from leaving hospital – the highest since monthly data began in August 2010. There are many reasons for delayed discharge, but the proportion due to issues with social care increased to 40% in March 2017. However, delays within the NHS family remain the largest category.



High occupancy levels can mean that hospitals become much less efficient, which in turn leads to more cancelled operations. These reached record levels over the winter. During the quarter ending in December, 21,249 patients had their operations cancelled for non-clinical reasons. This was up by 2,856 patients for the same quarter in the previous year.<sup>35</sup>

Running at these occupancy levels means lower levels of resilience and more trusts that are less capable of coping with surges in demand, as the increased number of trolley waits and ambulance handover delays showed this winter.

## Increasing pressure on quality of care

Any analysis of NHS care needs to be placed in the broader context of the continuing significant improvement in patient outcomes. Better prevention, earlier diagnosis and innovative new treatments are leading to better survival rates for conditions such as cancer, stroke and coronary heart disease. For example, stroke death rates<sup>36</sup> in the UK fell by almost half in the period from 1990 to 2010 and 10-year cancer survival rates<sup>37</sup> have been improving steadily, although they are often still lower than in comparable countries.

However, in its report on *The state of care in NHS acute hospitals*, which is based on inspections of all 136 NHS acute trusts and all 17 specialist trusts, the Care Quality Commission (CQC) argued that “the scale of the challenge that hospitals are now facing is unprecedented – rising demand coupled with economic pressures are creating difficult-to-manage situations that are putting patient care at risk.”<sup>38</sup>

Evidence on the degree and extent to which pressures are affecting quality of care is mixed. In its most recent annual report on care quality, the Nuffield Trust and Health Foundation concluded that care quality is being sustained in several areas such as public health, stroke care and patient satisfaction, but they also noted a recent slowdown in the progress towards eradicating healthcare-associated infections.<sup>39</sup> However, in a separate report the Health Foundation concluded that it is too early to tell whether rising pressures on the NHS are affecting the overall quality of patient care.<sup>40</sup> They also pointed to important gaps in our understanding of care quality in areas such as community services.

Informed by a near complete set of inspection results for all trusts, the CQC inspection data is also mixed. Of the 235 NHS trusts in England, 231 have now been inspected and rated with a majority of trusts rated as either requiring improvement or inadequate. Fourteen (6%) were rated outstanding; 91 (39%) were rated good; 113 (49%) were rated as requiring improvement; and 13 (6%) were inadequate.

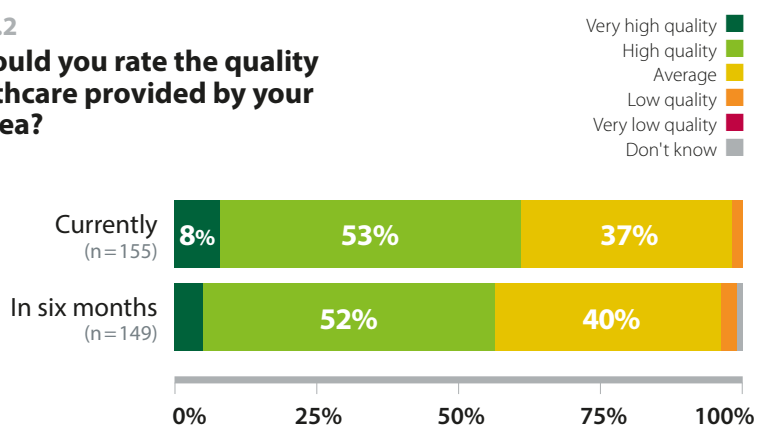
The CQC has concluded most hospitals are delivering good quality care and looking after patients well, even though they face constraints. They found many trusts have shown they can improve despite their challenges but that some trusts – even those rated ‘good’ – had blind spots in particular core services. They argued the best trusts balance money and quality effectively but that too few trusts have an effective patient safety culture in place. They also found leadership to be key, with successful trust boards working hard to create a culture where staff felt valued and empowered to suggest improvements and question poor practice. However, in their view, too few trusts listened effectively enough to staff.

Patient safety remains a concern, with 81% of acute trusts rated ‘inadequate’ or ‘requires improvement’ in this domain. However, the CQC found the majority of people are treated with compassion, dignity and respect with 93% of trusts rated ‘good’ or ‘outstanding’ in the caring domain.

The CQC’s latest inpatient survey<sup>41</sup> indicates that patient perceptions of the care they receive are still strong, with some small but statistically significant improvements in a number of questions compared to recent years. This includes patients’ perceptions of the quality of communication between medical professionals and patients, the standards of hospital cleanliness and the quality of food. However, patients’ perceptions were less positive when it came to waiting times, being involved in decisions about their care and treatment, information sharing when leaving hospital, and support after leaving hospital.

Responses to our survey of chairs and chief executives reinforce the mixed picture outlined above, with 61% saying they are confident their trusts are currently able to provide high quality care (this was 64% when we last surveyed them for our report in November 2016).<sup>42</sup>

**Figure 2.2**  
**How would you rate the quality of healthcare provided by your local area?**



## Improvement initiatives

There are a number of initiatives underway to improve quality of care, but it is too early to tell whether they will consistently deliver systematic improvement. These include quality special measures, where success has been varied. All of the trusts that were originally placed in the regime have now demonstrated sufficient improvements to emerge from it. However, some trusts have stayed in the regime far longer than expected, while two trusts have re-entered. This suggests the scheme is not working as effectively as it should be. Fifteen trusts remain in special measures.

Five NHS trusts are embedded in a five-year partnership with NHS Improvement and the Virginia Mason Institute in order to support them to develop a 'lean' culture of continuous improvement which improves patient care.

Other improvement initiatives, such as the national emergency care improvement programme and A&E delivery boards, are helping trusts to cope with demand more effectively. However, we are waiting to see whether these initiatives support a return to the 95% four-hour A&E constitutional target.

## Tackling variations in care quality

The persistence of variation in the quality and standards of care that exists within and between trusts – as evidenced by the CQC<sup>43</sup> – remains a concern. There are many causes of unwarranted variation, and some will be legitimate, for example when adopting innovations.

Trusts report that rapid elimination of unwarranted variation is often more difficult than might be immediately apparent. Reasons for this include: the need to validate outlying data; clearly establishing the reasons for variation; designing a change programme to tackle these causes; ensuring appropriate clinical alignment; and then delivering what is often a complex set of changes. This all needs to be achieved at a time when analytical, change and project management resource has been scaled back and management bandwidth is at a premium.

## WHAT PROVIDERS NEED

- NHS trusts need a smaller number of priorities, with a realistic delivery trajectory for each. A new government has the opportunity to review what is being asked of the NHS within its available resources.
- While we welcome the new performance trajectories announced by NHS England for the key four-hour A&E and 18-week elective surgery targets, trusts would prefer to be properly funded to meet all the standards outlined in the NHS Constitution. As we noted in a recent article in the *Guardian*, a lower elective surgery target will not make it easier to recover A&E performance and even the relaxed trajectory looks challenging.<sup>44</sup>
- We need to ensure patient safety risk is appropriately resourced to manage the pressures the NHS will face next winter. The government's strategy of creating NHS capacity through the extra £1bn social care funding allocated in the budget only offers a partial solution. More capacity and a longer-term approach will be needed.<sup>45</sup>
- Trusts report they lack the capacity and capability to reduce unwarranted variations in performance. NHS Improvement needs to review what support and investment is needed to drive the required changes at trust level.

The NHS is in the middle of the longest and deepest funding squeeze in its history. While the extra funding promised in the Conservative manifesto is welcome, spending on health will still fall as a percentage of our national wealth until 2022/23. NHS trusts made significant progress in reducing the provider sector deficit in 2016/17 as a result of a clear plan, financial support and a lot of hard work from trusts on the frontline. However, heavy dependence on one-off and non-recurrent savings, and much lower funding increases for the coming years, suggests trusts will struggle to eradicate the provider sector deficit. The National Audit Office (NAO) is right to argue that the NHS still does not have a clear, credible plan to match what is required of the NHS to the funding available.

## THE PROVIDER CHALLENGE

### Progress on reducing the deficit

After ending the 2015/16 year -£2.45bn in deficit (though the underlying deficit was, in reality, around -£3.7bn), the NHS provider sector was set a target of reducing the deficit to -£580m by the end of March 2017. This was considered a key strategic priority for the NHS in 2016/17. Official quarterly figures published in June 2017 by NHS Improvement revealed the sector ended the year with a deficit of -£791m. This is just under 70% less than the deficit in 2015/16 and a substantial improvement on the third quarter forecast issued in February 2017, which stood at -£886m.

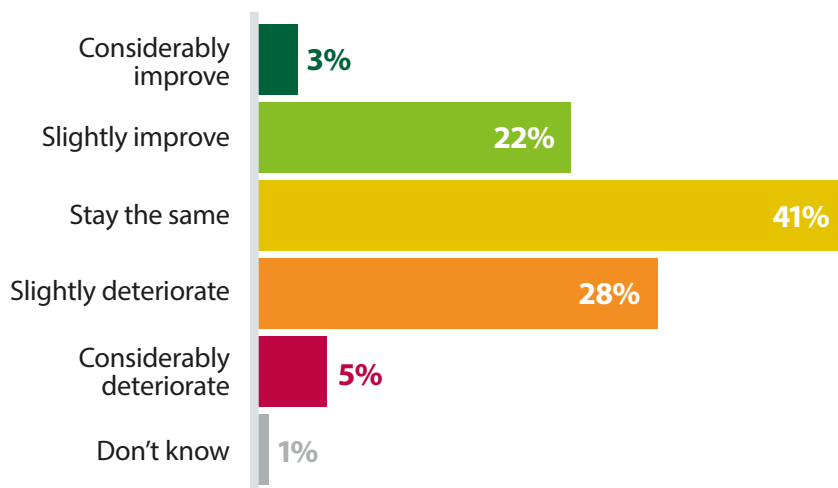
Despite the challenge of seven years of stretching cost improvement programmes, trusts have again managed to increase the level of cost improvement gain they made. In 2016/17 they realised £3.1bn of cost improvement gains, an increase of £208m, 7% compared to the previous year. This equates to 3.7% of turnover, an impressive performance.

One of the key areas of success has been reducing spending on agency and temporary staff, where following the Francis review and the need to recruit more staff, total spending in this area had risen to £4bn per year. In 2016/17, trusts reduced these costs by more than £700m – 24% – compared to the year before, with 85% of providers reporting a year-on-year reduction in their agency expenditure.<sup>46</sup>

This stronger performance is reflected in our survey of chairs and chief executives. When asked how they expect their trust's finances to develop over the next six months, a quarter predicted they would improve. A third expect their trust's finances to deteriorate, while most (41%) expect their finances to stay the same. The number of trusts in deficit at the end of 2016/17 was 105 compared to 153 in 2015/16.

**Figure 3.1**  
**Over the next six months, do you think the financial performance of your trust is likely to:**

(n=156)



This stronger performance has depended on the introduction of a new financial regime including £1.8bn sustainability and transformation funding linked to centrally set control totals for each trust. This regime was described as temporary, not least because of the potential distorting effects and loss of provider autonomy that it brings.

**1 in 3**

trust chairs/CEOs expect their local trust's finances to deteriorate over the next six months

## Reliance on 'one-off' savings

Despite these improvements, trusts are concerned about the sustainability of a deficit reduction approach that is highly dependent on short-term, non-recurrent, actions such as land sales, capital to revenue transfers and accounting adjustments.

In an NHS Providers survey of finance directors in February 2017, two-thirds of respondents said they were highly reliant on these one-off measures to reach their year-end financial position. We estimate that c.£1bn of savings in 2016/17 were likely to be non-recurrent.<sup>47</sup>

## Impact of reduced capital funding

The NHS is capital intensive, requiring significant investment to maintain buildings, modernise facilities, invest in new treatments and IT and fund much-needed transformation. In his review of NHS property and estates<sup>48</sup> Sir Robert Naylor concluded that a minimum £10bn of additional capital funding will be needed to support the sustainability and transformation partnership (STP) process and clear the maintenance backlog that has

been allowed to build up in recent years. Prolonged underinvestment including using capital to subsidise revenue has now become unsustainable, as highlighted by the NAO in a recent report.<sup>49</sup>

In its 2017 budget the government made an initial investment of £100m in A&E departments, £325m in transformation funding, and announced its intention to provide further capital funding. NHS trusts and NHS system leaders need to work together to create a compelling investment proposition for the November 2017 budget. It is particularly important that the government takes a realistic view of how much can be generated from land sales and how quickly. It must also recognise that the majority of the value freed up from land sale will be geographically concentrated in London.

## Financially challenging 2017/18 and beyond

Frontline NHS funding is due to drop from the 3.8% increase in 2016/17 to +1.4% in 2017/18, +0.7% in 2018/19 and +1.3% in 2019/20, providing a significantly greater challenge. While all extra funding is welcome, the government's manifesto commitment of £8bn for the NHS is unlikely to make a significant difference to the degree of extra challenge the NHS will face. As the Nuffield Trust and others have pointed out, the increase would not keep NHS spending rising in line with the wider economy, and falls far short of keeping up with costs and demand.<sup>50</sup>

Trusts therefore start 2017/18 with a larger than planned deficit and, on average, a 4.2% CIP saving requirement – up from 4% last year. The NAO, public accounts committee and others have stressed the importance of setting realistic savings target and that the 4% efficiency target previously set for trusts was “unrealistic and damaging to trusts’ finances”.<sup>51</sup>

## Funding for winter pressures

Following challenged NHS performance last winter, the 2017 budget committed £2bn of extra funding to councils in England over the next three years to spend on adult social care services to help ensure people receive the support they need and also relieve pressure on the NHS. £1bn will be available this year. The budget said that “local councils will need to work with their NHS colleagues to consider how the funding can be best spent”. An NHS Providers survey published in June<sup>52</sup> suggested that while 28% of trusts have secured a commitment that should help reduce delayed transfers of care, the remainder were unlikely to benefit from this extra social care money. As a result, 43% of trusts were concerned about their ability to manage the risk to patient safety in the coming winter.

## Improvement and support

NHS Improvement continues to provide a mixture of financial oversight, regulation and intensive support for trusts. Since our November 2016 report, two trusts have come out of financial special measures but a further three have now gone in, leaving nine still in the regime.<sup>53</sup> It is still too early to tell whether the financial special measures regime is a consistently effective tool and there remains a concern that trusts are sometimes placed into special measures due to wider system financial issues that are beyond their control. A number of trusts have participated in two rounds of a financial improvement programme with a third round currently in design.

## WHAT PROVIDERS NEED

- A realistic strategic plan for the rest of the parliament and a more detailed plan for the next two years which honestly sets out what can be achieved for the funding available. This needs to include an achievable trajectory to recover provider sector financial balance.
- A new longer-term financial regulatory framework, to replace what was always intended to be a short-term sustainability and transformation funding/control total regime. Provider autonomy must sit at the heart of this framework and we need to return to the days when the average trust, performing well, was able to produce a 4% surplus, enabling it to invest in the improvement of services. As part of this framework we also need to decide how the £1.8bn sustainability and transformation funding will be mainstreamed.
- Short-term, the NHS needs to quickly review where the extra £1bn social care funding will have the required impact and then develop and fund an alternative plan to create the required capacity across the whole system to manage next winter safely.
- A capital investment plan, which recognises the £10bn investment need identified in the Naylor report. This plan must take a realistic view of how much can be raised from land sales how quickly and strike the appropriate balance between government funding, land sale income and third-party capital.
- A rapid review of the estimated £5.6bn that is spent on non-frontline care in the Department of Health, its arm's length bodies, and in commissioning. It should set a clear target and timetable of how much should be reallocated to the frontline.

A programme of investment is needed to provide trusts with the capacity and capability they need to realise the more complex savings that have been identified in the Carter review.



Workforce is a top concern for trusts up and down the country, and the workforce challenge is now equal in scale to the NHS financial challenge. Although different trusts face different pressures, the sector as a whole is finding it increasingly difficult to recruit and retain sufficient staff with the skills and experience needed to meet the rising demand for services. Trusts are also struggling to match the staffing levels they require with the finances available. Even if money were not a constraining factor, insufficient staff have been trained within the UK to meet current and projected demand. These shortages impact directly on the safe and sustainable delivery of high quality care, with trusts finding they are increasingly having to close or suspend services for short periods of time or altogether.

## THE PROVIDER CHALLENGE

### Workforce now the top concern

The growing set of workforce challenges facing NHS providers are now the biggest concern of trust leaders. As a chief executive from an acute provider stated in our survey: "It is the only thing that keeps me awake at night. It speaks to our capacity to provide safe quality of care to patients."

There are a range of concerns, many of which are captured in summary form in figure 4.1 and explored in further detail in this section:

**Figure 4.1**

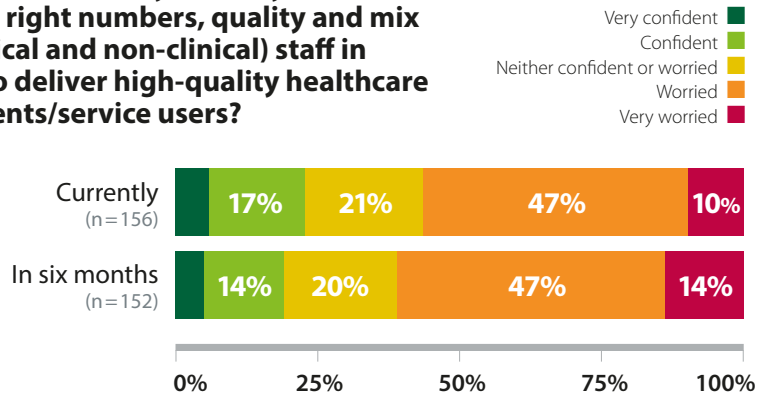
Challenge	Brief description
<b>Workforce shortages</b>	There are significant shortages of staff, most notably clinical staff such as nurses, some medical specialists, and paramedics. Demand for services, and in turn demand for staff to deliver services, has grown more quickly than the pipeline of new staff. At the same time, national workforce policy decisions have too often been dominated by unacknowledged funding considerations, which has created unintended consequences later e.g. cutting nurse training places by 10% around 2010.
<b>Workforce numbers/finances mismatch</b>	There is a mismatch between the number of staff required to meet rising demand for services and safe staffing and the NHS budget. There is a lack of transparency about how the NHS funding envelope constrains national workforce planning decisions about how many staff to train and influences trust-level forecasts of demand for staff.

<p><b>Problems recruiting and retaining overseas staff</b></p>	<p>We are not training enough doctors, nurses and other health professionals to be self-sufficient so the NHS currently depends on clinical staff from overseas to fill workforce gaps. Brexit has introduced unwelcome uncertainty for existing and potential EU staff. Tougher language tests for professional registration and increased immigration charges have also made it more difficult and/or expensive to recruit overseas staff. Post-Brexit referendum exchange rate shifts have also made the UK a less attractive place to work.</p>
<p><b>Increasing retention problems linked to pay restraint and work pressure</b></p>	<p>Trusts are increasingly struggling to retain existing staff as the job gets tougher and pay falls in real terms. NHS pay has been restrained for seven years and there is increasing demand from staff, NHS leaders, and a range of politicians, for a plan on how this restraint will end, when, what approach will be taken in its place, and how it will be funded. NHS workers report themselves as being under increasing pressure with the job becoming increasingly stressful, pressured and difficult. The junior doctors dispute has left a particularly difficult legacy with a key group of NHS staff.</p>
<p><b>Disjointed approach to NHS workforce strategy at the national level</b></p>	<p>Responsibility for NHS workforce strategy is fragmented across a number of different organisations – Department of Health, Health Education England, NHS Improvement, NHS England and local trusts – and there is no effective mechanism for ensuring a coherent and credible overall approach. As a result, there is no single agreed high-level NHS workforce strategy. There is no clear leadership of key strategic developments such as the introduction of student loans for healthcare students and the workforce transformation required for the NHS <i>Five year forward view</i> and new care models.</p>
<p><b>Failure to innovate and adapt quickly enough</b></p>	<p>Given the disjointed approach to workforce strategy, the NHS is struggling to innovate and adapt at the speed required – for example developing new workforce models or developing a new psychological contract for a generation of younger workers who are looking for a different employment relationship.</p>

Our survey showed that well over half of trusts (57%) are 'worried' or 'very worried' about their current ability to maintain the right numbers of staff – clinical and non-clinical – to deliver high-quality care (see figure 4.2). When asked what the picture would look like in six months' time, their level of confidence decreased and 61% were 'worried' or 'very worried'.

Figure 4.2

**How confident are you that your trust has the right numbers, quality and mix of (clinical and non-clinical) staff in place to deliver high-quality healthcare to patients/service users?**



## Matching workforce with funding

The pressures on workforce and funding are intertwined. Trusts are struggling to match the staffing levels they require with the finances available, and there are no quick fixes. Even if money were not a constraining factor, insufficient staff have been trained to meet current and projected demand. And, where staff can be recruited, trusts cannot afford to employ them and balance their books.

The workforce picture for healthcare providers continues to be one where the NHS needs a strategic, planned solution to the triple-headed problem of ensuring a supply of staff, meeting rising demand and affordability.

**61%**

worried they won't have the right staff numbers, quality and mix in six months to deliver high-quality care

## Pressure and morale

Frontline services faced intense and persistent pressure this winter, throwing into sharp relief the impact of staff shortages and rising demand on the morale of the workforce. Staff battled to manage, not only the highest ever A&E attendances, but the knock-on effect across the health and social care system. A range of reports have illustrated the impact of these pressures on staff. For example, the Royal College of Physicians highlighted the risk of staff burnout. In the words of one consultant:

"I have never before known a time when consultant colleagues are constantly exhausted, trainees so disillusioned (as director of medical education, I receive daily visits and emails from trainees who want to talk about leaving medicine) and hospitals under unremitting clinical and financial pressures. Of course, problems with recruitment also apply to other healthcare professionals – particularly nurses."<sup>54</sup>

The latest General Medical Council training survey shows, for example, that over half of all doctors in training say they work beyond their rostered hours at least weekly, and more than a fifth claim working patterns regularly leave them short of sleep.<sup>55</sup>

These morale issues are reflected in NHS staff survey feedback. While the survey results overall have held up well despite the increasing pressure, there are worrying individual results. These show that over 70% of staff are working extra hours and 37% of staff report feeling unwell due to work related stress in the last 12 months prior to the survey.

**Figure 4.3**

**Feedback from the staff survey in 2016 reflects the pressure on staff and their continued commitment.**

<b>70%</b>	staff working extra hours
<b>47%</b>	staff disagreed that there are enough staff at their organisation for them to do their job properly
<b>37%</b>	staff feeling unwell due to work related stress in the last 12 months
<b>28%</b>	staff experiencing harassment, bullying or abuse from patients, relatives and the public in the last 12 months

## Staff shortages

The NHS staff survey and our survey showed concern over the number of staff needed to do a proper job. The following issues impact on this:

- Specialty shortages** – the shortage of staff in some specialty areas, such as emergency medicine, nurses and midwives, presents particular difficulties for the delivery of services such as A&E and maternity. Also, there are also major shortages in non-acute services with a 13% decrease in full-time equivalents mental health and community nurses and a 42% drop in district nurses employed between 2009 and 2016 in the NHS.<sup>56</sup>
- Recruitment and retention** – sustained pressure on the frontline can lead to extremely stressful working conditions which, combined with the ongoing pay freeze, are beginning to have an adverse impact on trusts' ability to recruit and retain some staff groups. This has been clearly highlighted by the independent pay review bodies,<sup>57</sup> and NHS Providers has called for an agreed strategy, covering the life of this parliament, to end 'pay restraint'.<sup>58</sup> The issue was raised throughout the

general election and has now become a matter of political debate with many politicians arguing for a clear plan to end pay restraint.

- **Brexit** – the triggering of Article 50 is also having an adverse impact: currently the rights and status of 161,000 European Economic Area (EEA) staff working in health and social care are unclear;<sup>59</sup> at the same time it is yet to be decided whether and how the NHS will be able to recruit from the EEA in future. Recent evidence from the Nursing and Midwifery Council shows a 96% year-on-year drop in the number of EEA nurse registrations, though factors beyond Brexit may have an influence here.<sup>60</sup>

Workforce shortages impact directly on the safe and sustainable delivery of high quality care. Trusts are finding that they are increasingly having to close specialty services for periods of time or altogether. In many places, they are finding it difficult to fill rotas, requiring extensive use of agency staff or asking existing staff to fill gaps and work longer or extra shifts.

## Creating capacity

NHS workforce pressures are substantial. However, there are some developments which may, in the medium and long term, help the supply pipeline flow again and manage some of the workforce costs:

- **Agency spend** – despite the substantial pressures, there is continued progress on reducing agency spend, with the latest figures indicating a saving of £700m since the price caps were introduced in October 2015.<sup>61</sup> This makes a helpful contribution to the NHS bottom line, and also to the quality and safety of NHS care.
- **Training** – although applications for nursing had fallen by 23% as of January 2017, universities remain confident that they will fill the available places with students of the right quality, despite the changes to nursing bursaries.
- **New and more staff** – NHS trusts have embraced the new nursing associate role,<sup>62</sup> and are taking steps to boost the contribution of apprenticeships to the NHS workforce.<sup>63</sup> The government is also consulting on expanding the number of medical students by around 25%.<sup>64</sup> However, there is significant trust concern that expansion will take time to deliver and may not be affordable.
- **Local initiatives** – faced with the prospect of ongoing staff shortages more trusts are taking the initiative locally, with schemes to improve long-term workforce supply. These range from making links with local colleges which include guaranteed employment at the end of courses, to forming relationships with local secondary schools to promote careers in the NHS.

## WHAT PROVIDERS NEED

- A realistic, joined-up, long-term workforce strategy which ensures that frontline organisations have the right number of staff with the right skills in the right place to deliver high quality care within the allocated financial envelope. This will require a more coordinated and effective approach to national workforce issues between the different elements of the national NHS level system.
- Given persistent staff shortages, a credible and coherent plan to plug the short-term gap as well as a sustainable plan for workforce numbers that matches the projected NHS funding envelope.
- Urgent clarity on the status of current EU nationals working in the NHS and an immigration system that allows the NHS to recruit the staff it needs.
- An appropriate match between what is asked of the NHS and the funding available to alleviate the stress and pressure on NHS roles and to ensure that we are not consistently asking NHS staff to do the impossible.
- A strategy to move away from seven years of pay restraint to ensure that NHS roles are appropriately rewarded and remain attractive.

The existing fragmented NHS pattern of service delivery is no longer fit for purpose and trusts recognise the need for transformation. Trust leaders support the idea of system-based planning and the vision outlined in the NHS *Five year forward view* of moving to new ways of providing care, including accountable care organisations and systems. They see the integration of health and care as a potential means of addressing the challenges of rising demand, responding to the growing number of individuals with more complex health needs and improving health outcomes. New care models are making good progress in transforming care and are gathering pace across the country, but they still only cover small areas and are limited in scope. And there is no compelling evidence that they will deliver long-term financial savings or reduced hospital activity.

There is support for the concept of sustainability and transformation partnerships (STPs) as a means of delivering these changes but there are some key barriers to overcome. We also need transformation to move faster while also being realistic about how long it will take to deliver these changes.

## THE PROVIDER CHALLENGE

Given the diversity of the NHS and the range of different perspectives within it, there is a remarkable degree of agreement, thanks to the NHS *Five year forward view*, on the nature of the transformation the NHS needs to undertake. Figure 5.1 sets out some of the key changes the NHS needs to make.

**Figure 5.1**

### **Some of the key changes required to transform the NHS.**

<b>Change required</b>	<b>Brief description</b>
<b>Whole population management</b>	Focusing on how to improve the health outcomes of the entire population served, not just those presenting at a hospital or GP surgery.
<b>Prevention and wellbeing</b>	Investing more in ensuring the health and wellbeing of the population served and more in preventing illness, as opposed to just focusing on treating those who become ill.

<b>Moving care closer to home</b>	Ensuring that as much care as possible is delivered in a patient's home or a community setting close to where they live. Related to this, ensuring that acute hospital care is only used where necessary and avoiding hospitals treating patients who could be treated in other settings.
<b>Greater patient self management and control</b>	Enabling citizens, for example those with long-term conditions, to take greater responsibility and control of their own health and treatment.
<b>New care models</b>	Integrating care across health and social care, physical and mental health and primary and secondary care, ensuring patients receive seamless, joined-up care.
<b>Strategic commissioning</b>	Ensuring commissioning focuses on whole population health outcomes and avoids becoming bogged down in low level, tactical, contract management.
<b>Information technology</b>	Using information technology more effectively to support and enable the required changes, for example developing a single care model to be used by all health and care professionals involved in a patient's care.
<b>Building blocks to underpin and enable changes required</b>	Developing new contracting, funding, workforce and information governance models and organisational forms.

The NHS *Five year forward view*, launched in October 2014, is now 1,000 days old. How effectively is the NHS delivering the vision it contained?

## New care models

New care models are making good progress in transforming care and are gathering pace across the country. However, they still only cover small areas and are limited in scope (either covering one health condition or one demographic such as older people). The early impact of the 50 vanguards is encouraging as there is good evidence of improved patient outcomes. For example, Sutton Homes of Care's "Red Bag" innovation has reduced average hospital lengths of stay by four days. However, there is little evidence so far of financial and efficiency benefits.



This is confirmed by a recent Nuffield Trust review<sup>65</sup> of emerging STPs combined with an analysis of 27 initiatives to move care out of hospital. This concluded that while many of these initiatives have the potential to improve patient outcomes and experience, many would not deliver savings and some actually increase overall costs.

A recent National Audit Office (NAO) report also confirmed that integrated models of care can improve patient experiences and outcomes but that there is no compelling evidence of long-term financial savings or reduced hospital activity.<sup>66</sup> The NAO also examined the Better Care Fund, one of the key government initiatives to integrate health and care, and concluded that it has not achieved the expected value for money in terms of savings, outcomes for patients or reduced hospital activity.

The report highlighted a number of barriers to achieving integrated care, including misaligned financial incentives, the need to change workforce profile and the need to share information.

**Figure 5.2**  
**Barriers to integration.**

<p><b>Misaligned financial incentives</b></p>	<ul style="list-style-type: none"> <li>• Separate health and social care systems.</li> <li>• Payment systems in the NHS that promote competition and drive activity in hospitals.</li> <li>• Allocation of the £2.1bn NHS sustainability and transformation fund for 2016/17, of which £1.8bn was allocated to covering NHS deficits rather than transformation.</li> </ul>
<p><b>Workforce recruitment and retention</b></p>	<ul style="list-style-type: none"> <li>• Care Quality Commission data show vacancy rates as high as 20% in domiciliary care and 11% in residential care.</li> <li>• NHS workforce statistics show a 41% fall in district nurses between 2009 and 2015.</li> </ul>
<p><b>Information sharing – guidance to facilitate data-sharing and governance across the health and care system</b></p>	<p>There is patient demand for online services in 2016 (next steps on the NHS <i>Five year forward view</i>):</p> <ul style="list-style-type: none"> <li>• 10.4 million people are registered for online services</li> <li>• 1.1 million appointments managed online.</li> </ul>

62%

worried that their area  
isn't transforming  
quickly enough

It is worth noting that, on the ground, actual patterns of NHS service delivery are moving away from the agreed direction of travel set out in the *NHS Five year forward view*, for example its goal of strengthening community-based services and focusing on prevention. Recent research by The King's Fund<sup>67</sup> found that financial pressures are having the greatest impact on essential support and prevention services including genitourinary medicine and district nursing. Many of the cuts that have been made, including cuts to preventative services, are storing up problems for the future. An NHS Providers survey in late 2016 also found that intermediate community service capacity such as step up and step down beds was being reduced rather than increased despite the *NHS Five year forward view* vision of moving care out of hospital into the community.<sup>68</sup> The King's Fund's research also found instances where innovation was stifled because of the necessary funding, staff time or skillset being unavailable.

In other words, whatever the strength of the vision and the degree of agreement behind it, the NHS risks being pulled in the wrong direction through pressure on financial and staffing resources. We also still do not have a clear and robust delivery plan on how the NHS, in every local system, will move from a small number of vanguards into consistent adoption of new care models across the country.

## Devolution

Greater Manchester continues to lead the way on taking devolved control of its £6bn annual health and care budget. Considerable progress has been made in defining a strategy, setting up governance structures and identifying appropriate change programmes. Early changes such as the consolidation of the provider sector and plans to move to a single model of acute services are now in place. However, it is still too early to judge the ultimate success of this bold experiment. NHS England has recently announced a devolution health deal for Surrey, but other areas that initially declared an interest in a devolution health deal have since fallen away.

## STPs

STPs continue to be a key driver of local transformation. The *Next steps on the NHS five year forward view* outlined NHS England's and NHS Improvement's intention to allow different STPs to move at different speeds. Sensibly, the fastest will be able to progress without delay but others will not be forced into adopting a single uniform approach that they are not ready for.

The *Next steps* report set out an expectation that the most advanced STPs will evolve into locally integrated health systems – these are being called ‘accountable care systems’. The first eight systems, recently announced, will be expected to have collective decision making and governance structures to oversee transformation. In time, some will become accountable care organisations, where a single organisation provides or oversees the majority of health and care services for a local area.

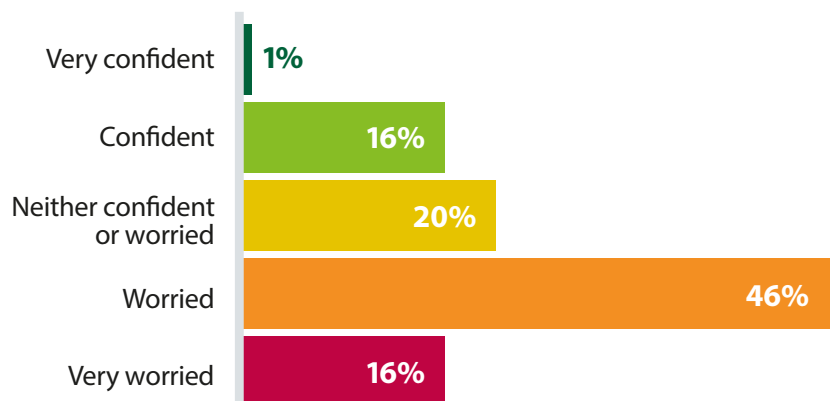
However, while there is support for the concept behind the STP process, trusts and other independent commentators have concerns over how achievable the plans are within the available timescales and funding levels. The Nuffield Trust for example has warned that the falls in hospital activity projected in many STPs will be “extremely difficult to realise”.<sup>69</sup> International experience, for example from American integrated care organisations and Ribera Salud in Spain, suggests that successful development of the kind of models being targeted takes 10 to 15 not three to five years.

The governance arrangements of STPs have been a long running concern for trust leaders. The *Next steps* report began to recognise the importance of existing governance and accountability structures, but also the opportunity for shared decision-making at the STP level. It also recognises that the 2012 Health and Social Care Act prevents the creation of a formal ‘mid-level STP tier’ with statutory powers.

In summary, while there are early signs of progress, the overall sense is of an NHS struggling to change at the speed required. Our survey reinforces these concerns: almost two-thirds of leaders are worried their local area is not transforming quickly enough. Fewer than two in 10 (17%) are confident that this is happening.

**Figure 5.3**  
**How confident are you that transformation activity in your local area will progress as well as it needs to over the next six months to deliver long term plans?**

(n=158)



## WHAT PROVIDERS NEED

- NHS trusts recognise the need for rapid transformation as set out in the NHS *Five year forward view*. To speed up the pace of change, trusts need:
  - much enhanced leadership capacity at the frontline to deliver the required transformation alongside the task of providing outstanding day to day care in an increasingly unstable context where demand is rising rapidly
  - a capital plan that reflects the fact that no other sector has ever attempted transformation on this scale without proper funding
  - some risks will need to be taken, including turning the arm's length body model on its head – from an approach based on assurance and regulation to one that supports and enables change and transformation
  - continued funding for the vanguards given their job is only three-quarters complete. The vanguards are still creating key transformational building blocks such as new contracting and funding models; new information governance approaches to enable joined up care records and new workforce models. They need targeted funding for at least one more year to ensure the task of creating these key building blocks for others to use is completed
  - clarity on where we are headed with STPs. If they are to be our main vehicle for transformation, we need much greater clarity on their longer-term status as the current picture is confused.
- National political and system leaders will also need to be realistic about the pace at which STPs can deliver change. Progress will vary across the country depending on the strength of the plans. Alternative plans should be developed where a more credible set of proposals are needed.
- Adequate investment and additional capacity in community services is needed to support programmes and initiatives that attempt to manage demand. Any attempts to shift significant amounts of care closer to home will require additional supporting facilities in the community, appropriate workforce and strong analytical capacity. These are frequently lacking and rely heavily on additional investment, which is not currently available.
- STPs have received criticism for the way in which they were produced and perceptions of a lack of meaningful engagement with the public, health care staff and others such as governors and non-executive directors. Trusts will need to be supported to communicate and engage their local communities in the proposed changes.

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