The voice of NHS leadership

Health and Social Care Select Committee inquiry on delivering core NHS and care services during the pandemic and beyond

Written evidence from the NHS Confederation: 7 May 2020

About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Wales and Northern Ireland.

In England, we represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems. Also, we run NHS Employers, which supports the health service in its role as the nation's largest employer, negotiating pay, supporting workforce development, and fostering good practice in recruitment and retention.

In Wales, we represent local health boards, and in Northern Ireland, we represent health and social care trusts.

Our Brussels office focuses on EU legislation, Brexit developments and our international engagement.

Key Points

- **Challenging landscape pre-COVID-19**
  The NHS has achieved significant feats since the COVID-19 pandemic broke out in the UK, yet the difficult landscape the health and social care sector was working in at the start of 2020 should not be forgotten. In many instances the new challenges presented by COVID-19 have served only to highlight existing challenges from workforce vacancies, missed performance targets, financial strains and the NHS's vital interdependencies with other public services and with industry.

- **Supporting NHS and social care workforce**
  We have seen a rapid transformation in clinical practice, innovative approaches to leadership and provision, and a much greater understanding of the skill, value and flexibility of our people and workforce. The impact of COVID-19 on the dedicated staff providing health and care and wider public services will be significant, with personal sacrifice and loss coupled with the

unrelenting and unprecedented demands made of them. We do not yet know what the long-term impact will be on staff mental health and wellbeing.

- **Restoring services**
  The health and care sector is now urgently developing plans to restore critical services. It is doing so alongside severe economic and social disruption, the prospect of higher unemployment and an expected rise in health inequalities. Many of our members are thinking ahead about the needs of patients and providers across their populations, anticipating, for example, the increasing mental health needs and needs within the acute, community and primary care sector. With this, the sector will need clarity on the regulatory and care quality standards that will be re-introduced and how this will be managed during the recovery period.

  There will be huge issues in restoring services which many feel will be more challenging than switching to a COVID-19 service in the first place. In part this is because the NHS will need to retain care for COVID patients while restarting other services. The levels of unmet demand, which were already an issue before the pandemic, will be very great and it is likely we will see a very significant increase in the acuity of patients. And winter looms, creating the risk of what one of our members described as a potential perfect storm.

  This will require a joined-up approach across health and care, capital and community recognising the interdependency of the whole system.
  It will also require a move from the top down, command and control mode of operation we have seen during the pandemic. We need to liberate local initiative and especially clinical and professional expertise to shape policy going forward.

- **Future changes to system architecture needed**
  COVID-19 has changed the way everyone works, and it has a profound impact on the health and social care sector. This is already presenting major challenges for NHS leaders but it is also being seen as an unexpected and welcome opportunity to ‘reset’ the NHS and indeed the wider care sector. It will call for a fundamental examination of the relationship between local organisations and systems on the one hand and the national bodies on the other. And at local level it is clear we can no longer regard health and care as two systems and in particular, we must abandon the all too common assumption that integrated care systems are NHS entities.

- **Capturing benefits of technology**
  There has been a number of developments in the NHS including the use and integration of digital services which have spread through the NHS and care sector at a pace previously unimaginable. Removing some of the obstacles that have made keeping up with technological change cumbersome would enable patients to benefit from faster, more personalised and joined up services.

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Delivering Core NHS and Care Services during the Pandemic and Beyond: Inquiry Questions and Response

Our role in supporting the NHS during and beyond COVID-19

COVID-19 has changed the NHS and social care. The immediate response from local partners has been exceptional. For a system placed under unprecedented, sudden and intense pressures, we have seen a rapid transformation in clinical practice, innovative approaches to leadership and provision, and a much greater understanding of the skill, value and flexibility of our workforce.

The NHS Confederation believes that the response to COVID-19 should lead to a new conversation across the UK about how we think about health and care. This should involve the full range of healthcare organisations from the Confederation working together with partners in social care and beyond to understand the opportunities. It should also stimulate a wider conversation with the public about how health and care can support individuals, families and communities and the ways in which the compact between the NHS/care system and society can be redefined.

1. Why a 'reset'?

1.1 The message coming from leaders and clinicians across the NHS and social care is clear – we should not simply seek to *return* to the ways of working and approach we once knew, but *reset* the way we plan, commission and deliver health and care.

1.2 The NHS Confederation has launched a campaign[1] to support this reset process. It will seek to influence national strategies, including those from NHS England and NHS Improvement, and it will aim to support local systems as they think through these fundamental issues in the coming months. We will also support the NHS in identifying issues and practices that have exposed weaknesses in the system. A key example of this is the unnecessary and unhelpful barriers between the health and social care which have contributed to disjointed service delivery. It has also sometimes caused delays of PPE and testing deliveries across the care sector.

1.3 The challenges facing our members should not be underestimated but it is clear that there is a real determination among local leaders themselves to embed and accelerate changes in service delivery. A significant amount of thought and planning has already started, and we will work in partnership with those already on this journey, as well as those just starting it.

[1] NHS Confederation: NHS Reset campaign www.nhsconfed.org/NHSReset

This campaign will support leaders to:

- Capture and spread the major innovations that have been delivered at pace.
- Rebuild local service provision to help meet the large growth in physical, mental and social needs that has been caused by the pandemic.
- As they look to reset their ambitions for how the health and care system can develop including its relationship with the public and public services.

1.4 The journey to a different future for health and care will clearly be influenced to a great extent by wider societal changes, not least the state of the economy. While the relationship between the public and the NHS and the care sector has never felt stronger, we do need to have an honest debate about what is possible, including what can be delivered when.

2. How to achieve an appropriate balance between coronavirus and 'ordinary' health and care demand

2.1 The impact of COVID-19 on communities has been unprecedented. The health and care sector has begun to develop plans for restoring critical services. This is likely to be in the context of a severe economic downturn, with much higher unemployment and widening health inequalities. In particular, local strategies will need to re-establish clinical services making sure they capture new ways of working and address the needs of different groups and communities.

2.2 In line with the NHS Reset campaign, many of our members are already thinking ahead about the needs of patients, anticipating, for example, increasing mental health needs and how to tackle the backlog within the acute, community and primary care sectors.

2.3 At present, many hospital trusts have had to place patients referred by general practice on a 'holding' list. The challenge as they re-start services is both making sure they sufficient clinical capacity and making sure they can effectively segregate COVID and non-COVID patients. The recent letter from NHSEI has sent a signal that it is time to restart the process[2] but it will be important that decisions are made locally and that the implications of restarting work are considered across the whole health and care system.

2.4 There is a need to re-establish routine activity in general practice, while acknowledging that the pressure from COVID-19 in the community continues to

[2] NHS England and NHS Improvement: Second phase of NHS response to COVID-19: Letter from Sir Simon Stevens and Amanda Pritchard https://www.england.nhs.uk/coronavirus/publication/second-phase-of-nhs-response-to-covid-19-letter-from-simon-stevens-and-amanda-pritchard/

increase as the number of patients discharged into the community who are recovering rises. The peak demand in the community is likely to be after that of the acute sector and plans need to take account of this. And just as hospitals need to segregate there will need to be continuing mechanisms to separate COVID-19 and non-COVID-19 patients through dedicated 'hot' sites. This pressure is affecting primary, community and social care services and needs to be given equal prominence to the concerns about hospital-based services.

2.5 One area which will require further thought when restoring services will be to build on the new ways in which patients are engaging with the services and embracing self-care as well as encouraging those that need care to come forward. Our members in Clinical commissioning groups (CCGs) point to the need to keep reducing the number of unnecessary investigations or procedures that provide no benefit. This is where the Evidence-Based Interventions Programme can offer system support[3].

2.6 We are clear that there is a higher cost associated with delivering COVID-19 and non-COVID-19 care side by side. This is likely to be made more difficult if there are continuing high rates of absence (caused staff having to self-isolate) and the increased demand from re-establishing routine care. There will be difficult choices ahead and the collateral damage will be with us for years to come.

Question

What plans do NHSEI and the CQC have for recognising the challenges NHS systems and providers will face as services return to normal and adjusting standards and regulatory frameworks to accordingly?

3. How to ensure that positive changes that have taken place in health and social care as a result of the pandemic are not lost as services normalise

3.1 We can already see that strategies for restoring services are seeking to understand how changes brought about out of necessity have improved services. It will be important that across the service lessons are learned to help build models and pathways of care that are more effective and better serve patient need.

3.2 One aspect of these changes has been the liberation of local leadership. Most of these innovations did not come about because of an order from the centre of a

[3] NHS England and NHS Improvement: Evidence-Based Interventions Programme https://www.england.nhs.uk/evidence-based-interventions/

national target. Instead they have been driven by local leaders and clinicians working together. Many changes have been delivered because the priority has been immediate action and delivery focussed on the patient rather than the organisational and bureaucratic barriers that would ordinarily apply. As the service restarts much of its day to day business, the NHS Confederation will be supporting a strengthened role for local leadership and indeed strong clinical leadership. This should cause the centre to reflect on its role in enabling this to happen.

3.3 The adoption of digital technology has been an obvious gain during the epidemic and it has again been achieved at an incredible pace and scale. Digital solutions are being used to allow patients to access services remotely and to keep in touch with support networks. Primary care and outpatients will never be the same again, but there are plenty of other examples where virtual services are demonstrating their value. Of course, care needs to be taken to make sure patient outcomes and experiences are monitored, so we understand the impact and ensure the new services are appropriate and effective.

Question

What steps is the Government and NHSEI taking to capture innovation and support systems and providers to deliver these changes across the health and care sectors?

4. Meeting extra demand for mental health services as a result of the societal and economic impacts of lockdown

4.1 There will be increased demand for mental health services after lockdown as those with pre-existing conditions seek help and new cases emerge following the impact of self-isolation, financial insecurity, bereavement, and increases in substance abuse and domestic violence. From early in the emergency period, members of our Mental Health Network (MHN)[4], have been planning how to cope with this heightened demand.

4.2 Mental wellbeing produces improved physical health, so the provision of appropriate psychological support should have a positive impact on the entire health and care system.

4.3 To help meet this extra demand, the government needs to continue to provide the NHS with “whatever it needs, whatever it costs” for a reasonable period. Ministers have pledged to treat mental health with the same urgency as physical

[4] Mental Health Network members https://www.nhsconfed.org/networks/mental-health-network/membership/mental-health-network-members

health, so we should expect to see evidence of this parity of esteem in the support given to the service.

4.4 This is an area which requires cross-government activity encompassing the Ministry of Housing, Communities and Local Government, the Department of Work and Pensions, the Department for Education and the Ministry of Justice. The third sector also has a huge role. Many charities have seen increased demand alongside reductions in income. Financial support from the government for mental health charities is welcome and but it will have to continue throughout the reset stage.

4.5 Work to model the anticipated surge in demand for mental health services has begun, using findings from previous epidemics and learning from other countries. It will be important to start planning now for what needs to be delivered.

4.6 The government should ensure that this learning and modelling is coordinated nationally.

4.7 A significant number of health and care staff will have been exposed to trauma for a prolonged period during the pandemic and this is likely to affect their mental health and/or wellbeing. This is something NHS leaders are acutely conscious of and the NHS Confederation in its role as NHS Employers has been issuing support and guidance[5] to organisations to support them as they support staff.

4.8 Our members providing mental health services are also increasing support to staff. This includes new support phone lines and fast-track access to psychological help. At the same time there is a need for national, evidence-based and trauma-informed guidance on how best to support staff wellbeing.

4.9 Nine out of ten adults diagnosed with mental health problems are supported in primary care.[6] This sector will have a huge role in supporting people whose mental health has been affected by COVID-19. Primary care networks, (another area of the Confederation) are in their infancy but there is a great opportunity now for them to work closely with their local community mental health team.

4.10 Work has already begun on a national suicide prevention response. While suicide rates tend to increase during times of economic distress, this is not inevitable. It will be important to take steps nationally and locally to help reduce suicides.

[5] NHS Employers COVID-19 guidance for NHS workforce leaders https://www.nhsemployers.org/covid19

[6] The Five Year Forward View For Mental Health https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Question

What steps does the government intend to take to model and plan for the anticipated surge in demand for mental health services?

What plans does the government have to produce national guidance on how best to support staff wellbeing?

5. Meeting the needs of rapidly discharged hospital patients with a higher level of complexity

5.1 The hospital discharge service requirements guidance[7] was amended in March 2020 to meet the needs of patients and service delivery during COVID-19. Key to this was ensuring adequate acute capacity by moving patients to community and social care more quickly assuming it was clinically safe to do so.

5.2 Community health services have responded well to the challenges of this much more rapid discharge process, and this has enabled thousands of patients with complex needs to be safely discharged from hospital in preparation for the peak of the outbreak, freeing up much needed acute capacity and supporting COVID-19 related healthcare needs in the community.

5.3 Existing demand on community services, and across the health and care system, was high before the virus hit. This pressure has been compounded by large volumes of patients being discharged from hospital with complex needs, with the possibility of patient choice being compromised and higher than average staff sickness absence levels.

5.4 Beyond the pandemic, we expect some increased demand for care in the community as non-urgent planned care, and other acute services are restarted. It also seems likely that community services will face a wave of pent-up demand once social distancing restrictions are eased. This means that COVID-19 will generate increased demand for community health services for the foreseeable future, with sustained need to support staff and patients who are shielding or self-isolating, to rehabilitate COVID-19 patients with complex needs, and support care homes.

[7] COVID-19 hospital discharge service requirements https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

5.5 NHS England and NHS Improvement's prioritisation framework[8] provided welcome flexibility to pause or partially stand down some community services, which released capacity to enable the rapid 'discharge to assess' model. The Community Network, run by the Confederation and NHS Providers, has called for a graduated approach to restoring community services as is being applied to the acute sector. Likewise, there is a determination to learn from and lock in the innovation that has taken place over the last few weeks.

5.6 Feedback from our members has also indicated that there is support for this speeding up of discharge procedures, especially in areas that were already moving towards system and integrated working. No-one wants to move back to the barriers that hindered effective joint working and there is a strong desire to use this opportunity to remove some of the traditional boundaries that prevent timely decisions.

Question

What will government agencies do to ensure that key elements of the hospital discharge requirements, in particular forgoing some bureaucracy to discharge in an effective and timely way, are continued following the pandemic?

6. Issues around provision of healthcare to vulnerable groups who are shielding

6.1 The NHS Confederation's PCN Network has heard from clinical directors that identifying patients for shielding, maintaining these lists locally and managing support and outreach to shielded patients has been problematic. This stems largely from the centralised process of collating information on those who should be shielded which may be drawn from incomplete, incorrect or old data sets. Many patients have been contacted who should not have been (either because they do not need to be shielded or have deceased, for example). Equally, there are many others who were not initially contacted for shielding who feel that they should have been.

6.2 As such, significant additional workload has been created for GPs in validating the lists, adding and removing patients, as well as responding to questions from patients about why they have been added to the shielding list, why they have *not* been added or more broadly what being on the shielding list actually means for them.

[8] COVID-19 prioritisation within community health services https://www.england.nhs.uk/coronavirus/publication/covid-19-prioritisation-within-community-health-services-with-annex_19-march-2020/

6.3 Another area of uncertainty has been who is responsible for providing support for those who have been shielded, including those in care homes – in terms of medicine delivery and food parcels, among others. This seems to differ by geographical area and further guidance on this would be helpful.

6.4 A positive to come from the effort to shield patients, however, is that it has demonstrated the key role of social prescribers in helping to 'manage' patients on the shielded list or those in the extremely vulnerable groups, particularly where their needs are not medical. With practices expected to follow up with patients on the shielding lists, many primary care networks (PCNs) employing social prescribers have used them to lead this process. This has not only helped to ease pressures on GPs but we have also heard positive reports of how effective social prescribers have been in communicating clearly to patients on issues such as self-care and maintaining good mental health during the pandemic.

Question

Who is responsible for ensuring that the needs of those on shielding lists are being met, including in terms of provision of basic goods?

7. Supporting mass testing and vaccination once they become available

7.1 Our experience so far of COVID-19 programmes directed by national government alone is that opportunities at the local level can be missed. It is vital that the government strategy for mass testing and vaccination should make full use of the local coordination role of PCNs, CCGs and local authority public health expertise rather than relying solely on technology or national capabilities. These local organisations know their populations and will have the insight into how best to improve access and begin the new contacting tracing arrangements which will be critical to managing the next phase of the pandemic.

Question

Have you considered the health and social care workforce at place level in coordinating the roll out of mass testing and vaccination, such as staff in PCNs, CCGs and local authorities?

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Conclusion

The NHS Confederation believes that the changes that have happened in response to COVID-19 must form the basis of a new conversation with the population about how we think about health and care and how these services develop and reform. We wold welcome further questions from the Committee on the issues raised in this paper.

Contact details

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