

# The Lord Darzi Review of Health and Care – NHS Providers submission

## About NHS Providers

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has 99% of all trusts in membership, collectively accounting for £74 billion of annual expenditure and employing more than one million staff.

## Key points

- Given the prospect of a longer term funding settlement, the impetus behind STPs and ICSs (despite lack of legislative change), the forthcoming social care green paper and a rising recognition that change is needed to avoid a crisis in patient safety and quality of care, this review is timely and we welcomed the findings in the interim report.
- While improvements have been made since the original *High quality of care for all* report was published; patient satisfaction with the NHS remains high; and some trusts, despite the unprecedented pressures, are improving, the interim report rightly highlights that patient safety remains a concern. We encourage the review team to consider the current risk of the finance/quality pendulum swinging too far and the impact this could have on safety.
- There is common agreement that more collaborative approaches will serve populations better and make better use of collective resources but there is a lack of clarity about how this vision, via STPs and ICSs should translate on the ground. Without removing ownership from local places, politicians and the national bodies need to send align incentives behind a more collaborative and less competitive approach, and indicate how functions such as commissioning should operate within the new landscape. It would be helpful for the review team to consider this.
- As change is being led within the existing legislative framework, there has been little requirement for statutory consultation. However we are keen to see a fuller process of engagement from the national bodies. In addition there is a lack of coherent narrative for the public about the purpose and 'end state' for new initiatives.
- Overall the difficulty of the task facing health and social care should not be underestimated - wide-ranging transformation is being undertaken against a backdrop of an increasingly unstable service and a widening financial gap, with complex new local system relationships being developed at a point when leadership and management capacity is already under pressure.

- We look forward to the final report and encourage the review team to be specific in its recommendations and set out a clear vision for how we achieve high quality care for all in the current context.

## Our perspectives on the interim report

We welcomed the interim report which set out a helpful picture of the current position in the NHS and the social care sector, and highlighted areas which need to be addressed. We agree with the interim report's assessment of the implications of austerity on the health care system. The NHS has coped remarkably well in the face of the longest and deepest financial squeeze in the NHS's history, by at least maintaining or improving the quality of care in many areas. Timely access to services has, however, been impacted – in March 2018, the NHS provider sector reported its worst ever A&E performance (84.6%), alongside waiting times for routine care increasing. We therefore support the interim report's conclusion that now is the time to reinvest in quality as the organising principle of the NHS and social care system. However we would welcome clarity in the review's final report on what 'high quality care for all' looks like in the current context and financial environment.

The interim report's suggestion that the NHS will need an additional £50bn and social care an additional £10bn annually by 2030 is particularly timely in the context of the Prime Minister's announcement for a longer term financial settlement for the NHS. However, we are mindful that this level of funding would present a major funding challenge for the government, and as part of the longer term settlement, we need to set a realistic ask of the sector, matched to the funding available.

We support the interim report's focus on revisiting what the ambition of 'high quality care for all' means in the current environment, along with revising the quality framework to support this. We also welcome the report's recommendation to develop a new 'National Quality Strategy' that addresses both health and social care, in close collaboration with the frontline, with a yearly refresh and comprehensive update every five years.

## Transformation and innovation

In the face of significantly increasing levels of demand and acuity, with funding levels not keeping pace, the need for health and care services to transform is widely recognised both locally and nationally. However the Department of Health and Social Care and the national bodies need to set out a stronger narrative for the future of integrated care models, system architecture and the overall transformation agenda. Through debate, transparency and local and national bodies working together, we need to go beyond the high level vision of the *Five year forward view*, while also recognising the challenge of pursuing transformational change against a backdrop of financial constraint.

## Sustainability and transformation partnerships (STPs) and Integrated Care System (ICSs)

There is broad consensus across trusts, commissioners and other health and care bodies that locally led collaboration and integration of services will make best use of available resources and improve care for patients. The 2015 planning guidance asked NHS and care organisations to collaborate in developing sustainability and transformation plans across 44 footprints to address the core gaps set out in the *Five year forward view*. In March 2017, NHS England published *Next steps on the Five year forward view* which made clear the expectation that STPs evolve as long-term partnerships rather than time limited plans. It also set out an ambition for STP footprints to become accountable care systems, now integrated care systems (ICSs), and for some geographical areas to develop accountable care organisations (ACOs). The national policy direction continues to evolve with the increasing predominance of the STP/ICS as the national bodies' desired vehicle for policy delivery and performance management.

### Progress to date

Progress across the country is variable. Some systems are progressing at pace to take more responsibility for managing performance, and to reconfigure pathways to improve quality and experience for patients. Others are however understandably still investing time and leadership capacity in building the trust required to progress new partnerships. In our recent conversations with trusts, a number of key factors contributing to the progress of STPs have become clear. Above all, local leaders from STP areas where plans are more advanced uniformly point to a history of trusted partnership working as the foundation for their achievements and future aspirations. They already have a shared culture and commitment, often describing the STP process as a vehicle to implement existing plans. The common enablers to progress we have identified are:

- **The quality of relationships between all key players in the local system** – GPs, local authorities, CCGs, acute, mental health, ambulance and specialist providers – alongside consideration of the voluntary and private sectors.
- **The quality and capacity of local leaders** and their ability to engage and mobilise the wider workforce, including clinicians, and engage with the public. Many people mentioned how difficult it is to find the capacity and resource to drive change until it becomes 'the day job'.
- **A collective commitment to prioritise the needs of patients and the system** at the expense of the individual institution, based on a shared understanding and analysis of local challenges.
- **A ruthless focus on a small number of practical priorities** and a drive for practical improvements on the ground in chosen priority areas, rather than just trying to build a grand plan.
- **A culture of pragmatism meets continuous improvement.** Trying new things, learning and making improvements if it doesn't work.

Significantly, this points to a set of 'organising principles' within the NHS and care system today which cannot be mandated by the national bodies in a traditional command and control fashion. While this is in many ways a positive step towards building greater ownership across partnerships at more local levels, the fact that STPs/ICSs are relatively new and lack a statutory footing could mean they are equally fragile

(particularly when based on individuals and their relationships) and carry considerable risk as they test out new ways of working. This is a key feature of the 'organising principles' we see emerging within the NHS and care sector today which it would be helpful for the review team to focus on. Our view would be that there are certainly benefits to retain within the new focus on collaboration, but that the relatively recent focus on STPs and ICSs gives rise to a number of key, unanswered policy questions, which we set out in more detail in the following section.

We fully support trusts' progress in collaborating more effectively with the full range of partners within the health and care system to reduce fragmentation and help improve services for local populations. However as change is being led within the existing legislative framework, there has been little requirement for statutory consultation and we would like to see a fuller process of engagement on how the system architecture is developing.

## The question of legislation

In our view the current direction of travel towards more collaborative working within STPs and ICSs leads logically to the following two polarised solutions:

- Arguing for legislative change to clarify roles and responsibilities within the system and place STPs and ICSs (or something similar) on a statutory footing. This could deliver greater clarity but could subject an exhausted system, and exhausted staff to another wholesale change process with potentially far reaching consequences for where accountability sits (currently with trust boards, CCGs and local authorities at local levels).
- Accepting the organic and incremental development of a diverse pattern of localised arrangements where self defined systems decide how and what to deliver on different footprints, recognising the challenge and risks of this approach.

Our view understandably falls somewhere in the middle of this spectrum. Collaboration is certainly possible under the existing legal framework, but it is time consuming and bureaucratic with many hurdles. Trusts tell us that it is challenging to navigate the existing legal framework, to create robust governance mechanisms and to manage risk effectively across a number of partners and within partnerships where the statutory backing is derived entirely from the component organisations.

As STPs develop delivery models (integrated care partnerships or other neighbourhood or place based delivery mechanisms) it will be important to ask: are internal governance arrangements suitably robust; are the structures in place for each STP legal; are accountability structures clear; and how will the oversight regime operate?

It is important to remember that current lines of accountability have not changed. CCGs, foundation trusts and NHS trusts retain their existing statutory duties, and so are accountable to their communities, commissioners, NHS Improvement (Monitor), NHS England and ultimately the Secretary of State and Parliament. If the system is to properly integrate there will be a need to create sustainable governance mechanisms which incorporate an appropriate level of challenge, assurance and lines of accountability.

## Integration and new care models

As your interim report sets out social care services in England are facing increasing pressure from a combination of growing and more complex demand, rising costs and shrinking budgets, and staff shortages. Social care and health care are highly interdependent and each plays a key role in ensuring that people are supported in the right setting at the right time. We support the integration between health and social care and the benefits this brings for patients, however we also recognise that in the current system this is difficult because of the different funding mechanisms between the two and it takes time. We explore this challenge further in a below section on long term funding. There are good examples of where health and social care is being integrated at a local level, but these are relatively small scale focussing on specific pathways or population groups and mainly at a sub-STP level.

In addition to social care integration, as the focus shifts to STPs and ICSs we should not lose sight of the work that has been taking place over the last three years as part of the new care models programme, set up by NHS England following the publication of the *Five year forward view*. Many of the 50 vanguard sites, which were selected to take a lead on the development of new care models, have made good progress in moving to new models of care and integrating services in a way that directly benefits people who use them and we should avoid losing this momentum. For example, the [All Together Better vanguard](#) in Dudley has reported that implementing GP practice-based multi-disciplinary teams involving social care, mental health and voluntary sector workers, has led to a reduction in patients' length of stay.

The new care models programme has also provided a wealth of valuable insight into how to large scale change across health and social care can be achieved, and how the national bodies can support local areas to innovate, share learning and overcome obstacles to change. They made considerable strides in developing local relationships across traditional divides and shaping services around the needs of people using them. For example, [Mid Nottinghamshire Better Together](#) vanguard worked to identify outcomes and indicators to incentivise care providers to support service users to achieve their own personal goals and outcomes. STPs and ICSs should continue to strengthen and build on these relationships, and make use of the learning and tools that the vanguards have developed.

There is a danger that as the national policy focus shifts to STPs and ICSs, the legacy of the vanguards is lost. It is important not to underestimate the scale of the change the vanguards have delivered and we should be mindful that while the national new care models programme has come to an end, many new care models are being developed across the country and will be developing new ways of working. We need to continue to support this development to ensure this momentum is not lost and that the transformation of services, which matters most to patients, is not swallowed up into STPs/ICSs and forgotten.

## National system architecture

The role of the national bodies is evolving: NHS Improvement is seeking to focus on improvement support rather than regulation (despite its statutory duties laid out in the 2012 Health and Social Care Act); the CQC is developing its approach to review systems rather than solely institutions; and NHS England and NHS

Improvement are seeking to work more closely together particularly at a regional level to mirror the collaboration of local systems through STPs and ICSs.

In March 2018, NHS England's and NHS Improvement's respective boards approved proposals to increase joint working between the two organisations from September 2018. We have welcomed the move to increased joint working between NHS England and NHS Improvement and believe it is right that the two bodies model the collaborative approach being asked of local organisations. NHS trusts have experienced ongoing frustration at the duplication across the two bodies and, at times, a lack of coordination or even contradictions in their messaging. These changes offer an opportunity for NHS England and NHS Improvement to review, consolidate and simplify their frameworks. In particular, we hope that the joint working will lead to a single view of finances and support a more collaborative approach to solving financial challenges across the whole sector. We also believe that greater joint working has the potential to deliver better value for money and increase efficiency; as money gets tighter, it is more important than ever that the national bodies are realising potential efficiencies and that any cost savings are diverted to frontline care.

NHS England and NHS Improvement have had joint regional directors heading up the regional teams in the south east and south west since last year. This approach will be extended under the new plans, which will see a move to seven regional teams, each led by a joint regional director for both organisations. NHS England and NHS Improvement will also increase integration and alignment of national programmes and activities.

While we are supportive of this closer working, there are a number of risks involved in the move to greater integration between NHS England and NHS Improvement. The two bodies will still have separate boards and ensuring their priorities and actions are aligned will not be easy. Similarly, legal responsibilities still rest with individual autonomous organisations, and it may be the case that local disagreement cannot be resolved despite there being a joint regional director covering both commissioner and provider sectors. In such a scenario, regional directors may find they are spending more of their time negotiating with the national bodies.

Any organisational change risks becoming a distraction and there is a danger that these changes distract the national bodies from the task in hand of solving some of the major issues facing the NHS. It is also crucial that both organisations maintain their distinct priorities and areas of expertise: for NHS England, this is supporting primary care to operate effectively and at scale, and defining the future of commissioning and specialised commissioning. For NHS Improvement, this is using an in depth knowledge of the challenges facing providers in order to support improvements and represent the sector.

Most crucially, NHS England and NHS Improvement must not focus on designing structures and processes at the expense of offering a clear purpose and vision for the whole system. Integration, both locally and nationally, are only a means to an end – improvements in health and care for people using services. The health care landscape has changed considerably over the last few years with the introduction of new care



models, STPs and ICSs. Closer working between NHS England and NHS Improvement is an opportunity to articulate a vision for the future of the health and care system.

We also believe the national bodies could do more to properly engage the sector and the public in these changes, and in the wider changes to the way health care services are designed and delivered. We have seen the potential hazards of failing to engage the public in the development of STPs. Not only must there be transparency and clear accountability for how decisions are made nationally, but effective and thorough engagement can also ensure that potential pitfalls are identified and mitigated early.

## Quality

The interim report provided a helpful overview of the current state of quality in the NHS and in the social care sector and the challenges facing the sector, as well as helpfully revisiting the quality framework originally set out *High quality care for all*. We support the interim report's recommendation to develop a new 'National Quality Strategy' that addresses both health and social care, in close collaboration with the frontline, with a yearly refresh and comprehensive update every five years. It will also be important that this new strategy builds on the work of the National Quality Board and is aligned with funding plans and other proposals.

While improvements have been made and patient satisfaction with the NHS remains high and some trusts, despite the unprecedented pressures, are improving, the interim report highlights that patient safety remains a concern. The CQC also rates 72% of trusts as 'inadequate' or 'requires improvement' in this domain. We believe this is due to: rapidly rising demand leading to increased pressure on access to services, as well as higher occupancy levels and lower resilience in the system. It is however important to consider this in the broader context of the continuing improvement in patient outcomes. For example the CQC finds that the majority of people are treated with compassion, dignity and respect with 95% of trusts currently rated 'good' or 'outstanding' in the caring domain.

### Variations in quality of care

The variation in the quality and standards of care that exists within and between trusts, **as evidenced by the CQC** and the review's interim report, persists. However, there are many causes of variation some of which will be legitimate, for example when adopting innovations. It is unwarranted variation - "differences that cannot be explained by illness, medical need, or the dictates of evidence-based medicine" - that should rightly be a cause for concern.

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.

The 'Getting it Right First Time' (GIRFT) programme has made good progress in addressing some of these challenges and supporting trusts to reduce unwarranted variation. However, for the GIRFT programme to remain successful we need to ensure it focusses on quality improvement rather than productivity and efficiency savings, coupled with realistic expectations of what it can achieve. Trusts are concerned that GIRFT's expectations expose them to threat of regulatory intervention - too often the default when national bodies want stronger results than trusts can achieve. Given the complexities of delivery, regulating trusts on GIRFT outcomes would not accelerate results; it would disempower clinicians, undermine objectivity, curiosity and innovation, and fracture the collaboration between managers and clinicians needed to make it work.

## Investing in improvement initiatives

There are a number of initiatives underway to improve quality of care, however it is currently unclear 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 stayed in the regime far longer than expected, while others have re-entered. This suggests the scheme is not working as effectively as it should be and we may need to consider alternative ways of supporting the sector to improve quality.

Another helpful approach has been five NHS trusts 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. Early feedback has been positive; however this programme is small scale and the sector needs to find a way to ensure that quality improvement initiatives are invested in at a national level, engaging and benefitting the whole health and care sector.

## The quality and finance pendulum

The recent independent review into Liverpool Community Health Trust conducted by Bill Kirkup has shone a light on the link between a focus on finance and structural reorganisation with declining quality of care. It would be helpful for the review team to explore this further in their final report, particularly as the risk of the pendulum swinging too far towards finance and reorganisation is currently quite high, given current financial constraints and an increased focus on structural reform through STPs and ICSs.

## Long term funding

In March 2018 the Prime Minister committed to "com[ing] forward with a long term plan for the NHS, in conjunction with its leaders, clinicians and health experts in this 70<sup>th</sup> anniversary year. The Government will provide a multi-year funding settlement in support of this plan ahead of the Spending Review". We welcome this commitment to develop a long-term plan and multi-year funding settlement for the NHS.

However, there are two central tensions with these funding discussions: (1) the level of additional funding that can be afforded and (2) what will the NHS "give" for the extra funding "get"? We are concerned that the settlement may well fall well short of the annual increases required to support the NHS identified by



independent assessments – around 4% real terms per annum– as this level of funding represents a major challenge for the government. We need to set the NHS a realistic and credible task, based on the resources it will have available.

The long term funding settlement needs to better support the NHS meet its efficiency challenge. The provider sector has already managed incredibly in light of the financial squeeze,, and is currently delivering productivity gains of 1.8% (compared to current UK economy productivity of 0.2%). However, to make a further step change, addition resources will be required and invested to support the sector to do this in terms of the workforce, revenue and capital.

## Developing a shared vision

To justify the additional funding to taxpayers the government will face significant pressure to set out a compelling vision for enhanced NHS performance and reform. There are three key issues that will need to be considered when agreeing this vision: (1) the need to be realistic about what more can be delivered and over what period; (2) Government recognition of the size of the gap that has built up over the past few years; and (3) establishing a shared set of priorities.

While the sector was supportive of the vision set out in the *Five Year Forward View*, the implementation of the plan left the NHS frontline in a position of being overcommitted to undeliverable targets. We must avoid making this mistake again and the sector must be fully engaged in establishing a robust, realistic and reasonable delivery ask.

## Closing the gap – stabilising current performance

The longest and deepest funding squeeze in NHS history has created a gap that needs to be filled before additional asks and major reform can take place. Operational performance and workforce shortages need to be addressed before any further reform is offered.

There are already a number of areas requiring urgent investment if the NHS is to recover its performance against targets, relieve operational pressures and secure the workforce on which it depends:

- There is an underlying provider sector deficit of around £4bn
- Key constitutional targets such as the 4-hour A&E target and the 18-week RTT target have been successively missed. Recovering the RTT target alone has been estimated to cost £3 to 4bn, with further funding required to maintain performance
- The lifting of the pay cap needs to be fully funded. The cost of the Agenda for Change pay rise alone is likely to cost £1bn a year
- The workforce also needs to be expanded in line with the new national strategy, which will incur significant extra cost
- The backlog of capital maintenance needs to be addressed. This currently stands at £5bn (the cost of which could be spread over a number of years)

- Capital requirements to enable the transformation set out in the *Five Year Forward View* have been estimated at costing £5bn (again, this could be spread over a number of years).
- Stabilising social care has been estimated at costing £2bn a year

## Social care

When considering a long term funding settlement for social care a similarly principled approach to that covered above for the NHS – while acknowledging the likely mix of self- and state-funding – must be adopted for social care. Within that, where and how the line is drawn on self-funded social care will affect the NHS and so the likely impact on the NHS needs to be assessed in advance.

The mix of local government funding sources will continue to change in the coming years, away from central grants and towards local business rates. There is a considerable risk that this will put further pressure on budgets at a time when – for social care to avoid falling over the precipice – local government must be able to ensure a continuing service at adequate scale with an appropriately sized and skilled workforce. Significant capacity has already been lost and rebuilding this will require concerted investment. At this point, further eroding the capacity of the social care sector is likely to have an accelerating effect, reaching the tipping point of sustainability faster. The impact on the NHS also needs to be taken into account given their interdependence: when social care provision is cut, the NHS also bleeds.

## Workforce

Workforce continues to be one of the pressing challenges for trusts, often over and above finance. In our report, *There for us: a better future for the NHS workforce* (There for us), published in November 2017, two thirds (66%) of trust chairs and chief executives cited workforce as the most pressing challenge to delivering high-quality healthcare at their trust. This challenge is a fundamental strategic issue which is now undermining provider sector performance and risks preventing the delivery of service transformation.

We welcomed the recent consultation on a draft health and care workforce strategy for England to 2027 as a step towards the national bodies recognising the scale of the challenge and developing and communicating a more coherent approach.

However, alongside a focus on long term solutions, there must be a real sense of urgency given the scale of the workforce challenges currently facing the NHS and the impact this is having now. In *There for us* we detailed actions that can and should be taken by the government and the national bodies within one year, including:

- Secure the European and international pipeline for staff, underpinned by immigration policy which supports the NHS meet current levels of demand
- commitment to an immigration policy which supports trusts to recruit staff internationally;
- funding an end to pay restraint and reversal of cuts to national funding for continuous professional development, and;

- work with trusts, higher education institutions, and unions, to ensure the intended 25% increase of nursing students from 2018 is delivered and that any risks to application rates or the number of places set to be offered are identified, monitored, and addressed as required.

Not only is the NHS currently unable to meet the standards of care required by the NHS Constitution within its current funding envelope, but the result of these financial and workforce pressures is that in some cases, patterns of NHS service delivery are moving away from the agreed direction of travel set out in the *Five year forward view*, with cuts made to preventative and community-based services.

## Importance of international recruitment

As is often pointed out, growing the domestic workforce will take time. Improving retention and increasing return to practice have a role to play, but so does international recruitment. 85% of trust chairs and chief executives told us that it will be important or very important for their trust to recruit from outside the UK over the next three years. As we stressed in *There for us*, immigration policy – both the existing non-EU system and a future EU system – and professional regulation – in particular language requirements – need to be a support rather than a hindrance.

Trusts must be supported to recruit internationally to fill vacancies that cannot currently be filled from the domestic workforce. International staff also bring a diverse range of skills and experience. In particular, in the immediate term, we need to see a solution to the current problem of trusts being unable to gain certificates of sponsorship for clinical staff such as doctors who have been recruited from outside of the EEA. Where trusts cannot get certificates of sponsorship doctors often decide to go and work elsewhere, often leaving the trust to fill the vacancy on a temporary basis by paying premium locum rates. International recruitment is expensive and it is deeply frustrating when staff offered jobs are unable to take them up due to lack of visas.

It is also important – as we move towards exiting the EU – that international staff already working in health and care know that they are valued and we want them to stay and that messages from the national bodies continue to convey this.

## The leadership challenge

Provider leadership is being stretched thinner and thinner, just at a time when it's most needed, to maintain and improve current performance, help address the needs of the workforce, and deliver service transformation. National-level action is needed to secure the pipeline of future leaders and ensure that once in post they are supported to lead trusts to address the challenges faced.

## Conclusion

We are at an inflection point in the NHS and in social care. Given the prospect of a longer term funding settlement, the impetus behind STPs and ICSs (despite lack of legislative change), the social care green paper and a rising recognition that change is needed to avoid a crisis in patient safety and quality of care,

this review is timely and we look forward to the final report. We encourage the review team to be specific in its recommendations, to set out a clear vision for how we achieve high quality care for all in the current context.