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Written submission to the Department of Health and Social Care's Major Conditions Strategy consultation

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

NHS Providers has all trusts in England in voluntary membership, collectively accounting for £115bn of annual expenditure and employing 1.4 million people.

Tackling the risk factors for ill health

How can we support people to tackle the risk factors for ill health?

Co-ordinated, strategic, cross-government action to tackle risk factors for ill health must begin with addressing economic inequalities and the wider determinants of health, with the recognition that certain groups and individuals will require targeted support. For example, people living in poverty, some ethnic minorities subject to structural racism, and people with a learning disability. Research has also demonstrated the links between health and geographic socioeconomic inequalities. We must also see adequate focus and support in the strategy on improving outcomes for children and young people.

The strategy must help foster partnership approaches between local authorities, integrated care boards (ICBs), primary care, and trusts to increase the impact of prevention programmes, including secondary prevention schemes, with a focus on scaling those most successful at engaging those most at risk. Factors the strategy should focus on include: funding to support scale and spread; networks to spread innovations and share knowledge; time for scaling and embedding; support from leadership and management; policy and financial levers to encourage adoption; alignment with national and local priorities; and commissioning for sustainable spread. More broadly, the strategy must complement work to implement NHS England's Core20PLUS5 framework.

Trusts are already playing an important role in supporting both primary and secondary prevention by acting as anchor institutions within communities and reducing barriers to individuals accessing and engaging with services. The strategy should support this work to continue. As anchor institutions, trusts are contributing to improving local health by widening access to good employment. Many are using their purchasing power to benefit their local economies through contracting on fair terms with local firms. Many are also using their estates to provide green space and, in partnership with local authorities, support good local housing. Key enablers of anchor working include: visible leadership and board buy-in; making anchor working part of 'business as usual'; building relationships with system partners and the local community; and empowering staff to innovate.

The strategy must focus on tackling the barriers to making progress on prevention, such as: the data available in local systems; the availability of dedicated funding for prevention and the extent it is targeted to those most in need; and intense operational pressure which has diverted focus from longer term transformation. Improving data collection and reporting is vital to monitoring service usage and identifying groups that may require additional support.

Between 2015/16 to the end of the decade, public health funding was cut by £531 million in cash terms. In the context of broader constraints on local government funding, this has undermined councils' efforts to improve the health and wellbeing of their communities and placed additional strain on the NHS. There must be increased support for public services, such as public health and social care, given the crucial role these services play in providing wider care and support and helping to both prevent ill health and avoid deterioration. There remains a need for a clear vision of reform, and tangible, fully funded measures for social care to increase access and improve quality of care.

Supporting those with conditions

How can we better support local areas to diagnose more people at an earlier stage?

Transforming diagnostics is a key part of the NHS' commitment to tackle care backlogs and improve patient experience and outcomes. There must be a focus on narrowing health inequalities as well as the numbers of people diagnosed earlier. Addressing inequities between conditions should also be a focus – for example it can take years for individuals to receive a mental ill health diagnosis. We would also welcome the strategy looking at how to better identify the health and care *needs* of, as opposed to solely *diagnosing*, more people earlier: not only because of the challenges associated with diagnosis for particular areas such as mental health, but also given the strategy is seeking to reduce

care and treatment that are too narrowly focused on specific diseases or organs in the body and treat people more as a whole. Both primary prevention and secondary prevention can play a role here.

Workforce shortages and capital constraints do however limit the NHS' ability to diagnose more people earlier. We need a fully costed and funded long-term workforce plan to ensure the NHS has the right number of staff with the right mix of skills. Trusts face pressing workforce shortages in key professions such as radiography. Community services are also already very stretched, with significant shortages in many community-based roles and long waits for diagnosis and treatment in community services for children and young people particularly. Delivering more acute diagnostic services requires adequate capital and revenue investment to buy and maintain diagnostic equipment.

The strategy should also support trusts to continue to focus on using digital innovation where possible, prioritising treatment by clinical urgency, and providing information and support to patients while they wait for care.

The establishment of community diagnostic centres is a crucial driver of success, relocating and adding much needed capacity for certain diagnostics. We would welcome further development of this, often systems-led, approach, alongside increased investment in, and prioritisation of, wider community services to support earlier diagnosis in other pathways, including neurodiversity and community paediatrics, and more preventative models of care. Improved data sharing to better understand local health needs and where there are potential unmet needs should also be prioritised.

Greater investment in primary care is also crucial. New practitioners in primary care settings, such as in mental health, are a welcome development and should continue to be supported to grow sustainably and work with wider neighbourhood teams. More broadly, primary care has a key role to play in earlier diagnosis efforts by using all touch points to probe physical and mental wellbeing. This requires easy access to appointments and GPs having the time, confidence and access to wider specialist support, to offer expanded services, particularly when it comes to mental health. Efforts to streamline direct access to community services should also be supported to continue.

The strategy also needs to take into account the fact that some communities access care via other pathways – often A&E and/or at crisis point – and therefore should focus on building appropriate skills of broader public and voluntary sector staff to be able to support efforts to diagnose and/or identify needs earlier.

How can we better support and provide treatment for people after a diagnosis?

Despite the NHS working incredibly hard to deliver safe, high-quality care in a climate of increased operational pressure and years of constrained funding, satisfaction with a number elements of the service has dropped in the context of such pressures and long waiting times for care.

Trusts are committed to giving their patients timely, safe and effective care which is also compassionate and responsive to their individual needs. For this to be possible, it is essential that we have a fully-funded long-term workforce plan to recruit and retain staff, and proper investment in preventive healthcare and social care reform.

We also need to see a long-term strategy for capital investment, outlining ambitions for transforming the wider health and care estate, including how to effectively address the maintenance backlog. Policy makers must be cognisant of the productivity improvements that could materialise from an increase in the national capital departmental expenditure limit (CDEL). Strategic capital investment allocations must be underpinned by a whole-system approach to estate transformation: mental health and community services have the potential to play a key role in improving productivity and supporting the delivery of the government's recovery plans. Capital budgets must also not be raided to fund additional revenue pressures over the current, and future, spending review periods.

Quality and safety need to be actively upheld and promoted as central to care delivery in the strategy. Trusts and staff need to be empowered and supported not just to better manage day-to-day pressures but also to continually focus on how to improve the way they deliver care in the future. Within NHS organisations we need cultures of openness and transparency so that staff and patients feel empowered to raise concerns and are reassured that their concerns will be acted upon – while also needing to learn from when care goes right, rather than just learning from when things go wrong. Positive behaviours must also be modelled at all levels of the system including by national and regional bodies.

Beyond getting the above fundamentals right, the strategy should seek to build on the collaborative and innovative work trusts are already carrying out to deliver improvements in patients' experience of accessing the health and care they need in a timely way and supporting them to stay well at home, such as: through preventing avoidable admissions; managing demand more effectively; building additional capacity sustainably; and using technology to deliver more care in community settings. Our engagement with members suggests current secondary prevention initiatives in trust settings are

dispersed, diverse in scope, and often limited in evaluation, which we would welcome the strategy focusing on addressing.

The strategy should also help trusts to build on their existing commitment to listen to patient and community voices, developing services with their views in mind, and to embed equality, diversity and inclusivity throughout their work. Patient voices, and the views of the public, must remain central as the NHS evolves. The strategy could also focus on scaling up support for health literacy.

How can we better enable health and social care teams to deliver person-centred and joined-up services?

The strategy should build on existing work between trusts and partners to better plan and provide for their communities' needs. Trusts are doing this both as part of integrated care systems (ICSs) and within provider collaborative arrangements.

Provider collaboration is driving integration and delivering benefits for patients both at scale and at place. It requires commitment, strong leadership and a clear shared vision. It takes time and patience to build the right relationships, to develop and embed collaborative ways of working, and deliver improvements.

Collaboration is delivering more person-centred and joined-up services in a number of areas which the strategy should support further. For example, mental health trusts have been working collaboratively for several years to redesign care pathways and improve services and wider organisational management, as well as ensure mental health is embedded as a priority in system decision-making. System working provides an opportunity to further pursue equity of treatment for people with mental illness.

Collaboration at scale also presents an opportunity to address the variation in community services that currently exists. Some ICSs, such as Sussex ICS, are setting up community and primary care collaboratives to provide a coherent voice for 'care in the community' and ensure services are sufficiently prioritised in planning and funding discussions.

For specialised services, there is an opportunity to support clinicians to share practice in a systematic way that drives up standards and quality of care and supports clinical research and innovation. There is also potential to explore new approaches to deploying highly skilled staff across larger geographies to improve access. Furthermore, there is scope to redesign services, transforming pathways of care

and driving education and research across regional footprints, and to take on some commissioning functions.

Ambulance trusts are well placed to participate in, and lead, collaboration across systems where it makes sense to, such as reducing unwarranted variation in access and quality of urgent and emergency care (UEC). Yorkshire Ambulance Service NHS Trust is working as part of the Northern Ambulance Alliance to embed integrated leadership teams within all three ICSs it works across to ensure there is shared knowledge about 999, 111 and other UEC protocols. West Midlands Ambulance Service University NHS Foundation Trust is looking to realise the benefits of sharing population health data with partner trusts to help reduce hospital admissions.

Trusts are also embracing new models of care with primary care partners, which include trust oversight of general practice and engagement with primary care networks or large-scale primary care providers. Trusts are equally committed to working closely with local authority partners, including to develop multi-disciplinary teams (MDTs) across mental health and social care. There needs to be parity of esteem in terms of pay and progression and training opportunities between health and social care roles, and within MDTs.

Increased revenue and capital funding for digital infrastructure to support enhanced data sharing across the NHS, and between the NHS and social care, is crucial to local areas having a holistic view of people's health and care needs. We need to ensure services have the technology, training and support to share data with other services.

How can we make better use of research, data and digital technologies to improve outcomes for people with, or at risk of developing, the major conditions?

Harnessing the opportunities data and digital ways of working provide can enable delivery of more joined-up care and better outcomes. Digital investment remains a vital enabler to transform service delivery, enable full interoperability, improve productivity, and reduce the costs of service provision.

There must be a focus on getting the digital fundamentals in place for trusts and system partners, which include:

- strong digital infrastructure (e.g. reliable wi-fi);
- secure data environments which store and allow access to data for research, innovation and care improvement;

- effective electronic patient record systems that help staff to deliver safer care, improve patient and staff experience and enable data-driven decision making; and
- shared care records that join up data across organisations giving a view of patients' flow through the health and care system.

Digital progress is not just about the technology; it is also about the culture, processes and operating models needed to meet the raised expectations of patients and staff in the internet era, which will be crucial for the strategy to focus on. The transformative role digital tools can play may mean rethinking current pathways and processes around digital capabilities and user needs. This includes technology enabled care, innovation in diagnostics, and population health management that uses high quality data to target high-risk populations.

Examples of where remote monitoring and digital innovation are realising benefits include:

- Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust's work to embed virtual wards for community respiratory and heart services, which has resulted in reductions of face-to-face consultations by 45%, a fall in annualised death rates by 42% and increased reported patient satisfaction.
- Coventry and Warwickshire Partnership NHS Trust is using digital care assistant technology, Oxehealth, to monitor inpatients with dementia, leading to a 33% reduction in falls and a 71% reduction in time spent by nurses on enhanced observations.
- An AI skin cancer pathway at University Hospitals Birmingham has led to over 2,000 hospital appointments avoided so far.

Better use of research, data and digital technologies is underpinned by investment in cross-functional, multidisciplinary teams (rather than just projects) that include: design; analytics; digital, data and technology; and clinical and operational skillsets. Designing and delivering successful digital programmes relies on strong clinical and board leadership that encourages an innovative culture and empowers teams.

All the above relies on having appropriate funding mechanisms and allocations for digital. Constraints on what money is available, when, and how that money can be spent often make it difficult for trusts to invest in digital appropriately. Sufficient and sustained funding is needed to increase the baseline digital maturity of trusts.

The strategy needs to strengthen clinical and research excellence. The NHS is primed to pioneer and capitalise on innovation, particularly in artificial intelligence and digital technology, through its links

with world class universities, and the unique patient datasets it generates as a universal service. More broadly, priorities for future research, innovation and data improvements over the coming decade need to be aligned to key strategic priorities and operational pressures facing the sector.

Mental health

How can we better support those with mental ill health?

The strategy needs to be radical, bold and transformational, with a focus on how to shift resources upstream and deliver a far more proactive and holistic model of care. Support for children and young people must be an absolute priority to better meet significant needs now, and prevent a mental health epidemic in future years.

Sustained focus and support is also needed to deliver, and build on, existing plans to better address inequalities in access, experience and outcomes. We need to focus on redressing disparities for other vulnerable and underserved individuals in society such as those with a learning disability and autistic people.

This will be achieved through:

- Parity of esteem. We are still operating in the context of a 'care deficit' where we accept that not all those that need mental health care and treatment will seek or be able to access it. The mental health investment standard needs to be applied as a minimum threshold and based on need. There is also further to go to tackle the stigma faced by those with serious mental health illness.
- The right level of support and investment to better support those with mental health needs. Recent increases for mental health follow decades of underfunding and trust leaders have long expressed concern about the ability to maintain the quality of services given the mismatch between demand and capacity. They have stressed the importance of longer term funding schemes that bring certainty, support care quality and safety, and do not divert resources away from core provision.
- Increased support for wider public services, in particular public health and social care. A lack of suitable social care provision was cited by trust leaders as a key reason why demand for children and young people's mental health services is not being met. We also need to recognise the interdependence between mental health services and other public services such as justice, housing, welfare and education.

- Better data collection and quality to ensure a clear understanding of mental health activity, access and outcomes, and in turn enable better commissioning. Investment in the skills required to analyse population-based trends is also needed.
- A fully funded and costed workforce plan that builds further, and faster, on the steps already being taken to grow the mental health workforce and the skills of the wider workforce. The shortfalls in the number and skill-mix of staff remain the most pressing challenge to the sustainability and accessibility of services.
- Capital investment in mental health services to provide a more therapeutic environment and deliver existing priorities. We need to see an overall increase in the national capital departmental expenditure limit, and mental health trusts must be given appropriate consideration as part of the operational capital prioritisation process.
- Increase focus on research into new treatments and interventions for mental ill health to improve outcomes for people in the future. Trust leaders are keen for a more robust evidence based around what works to be developed so that this can be embedded into future service delivery.

Cancer

How can we better support those with cancer?

Cancer is a priority for trust leaders who know the risks to patients who have to wait for diagnosis and treatment. There has been some progress, with the latest national activity and performance data showing the NHS consistently seeing more people within two weeks for suspected cancer than before the pandemic and just over 7 in 10 people referred now getting a diagnosis within 28 days of urgent GP referral.

However, trusts know that too many people are waiting longer to start treatment after diagnosis. Severe staff shortages and insufficient capacity to meet growing demand affect cancer services alongside other services in the NHS which are overstretched. Trusts are doing everything they can to see patients as quickly as possible, but they need more staff and resources.

To improve cancer services, it is vital that the government publishes urgently its fully costed and fully funded long-term NHS workforce plan to ensure that the NHS has the staff it needs to meet increased demand for cancer and other services. Reducing the cancer backlog and delivering more diagnostic services also requires capital investment.

We would welcome in particular continued focus and support from the government and NHS England for community diagnostic centres, which are an effective way of increasing diagnostic rates, bringing services closer to communities and helping to address inequalities in access.

One example of the effectiveness of this investment is Barking Community Hospital, which was able to improve access and reduce waiting times for vital tests for cancers in its first two years of operation. While improved access is a short-term measure of success, greater diagnostic capacity and focusing on improving access in underserved more deprived areas, should translate to population health improvement. Improved health and narrowed health inequalities is the true goal of the centre and the route to this is via improved access, reduced waiting times and better patient flow. The future of the centre depends on the right amount of revenue funding as well as ongoing investment in maintaining diagnostic equipment being available.