# NHS RESET:
# A NEW DIRECTION FOR HEALTH AND CARE

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## ABOUT NHS RESET

COVID-19 has changed the NHS and social care, precipitating rapid transformation at a time of immense pressure and personal and professional challenge. One message from leaders and clinicians across the UK has been clear: we must build on the progress made to chart a new course.

NHS Reset is an NHS Confederation campaign to help shape what the health and care system should look like in the aftermath of the pandemic. Recognising the sacrifices and achievements of the pandemic response, it brings together NHS Confederation members and partners to look at how we rebuild local systems and reset the way we plan, commission and deliver health and care.

NHS Reset is part funded through sponsorship by Novartis Pharmaceuticals UK Limited.

Find out more at **www.nhsconfed.org/NHSReset** and join the conversation on social media using **#NHSReset**

## 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, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

To find out more, visit **www.nhsconfed.org** and follow us on Twitter **@NHSConfed**

NHS Reset: **a new direction for health and care**

# CONTENTS

# KEY POINTS

**COVID-19 is the greatest challenge we have faced as a country for more than two generations.**

As we head towards what could be one the deepest recessions, its impact will be felt for years to come. So many have already lost friends, colleagues and family members, and our families and communities have experienced unprecedented changes in the way we lead our lives.

The NHS has responded well to the challenge. Earlier this year, there were dire predictions that it would not be able to cope. Yet in spite of having to adapt and develop to an extraordinary degree, the service not only managed a huge wave of COVID-19 patients but also continued to treat millions not infected with the virus. At the same time, many services did have to be paused or suspended, affecting hundreds of thousands of patients and frustrating the staff who would normally have treated them.

Perhaps the most surprising development though has been the way in which so many services have, out of necessity, been transformed – sometimes in ways previously unimagined. Changes that would have taken years have been delivered in weeks. The challenge now is to make sure such beneficial changes are sustained for the benefit of patients and health and care staff as we head into winter and beyond.

The road to recovery will be long, and we face a second surge. The NHS went into the pandemic under significant pressure, with demand for care outstripping the service's ability to meet key performance targets. The service is now facing a triple whammy. It must deal with local outbreaks and a second surge. It has to manage a huge backlog of treatment that has built up during the pandemic. And it must do this and restore services with reduced capacity as a result of infection control measures. On top of this, leaders are reporting that some staff who have been in the thick of this battle are exhausted. There is unlikely to be much respite before winter.

There is near universal support for the NHS and appreciation of what it has done, but as we embark on the next phase in these unprecedented times, it is reasonable to ask for a reassessment of what the NHS can realistically be expected to deliver. What capacity and resources does it need to meet the challenges ahead, and what steps are needed to liberate and empower local leaders to work with and find the right solutions for their communities?

> In spite of having to adapt and develop to an extraordinary degree, the service not only managed a huge wave of COVID-19 patients but also continued to treat millions not infected with the virus

4

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Our NHS Reset campaign has involved six months of engagement with health and care leaders, including a new survey of 250 NHS leaders. From this, we have identified five factors we believe will be fundamental to achieving a sustainable health and care system:

# 1. Honesty and realism

The support and understanding of the public has been critical to enabling the NHS to respond effectively to the pandemic. The public rightly now expect routine services to resume and to receive the care and treatment that has been delayed during the worst stages of the pandemic. In recent months, the NHS has made huge progress in restoring services toward previous levels. However, the pandemic's impact on the capacity of the NHS is likely to go on for several years. The service needs government investment to support new ways of working that will enable it to fully and safely restore services, as well as the understanding of the public while it adjusts and deals with a large backlog of patients needing care. Political leaders will need to help manage public expectations about what is possible.

## What NHS leaders say

Three-quarters of NHS leaders who responded to our survey said they were not confident of meeting targets to restore routine operations to last year's levels by the end of October. Only half said they were confident in being able to restore cancer services.

# 2. Extra funding

In 2018, the NHS received a five-year funding settlement worth £20.5 billion, but given the impact of coronavirus, this will have to be reassessed in the government's planned Comprehensive Spending Review in November 2020. It is clear that additional revenue and capital funding will be needed to cover the additional costs of rising demand, while also enabling the NHS to play catch up with the backlog of treatment.

The expected surge in demand for mental health – likely to be up by 20 per cent – will also require additional resources. Nor will the NHS be able to respond effectively without a sustainable social care system, which will require a long-term funding settlement. It is reasonable that in return taxpayers and the Treasury will expect the NHS to drive through the major transformation programme set out in the Long Term Plan. There is certainly commitment among health leaders at local level to continue to innovate and deliver services in new ways that improve the quality of care and achieve greater efficiencies. And the pace of that change looks set to increase.

## What NHS leaders say

More than nine in ten leaders responding to our survey said lack of funding will be a significant barrier to delivering on their waiting time targets. Fewer than one in ten were confident that they would achieve the goals of the Long Term Plan within their existing funding settlement for day-to-day 'revenue' spending, with almost three-quarters saying they did not have enough capital funding to upgrade their buildings, IT and other infrastructure.

## 3. A lighter, leaner, culture

During the pandemic the regulatory burden on local leaders has been reduced, giving way to leaner and more agile ways of working. The NHS has innovated at speed, led by clinicians and empowered by a changed leadership culture reflected in behaviours at both local and national level. This must be sustained – we need to hold on to this different way of doing things and strip away the unnecessary bureaucracy, reporting and regulation that for too long has stifled the service. We need everyone to embrace a culture that empowers local leaders and clinicians to lead, giving them the ability to make good decisions for the communities and partnerships they serve.

**What NHS leaders say**

More than nine in ten leaders believe there must be much more flexibility and freedom for local NHS bodies to listen to and co-produce local services with patient groups and communities. This is a key feature of high-performing health systems and needs to be embraced by politicians and at every level of the service.

## 4. Integrating health and care

COVID-19 has shown that the integration of health and social care is crucial to putting the NHS on a more sustainable footing. The pandemic created a common purpose that in many areas broke down barriers and enabled services to be transformed. There is now a widespread acceptance that the 2012 Health and Social Care Act, and the way we choose to interpret it, has left a confused architecture for the NHS that wastes time, effort and money. The UK government and NHS England and NHS Improvement should work with representative bodies and their members to create a legislative framework which brings simplicity and clarity, a common purpose for local leaders, and the conditions to support system thinking, population health and local partnerships.

**What NHS leaders say**

Eight in ten NHS leaders agreed there should be a shared statutory responsibility on all partners in an integrated care system to deliver the 'triple aim' of better population health, patient experience, and financial sustainability.

## 5. Tackling health inequalities

COVID-19 has not affected our communities equally. Despite the NHS being a universal service, those living in poorer communities and from black and minority ethnic (BME) backgrounds already suffer from poorer health outcomes than the rest of the population. The virus has both highlighted and exacerbated health inequalities. If there is to be a serious effort to reduce the level of health inequality, it will require sustained and funded action at national and local level. There does appear to be a commitment to do this, but it will require a radical and conscious shift in every health economy towards a strategy based on population health.

**What NHS leaders say**

Almost three-quarters of NHS leaders believe that BME communities continue to have poorer access and outcomes from NHS services, while almost nine in ten leaders believe the NHS must deliver a step change in how it cares for diverse and marginalised communities.

# Where next?

The scale and pace of innovation has been one of the unexpected consequences of the pandemic. Our work with NHS leaders shows clearly their determination to seize the opportunity to sustain these positive changes and deliver services in new and better ways to the public. From GP surgeries to outpatient clinics, from intensive care to virtual speech therapy, there has been one change after another and widespread adoption of new technology. These have been combined with real advances in partnership working at local level, with NHS leaders being empowered to find the right solutions working with their clinicians, their partners and their communities.

No one can be in any doubt that the road to recovery for the health and care system will be long and challenging, and we face the real prospect of a second surge. We have learned much and are in a better position to manage this than first time round, but the strain will be felt across the country. However, the pandemic presents an opportunity to re-cast services. This report reflects our members' views and sets out a possible direction for the NHS and a future which should lead to improving health for individuals, families and communities.

We encourage members and our partners to continue the NHS Reset conversation by sharing their views on this report at
**NHSReset@nhsconfed.org** and on Twitter 🐦 **#NHSReset**

# INTRODUCTION

**01**

**Never before has the health service experienced pressures like those felt during the first wave of the COVID-19 pandemic.**

Despite immense challenges, staff across the health and care sector adapted quickly to difficult circumstances, pulling together to provide the best possible care, treatment and services. We should be proud of the resilience the system has shown and of the remarkable determination and ingenuity of staff across the country.

The coronavirus outbreak has been – and continues to be – an extraordinary period in the life of the NHS and its partners. As we look ahead to a potentially difficult winter, and tackle a second surge, what lessons can be learned from how the health and care sector has responded so far?

Bringing together NHS Confederation members and partners, the NHS Reset campaign has convened the health and care system to reflect on the learning from the last six months and what it means for the future. In doing so, we have identified five factors we believe will help to fundamentally reset the way health and care is planned, commissioned and delivered.

Over the course of nearly 50 webinars, roundtables and private meetings, we have explored with more than 2,500 senior leaders, frontline clinicians, stakeholders and parliamentarians the shifts in culture, regulation, reporting, assurance and behaviour that accompanied the response to COVID-19. More than 60 insightful blogs from health, social care and voluntary sector leaders, clinicians, carers and service users, have considered how the system can hold onto the positive gains of this period and learn for the future.

This report summarises the insights from our engagement so far and identifies five key factors. At the time of publication, the NHS is starting to see an increase in emergency department attendances and the number of COVID-19 infections. The NHS is not out of the woods and focus will rightly be on how to manage the extra demand on services as we head into winter. However, with an eye on the longer term outlook, there has been one enduring message that we have heard from NHS leaders: the health and care system must build on the remarkable progress of recent months to chart a new course.

**2,500**
senior leaders engaged

**252**
survey respondents

8

Our work is supported by the findings of a September 2020 survey of more than 250 NHS leaders from across the NHS. This has enabled us to gain a clear picture of how different parts of our membership are feeling ahead of what is set to be a difficult period for the sector.

For the NHS Confederation, the lessons we have learned over the last six months will form the basis of our programme of work over the years ahead. The NHS Reset campaign has been a conversation, a discussion and reflection on a unique period in the history of the NHS – and a period that looks to unfortunately continue. The conversation does not stop here and we encourage all members, stakeholders and partners to join it.

## Survey methodology

During August and September 2020, we survey NHS leaders on a range of issues, including the operational environment, staff wellbeing and COVID-19 pressures.

We received 252 responses from NHS leaders across all parts of the health system: hospital, mental health, community and ambulance service trusts; clinical commissioning groups; primary care networks (PCNs); and sustainability and transformation partnerships (STPs) and integrated care systems (ICSs). It should be noted that none of the questions asked in the survey were compulsory, meaning that the sample size will differ for each of the statistics referenced in this report.

Further information about the data featured in this report is available on request.

## 50
webinars, roundtables and private meetings

## 60+
blogs

# HEALTH INEQUALITIES

# 02

## The issue

No single issue defines the coronavirus pandemic more than health inequalities. Far from being a "great leveller"[1], the pandemic has had an unequal and profound impact on people and communities across the UK. As evidence emerged during the early weeks of the pandemic, particularly on the impact on people from black and minority ethnic (BME) backgrounds and people with disabilities, it turned the spotlight on troubling differences in health outcomes; on disparities in access, quality and experience of care; and on the range of social and economic factors that impact on health. Yet health inequalities have been a decades-long issue.

The first Marmot report in 2010 highlighted the scale of health inequalities in England, their impact on people's lives and the actions required to address them[2]:

> "The health of the population is not just a matter of how well the health service is funded and functions, important as that is: health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health."

The second, published just weeks before the pandemic hit the UK's shores, showed that health inequalities had widened between 2010 and 2020, and that improvements in life expectancy had ground to a halt.

The NHS has a defined role in tackling health inequalities, one that is clearly described in legislation and in policy. The Health and Social Care Act 2012, for example, introduced a duty on the Secretary of State, NHS England and clinical commissioning groups (CCGs) to 'have regard to the need to reduce inequalities in access to care and outcomes of care.' Under the terms of the legislation, tackling inequalities in health should be one of the overarching purposes of integration and the move towards whole-system working. The NHS Long Term Plan (LTP) reinforced the need for a systematic approach to prevention and reducing health inequalities, as part of the government's ambition for five extra years of healthy life expectancy by 2035.

But as yet, neither legislative provisions nor policy directives have so far succeeded in shifting the needle.

> The NHS was not designed for inequality or inequity; it was designed to eradicate it. It should shame us that we are heading in the wrong direction. We have to make this core business – there isn't a plan B for the NHS

Lord Victor Adebowale, Chair, NHS Confederation

## 90%

of respondents believe that addressing health inequalities must be at the forefront of the reset process

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COVID-19 has – and will continue to – widen the health inequalities gap. If the government is serious about 'levelling up', about the creation of healthy, happy and economically productive communities, and if the NHS is serious about addressing systemic unfairness and injustice, then we need to build an NHS that prioritises population health approaches. This requires a systemic and sustained reduction in health inequality. Now is the time.

> "For decades there have been multiple explorations and government initiatives on the correlation between health, inequalities and the social determining factors…we are still asking how we can address the wider social determinants of health. There is a high level of national interest now and new openness to discuss race, communities, systems and inequalities in a way that has not been done before."

Samira Ben Omar, Assistant Director of Equalities,
North West London Collaboration of CCGs and Co-Founder of the Community Voices movement for change

> "We should never for a moment forget that we don't all have the same chance in life and do not all have equal opportunities."

Dame Jackie Daniel, Chief Executive,
Newcastle Upon Tyne Hospitals NHS Foundation Trust

## What NHS leaders have told us

### Time to act

Eighty-four per cent of respondents to our member survey believe that COVID-19 has demonstrated that the NHS must deliver a step change in how it cares for diverse and marginalised communities. Members have described a determination to reset the way the health sectors think about and acts on health inequalities – and to put the issue at the centre of NHS and public policy. They have also identified inequalities in health as the single issue that health and care partnerships can unite around in the future.

> "Hospitals are anchor institutions for our communities. We have a bigger role to play in the future than just providing healthcare."

Brendan Brown, Chief Executive,
Airedale NHS Foundation Trust

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# 80%
of respondents believe that success in tackling health inequalities must be a key measure when reviewing the performance of senior NHS leaders and their organisations

# 74%
of respondents believe that BME communities have poorer access and outcomes from NHS services

## Local flexibility, national framework

Local flexibility is seen as key to tackling local health inequalities. An overwhelming majority of survey respondents (91 per cent) agreed that there must be much more flexibility and freedom for local NHS bodies to do this.

Our engagement suggests that a national framework is needed for this, one which reconciles local and national accountability and affords the autonomy to co-design services to meet specific local needs. This would need to be backed by appropriate ringfenced funding and action to make services genuinely inclusive and accessible. This is especially important for population health planning. A move to a blended payment model would encourage care on the basis of outcome rather than activity.

## A sustained focus on community engagement

Leaders acknowledged the need for a sustained and proactive approach to community engagement, and better knowledge sharing and learning between different parts of the health and care system. Work undertaken by Public Health England has clearly demonstrated the importance of community-centred approaches to health and wellbeing, and the importance of sustaining and strengthening resilience throughout the pandemic.

> "Truly engaging people will lead to a reduction in avoidable inequalities and increase social connectedness to build healthier, more cohesive communities."

Rachel Power, Chief Executive, The Patients Association

## Joined-up approaches are vital

Our members have told us the pandemic has exposed the need for joined-up approaches in health policy, infrastructure and outcomes – this should be reflected by all government departments. A 'health in all policies' approach to level up and release the economic potential of deprived communities is essential.

> "It's about making reducing inequalities as important as every other statutory obligation that we have, be that financial balance, be that meeting performance and quality indicators. Because it's that important in terms of what benefits it can bring to people's lives, health outcomes and the opportunities they have for the future."

Rachel O'Connor, Assistant Chief Executive, Birmingham and Solihull Sustainability and Transformation Partnership

**96%** of respondents believe that to address health inequalities successfully, there needs to be a cross-government approach to addressing issues including homelessness, poor housing and poverty; and support for marginalised and vulnerable groups

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## Concerns over the digital shift

A positive trend during the first wave of COVID-19 has been the scale of digital innovation, which has transformed the way the health and care sector delivers care. From GP surgeries to outpatient clinics, there has been a significant acceleration of the adoption of new technologies.

But there are concerns across our membership about how the increasing use of digital platforms may create and exacerbate health inequalities across different demographics. Many are concerned about those most at risk of being left behind by the digital shift, including the estimated 4.8 million people across the UK who have never used the internet. Others who may face exclusion include those from low-income households and those who do not speak English as a first language.

It will be crucial to ensure that there is ongoing evaluation of digital inclusion and literacy at national level.[3] Capital investment will be needed for intuitive systems which enable public access equally across all communities.

# What NHS leaders need

### Health inequalities as core business

Tackling health inequalities needs to become core business for the NHS and social care, and a primary focus of integrated care systems and their constituent place-based partnerships.

### Culturally appropriate services and to prioritise groups most likely to be affected

It will be important to ensure that services are culturally appropriate and that groups that are more likely to be adversely affected by COVID-19, and which have historically poorer access to care and lower recovery rates, are prioritised. These include BME and LGBTQ+ communities, children and young people, and people with a learning disability and/or autism.The health and care sector will need to invest in understanding its communities better and gain better insight into the problems that people, patients and communities face.

### Tackling racism, discrimination and unequal representation

A system-wide approach is needed to tackle racism and discrimination. The NHS has a crucial role in eradicating racism within its structures and processes, which will help to substantially reduce health inequalities. NHS organisations need to build diverse leadership capacity from among the communities they serve. These leaders need to be supported to maximise their potential and effectiveness as role models.

Our most recent report from the Health and Care Women Leaders Network[4] highlighted that while progress has been made to increase the proportion of women in leadership roles across the health service, there is much more to be done to meet the NHS target of 50:50 representation by the end of the year, a target set by the regulator. The same report also highlighted there were still 70 all-white NHS trust boards, and six all-white arm's-length body boards. It builds on a report from our BME Leadership Network in 2019 which revealed that in recent years, despite some progress in executive appointments, there has been a reduction in appointments of non-executive directors and non-executive chairs from women, BME groups and other groups covered by the Equalities Act 2010.

## Addressing the wider determinants of health

The health and care sector has an important role beyond that of just delivering care. Sustainable change means tackling the wider determinants of health: employment, skills, educational attainment, air quality and housing. Preventing ill health is a key component of tackling health inequalities and the sustainability of the NHS. A long-term and committed shift to investing in the prevention agenda is needed.

As the largest employer in the country, the NHS has a key role as an anchor institution in helping to tackle inequalities locally in its procurement practice and employment and apprenticeship opportunities.

## Leading change

Whole system culture change is needed across public services, and the NHS at national and local level can take the lead on this. A joint approach is essential and should include local authorities, social care, the voluntary sector, private sector providers, housing, environmental, employment and education and training services. ICSs are pivotal to bringing all of this together.

## Digital literacy

The NHS should work with patient and carer organisations to support appropriate patient education at local level. Progress on digital literacy levels, access and inclusion must also be assessed regularly at national level to ensure that the benefits of digital transformation are being enjoyed by all demographics.

## Our support

We will be supporting members to tackle inequalities in health, including through the work of the NHS Race and Health Observatory. The observatory, which we host, will focus on evidence-based, actionable insights examining ethnic health inequalities in outcomes for patients and communities. Our BME Leadership Network will also shortly publish the findings of a research study into the impact of COVID-19 on BME communities.[5]

We are also pleased to be supporting two major studies: 1) led by the University of Leicester, investigating why people from BME backgrounds have a higher risk of developing severe COVID-19[6] and 2) led by King's College London and City University of London, investigating how discrimination experienced by both patients and healthcare practitioners may generate and perpetuate inequalities in health and health service use.[7]

Our recently-launched Health and Care LGBTQ+ Leaders Network has been exploring the particular health inequalities experienced by LGBTQ+ staff and patients during the pandemic, and how this has affected their physical and mental health. And throughout the NHS Reset campaign,  we have been raising concerns over the inequalities in health experienced by people with mental health issues.

We will continue to work on improving and prioritising health inequalities, alongside our members. Empowering diverse voices and helping to create a diverse leadership in the NHS is critical to this challenge. We convene leaders, promote discussion and develop solutions to challenges through our equality, diversity and inclusion networks and programmes – the BME Leadership Network, Health and Care Women Leaders Network, Health and Care LGBTQ+ Leaders Network and NHS Employers' Diversity and Inclusion Partners programme – alongside public policy in this space.

Our independent taskforce on increasing non-executive director diversity in the NHS, which will report in autumn 2020, will oversee the development of an equalities and diversity framework for the recruitment and retention of chairs and non-executives in the NHS in England.

A set of companion pieces to this report reflect in more detail our members' discussions over the last six months, alongside a selection of case studies that show practical actions that NHS organisations can take in this area.

We are always telling communities what they need, rather than genuinely listening and co-producing. PCNs have an opportunity to re-frame the narrative, to listen and build bridges and to work with communities in a meaningful way over the longer term

Dr Mark Spencer, GP and Co-Chair, NHS Confederation's PCN Network

# THE HEALTH AND CARE WORKFORCE

# 03

## The issue

The NHS workforce was already carrying over 90,000 vacancies prior to COVID-19, with a further 120,000 vacancies in social care. In our member survey, 85 per cent of respondents said they believe that understaffing across the NHS is putting patient safety and care at risk.

The pandemic has been without precedent in the demands it has placed on health and care staff across all settings and disciplines, leading to significant levels of stress and anxiety.
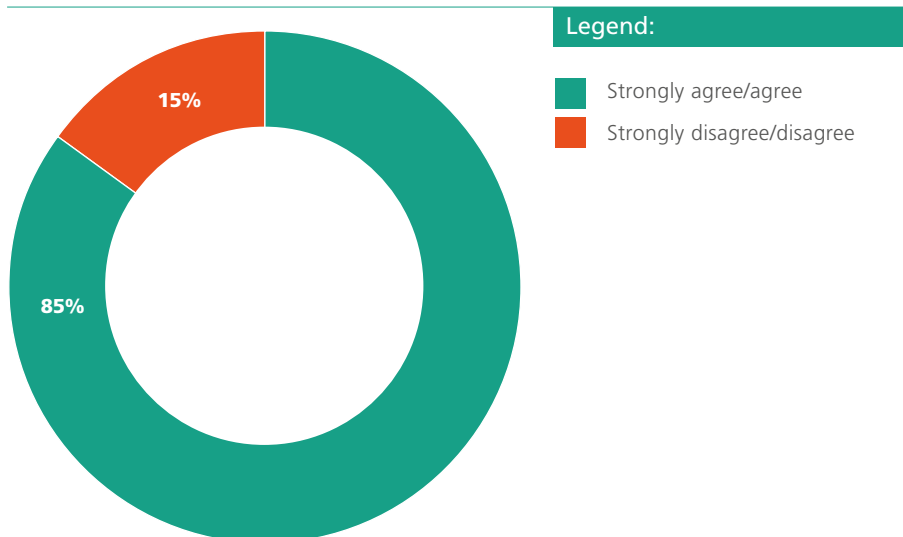
The disproportionate impact of the virus on ethnic minority communities was mirrored in the impact on black and minority ethnic (BME) staff. Long-standing differences in treatment between BME staff and their white colleagues were thrown into stark and challenging focus by the virus and have shown how far the sector still needs to go to tackle workplace discrimination.

Staff across the NHS have made significant changes to their way of working throughout this period. Our members recognise that the impact will be felt more significantly by some staff than others. Increased infection, prevention and control measures, the systemic use of personal protective equipment (PPE), and the need to retrain and work outside normal roles have all taken their toll. Members have reported concerns about the impact of this pressure on staff.

> The pandemic has taken an awful toll in loss of life among health and social care staff and the population as a whole

Clare Panniker, Chief Executive, Mid and South Essex NHS Foundation Trust

**Understaffing across the NHS is putting patient safety at risk \***



**Legend:**
- Strongly agree/agree
- Strongly disagree/disagree

85%
15%

\* 206 people answered this question, of which 150 had an opinion (56 were neutral/I don't know). Of those with an opinion 85% agreed and 15% disagreed.

NHS Reset: **a new direction for health and care**

16

Employers focused on staff wellbeing during the peak of the pandemic and delivered a range of programmes to support staff. The challenge now is how to sustain that work, particularly given the uncertainties associated with COVID-19 and how it will continue to impact the population and NHS.

> "COVID-19 is here to stay – how do we support staff over an elongated period of time?"
>
> Sam Higginson, Chief Executive,
> Norfolk and Norwich University Hospitals NHS Foundation Trust

While employers are concerned about the impact of COVID-19 on existing staff, some also recognise the chance to think differently to improve workforce supply. Creating the Workforce of the Future, for example, which explores how the NHS can work more closely with colleges, describes part of this opportunity. NHS Employers, which is part of the NHS Confederation, delivers Step into Health to improve recruitment from those leaving the armed forces. It is also partnering with the Prince's Trust in a new programme to improve access for young people to roles in the NHS.

The wider economic impact of COVID-19 may make health and care careers more attractive in the future and enables the NHS to support local communities.

## What NHS leaders have told us

### Impact on staff wellbeing

The impact of COVID-19 on the mental wellbeing of staff has been substantial. Mental health services have not yet seen the peak of demand and there are serious concerns over staff burnout, particularly among BME staff who are at greater risk. Our member survey showed that nine out of ten respondents are concerned about the long-term impact of COVID-19 on the wellbeing of their staff. Our report, The NHS After COVID-19[8], details concerns about the impact on BME staff.

"Our Health and Care LGBTQ+ Leaders Network has been exploring the experiences of LGBTQ+ staff over this period and how it has affected their physical and mental health."

17

## Pre-existing workforce shortages are starting to bite

Colleagues across all parts of the system have mobilised their resources, including volunteers and students. Current staff stepped up and into other roles; leavers offered to return; and corporate and administrative team colleagues adapted quickly to new ways of working. But as services are restored, pre-existing workforce shortages are starting to show. At the same time, members are keen to ensure that staff who have worked tirelessly for the last few months are able to take a proper break.

## Greater than the sum of our parts

Members are keen to continue working with each other to share ideas and to maximise the potential of their workforce. They recognise their role in 'place' and their ability to act as anchor institutions, providing local training and employment opportunities. They also recognise that working in partnership across their integrated care system provides career opportunities for staff. As explored in our joint report with the College of the Future, colleges can play an important role in supporting the closer integration of health and social care.[9]

## Investment in infrastructure

Members recognise the benefits of technology in supporting staff to do their jobs more easily. However, cumbersome and outdated systems are at odds with how most staff manage their lives outside of work. If the health service is to be an attractive employer to new recruits, and retain them, it needs to invest in the infrastructure provided to staff.

## Facilitating workforce availability

There were frustrations when the interaction between national, regional, integrated care systems and local providers did not work, but it was also very positive when it did. This positive enablement and support was particularly seen in the changes to legislation to support overseas staff to stay in the UK and continue to work. The introduction of Disclosure and Barring Service fast track checks and the creation of temporary registers for returning healthcare professionals all assisted with workforce availability. While the impact of new immigration proposals may have been limited within the NHS, the impact on social care has been more significant.

18

## Brexit considerations

Some members still have concerns about Brexit and the impact on staffing, particularly in relation to staff morale.

## Financial matters

Significant financial investment will be required to deliver the solutions needed to tackle workforce burnout and address the significant vacancies in the longer term.

# What NHS leaders need

## Action on inequality and discrimination

Members will need to address inequality and discrimination in workplaces. They will be the lead influencer in improving the experience people have at work.

## Investment to support staff wellbeing

As competing priorities emerge, local employers will need investment to ensure that staff wellbeing remains a central focus. National action on the education of vital clinical staff is an essential part of supporting staff experience and wellbeing. Employers recognise the challenging economic climate but also need clarity on investment in pay. This cannot be at the expense of other budgets for patient services or education.

## Clarity and investment

Members urgently need clarity and investment in the Comprehensive Spending Review. In particular, they need: commitment to increase support for undergraduate study; support for workforce placements of additional healthcare professionals; and continued support for national recruitment campaigns for health and social care.

**Only 1 in 10** leaders feel confident that they currently have sufficient workforce capacity to achieve the ambitions set out in the NHS Long Term Plan up to 2023/24

19

# FUNDING AND CAPACITY

# 04

## The issue

Prior to COVID-19, the NHS was struggling under the weight of demand. Targets were regularly missed (in some places for several years) and waiting lists were continuing to grow. Winter 2019 was challenging, with declines in many of the operating standards. Particularly notable was the increasing delay in ambulance handovers and the continuing rise of the four-hour A&E waiting time.

In the early stages of COVID-19, there were significant reductions in the services the NHS normally provides, as infection control measures were implemented and beds and staff were diverted to treat patients with COVID-19. For example, A&E attendances fell from 2,112,165 in April 2019 to 916,581 in April 2020 – a decrease of 57 per cent. Despite this, the NHS continued to treat millions of patients not infected with the virus.

The support and understanding of the public has been critical to enabling the NHS to respond effectively to the pandemic and save the lives of many people. The public rightly expects normal services to resume and to receive the care and treatment that has been delayed. However, the continued uncertainty and potential second surge make this increasingly difficult to achieve. In recent months, the NHS has made progress in restarting services and restoring them to previous levels. This has been achieved despite fatigued staff and the need to make significant changes to how the NHS provides care safely.

However, the pandemic's impact on the capacity of the NHS is still being felt and that is likely to continue for several years. The service needs government investment to support the introduction of new ways of working that will enable the NHS to fully restore services, and the understanding of the public while it adjusts and deals with a large backlog of patients needing care.

# What NHS leaders have told us

## Patient safety is a primary concern

Our members greatly appreciate the support shown by the public during the pandemic – both the public recognition of the commitment of NHS staff to care for them but also being so understanding as usual services were curtailed. Members are now committed to resuming services at scale and pace, wherever they safely can, and tackling the service backlog.

Patient safety is a central concern in restarting services in light of the increased risks to both patients and staff from COVID-19. However, there is also a delicate balance to be managed between minimising immediate risks to patient safety during a pandemic and mitigating against the longer-term risks associated with delayed treatment.

## Step change in the use of technology

Innovative ways of using technology have, in many areas, helped providers to adapt to the pandemic and increase activity. In primary care, for instance, 71 per cent of routine GP consultations were delivered remotely in the four weeks to 12 April, compared with about 26 per cent face to face.[10] This reversed the pattern of the same period last year, when 71 per cent of GP consultations were face to face and 25 per cent were remote.

There is also a growing use of artificial intelligence (AI) in diagnostic services. The pandemic has encouraged a step change in the use of technology and the NHS is still learning about how best to take advantage of this following the first peak. There are undoubtedly more opportunities to improve services that are yet to come.

## Capacity constraints and demand challenges

Despite this, the NHS now faces a number of practical problems to the delivery of care that have arisen as a direct consequence of the pandemic. These include:

- **Workforce:** reduced staff capacity, including accrued leave not taken during the pandemic, staff burnout and the time taken to don and doff PPE, which limits the time spent with patients.

21

What will be the impact of the swathes of cancelled non-urgent operations? The numbers are important, but behind each of these numbers is a patient and a family, and their experiences should help shape the future of health and care

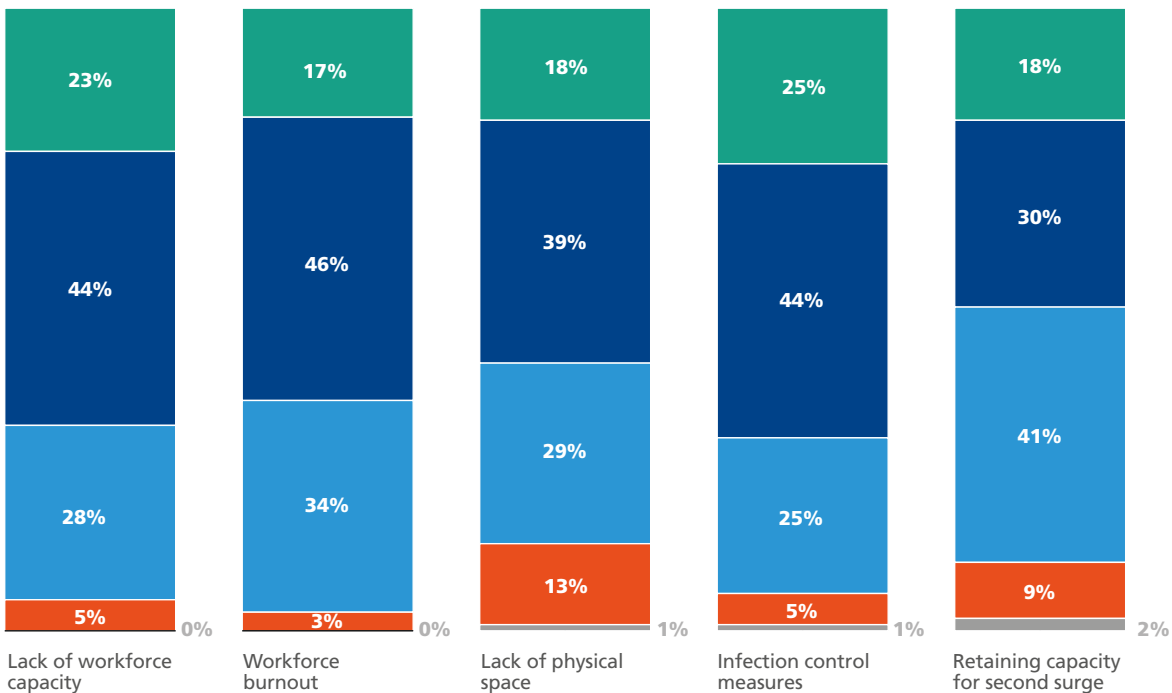Imelda Redmond, National Director, Healthwatch England

- **Infection control:** the increased burden of infection prevention and control measures associated with COVID-19, which members have cited as a significant barrier in their ability to resume services quickly.

- **Physical space:** social distancing for staff and patients means space constraints in some sites, which limits the volume of services that can be safely provided.

- **Second surge:** the NHS has to retain spare capacity in the event of a second surge or local lockdowns, which are now looking more likely. This is very difficult to plan for in light of so many uncertainties.

- **Testing:** both for patients and staff, remains a critical barrier to recommencing services. The Prime Minister this month has conceded that the COVID-19 testing system nationally "has huge problems". These problems must be addressed by the government as a priority so that NHS staff are able to get on with delivering care to patients as quickly and efficiently as possible.

22

Legend:

- ■ Very significant impact
- ■ Significant impact
- ■ Slight impact
- ■ No impact
- ■ I don't know

**For each barrier, indicate the extent to which they are restricting your ability to meet the requirements of the service**

| Lack of workforce capacity | Workforce burnout | Lack of physical space | Infection control measures | Retaining capacity for second surge |
|---|---|---|---|---|
| 23% | 17% | 18% | 25% | 18% |
| 44% | 46% | 39% | 44% | 30% |
| 28% | 34% | 29% | 25% | 41% |
| 5% | 3% | 13% | 5% | 9% |
| 0% | 0% | 1% | 1% | 2% |

The NHS is also anticipating significant increases in demand for its services in the next couple of years, both from a backlog that has built up and from new demands on its services:
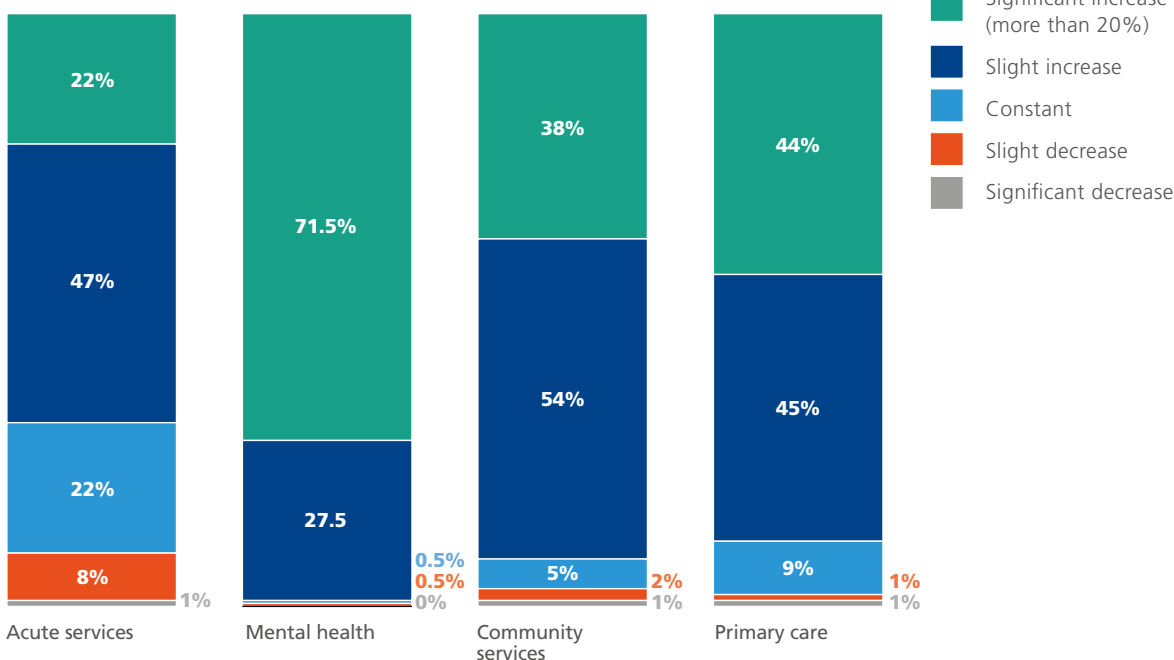
- **Waiting lists:** a third of trusts are expecting increases in their waiting lists of 20 per cent or more in the next 12 months.

- **Mental health:** providers of mental health services are anticipating a 20 per cent increase in demand against a 10-30 per cent decrease in capacity.[11] Our report on mental health, published in August 2020, describes this is detail.[12]

- **Primary care:** practices are expecting a significant surge in patients while also dealing with a backlog of immunisation and screening programmes.

- **Community services:** widespread concerns about the long-term demand on community services due to patients requiring ongoing treatment and long-term rehabilitation services as part of their COVID -19 recovery. The community sector must be strengthened if it is to meet rising demand.

NHS community health services now face a 'long tail' of tens of thousands of patients who have suffered the most severe effects of COVID-19 and need post-discharge rehab care

Andrew Ridley, Chair,
Community Network

23

**How do you expect the pandemic to impact the number of people seeking healthcare from the following services through to spring 2024?**

Legend:

- Significant increase (more than 20%)
- Slight increase
- Constant
- Slight decrease
- Significant decrease

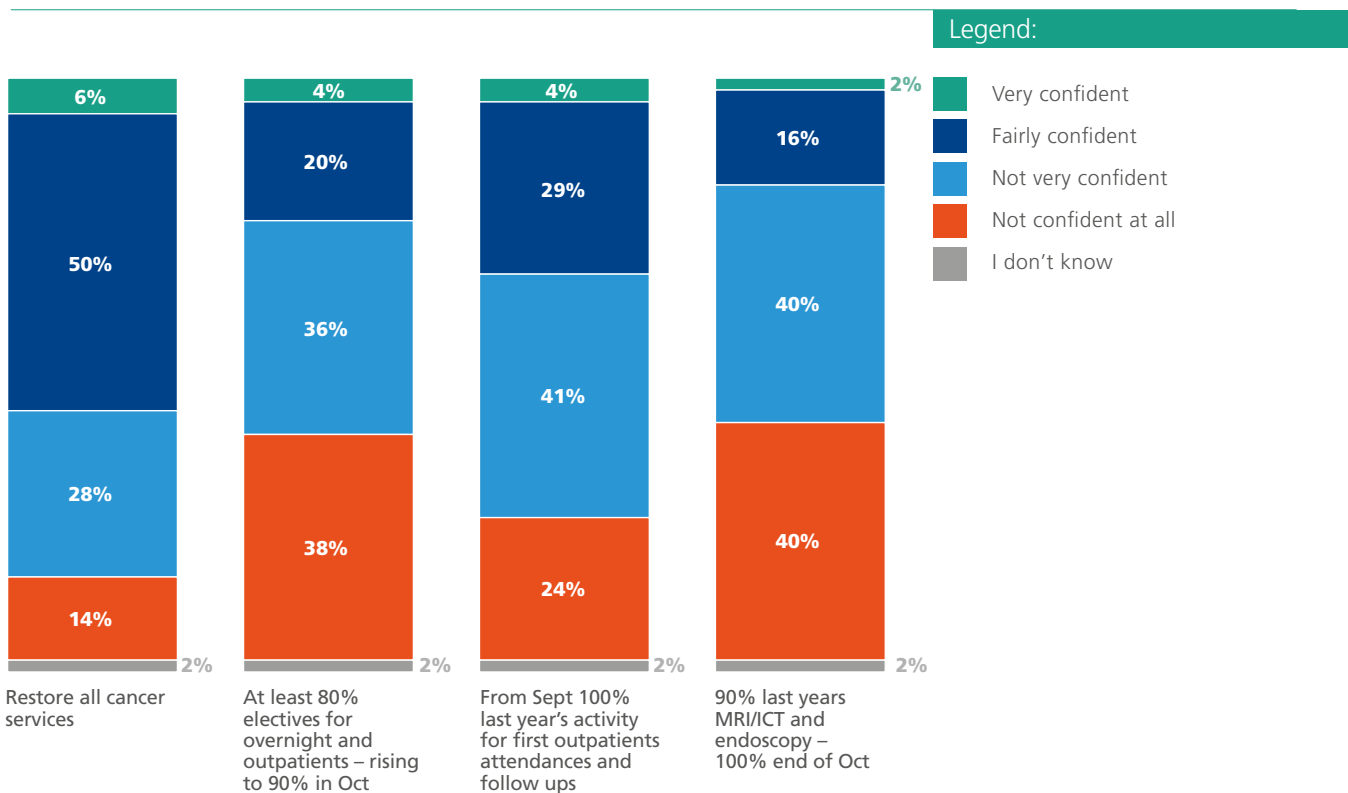| | Acute services | Mental health | Community services | Primary care |
|---|---|---|---|---|
| Significant increase | 22% | 71.5% | 38% | 44% |
| Slight increase | 47% | 27.5 | 54% | 45% |
| Constant | 22% | 0.5% | 5% | 9% |
| Slight decrease | 8% | 0.5% | 2% | 1% |
| Significant decrease | 1% | 0% | 1% | 1% |

The NHS is ambitious in its aims to restore services for patients, and in late July NHS England and NHS Improvement published its 'phase three' guidance which included targets for when services would be resumed. However, unsurprisingly, in view of these capacity constraints and demand challenges facing NHS organisations, there is little confidence that it will be possible to fully restore all services in the short term. This is a consistent pattern across the healthcare system and particularly for acute, primary and community services. The most positive picture seems to be in the restoration of cancer services, with around half of acute providers and ICSs expressing some confidence in being able to restore full operation of all cancer services. This reflects the clinical priority of these services to patients.

## Long Term Plan commitments

Staff are doing their best to get services back on track and have made significant progress in recent months. However, there also needs to be a sense of realism about what can be delivered and that full restoration of services is unlikely to be possible in the short term.

24

**How confident are you that you will be able to meet the service resumption targets set out in the phase three letter?**



Legend:
- Very confident
- Fairly confident
- Not very confident
- Not confident at all
- I don't know

**Restore all cancer services**
- 6% Very confident
- 50% Fairly confident
- 28% Not very confident
- 14% Not confident at all
- 2% I don't know

**At least 80% electives for overnight and outpatients – rising to 90% in Oct**
- 4% Very confident
- 20% Fairly confident
- 36% Not very confident
- 38% Not confident at all
- 2% I don't know

**From Sept 100% last year's activity for first outpatients attendances and follow ups**
- 4% Very confident
- 29% Fairly confident
- 41% Not very confident
- 24% Not confident at all
- 2% I don't know

**90% last years MRI/ICT and endoscopy – 100% end of Oct**
- 2% Very confident
- 16% Fairly confident
- 40% Not very confident
- 40% Not confident at all
- 2% I don't know

The service needs the public's continued forbearance and understanding, as well as investment from the government to help it adjust. Since COVID-19 hit the service, over 85 per cent of leaders responding to our survey said they are not confident of being able to deliver the NHS Long Term Plan within their revenue settlement. Similarly, almost three-quarters believe they have insufficient capital funding to achieve the goals of the Plan.

# What NHS leaders need

## Increased financial support and clarity

The NHS needs additional revenue and capital funding over the next three years to help it adjust to the impact of COVID-19. In particular, the service needs a multi-year settlement to give it certainty and enable it to plan and invest for the future. As one member told us: "It is not possible to plan diagnostic services without knowing how many MRI scanners you will have."

## Simplified bidding process

Members have told us of significant challenges in the bidding process for funding, particularly in relation to capital investment. These range from unrealistic spending timeframes to lengthy bidding processes. The political nature of capital bids often plays a role in the bidding process and places an additional burden on members.

## Realistic expectations and messaging

Future public messaging on NHS capacity needs to be honest and realistic. The commitment of NHS staff to do their best for the public has been demonstrated many times over during the pandemic. Politicians and national bodies need to support the NHS to manage the realities of recovering services, not set unrealistic targets and impose financial penalties.

# INTEGRATION AND SYSTEM WORKING

# 05

## The issue

The health and care system – including NHS, community and local authority services – has been on a journey towards more integrated models of delivery, through the introduction of integrated care systems (ICSs) and through place- and neighbourhood-based working.

COVID-19 has demonstrated the critical importance of integration. Many of the solutions that have been developed in response to issues such as PPE and resource shortages, patient discharge and community outreach have centred around collaboration and partnership working across primary, secondary and community services, and with local government and community partners.

However, while the NHS Long Term Plan (LTP) sets out a clear ambition for the shift to more collaborative working through ICSs, there remain several uncertainties about how these systems should operate and the extent to which system frameworks should be underpinned by new legislation.

We have been at the forefront of the evolving discussion around system by default. Through our ICS and other member networks, we are leading the national debate around how to put systems, partnerships, neighbourhoods and integration at the heart of a future NHS.

> COVID-19 has demonstrated the critical importance of integration

"The accountability of public service works best when it is defined and brought together in the context of the people it aims to serve. This is what happens with devolution. It has consequences of course for the old model of hierarchical accountability within the NHS, but those consequences I think are beneficial and can ensure that the national promise coexists with local accountability and relevance."

Professor Donna Hall, Chair,
Bolton NHS Foundation Trust

26

# What NHS leaders have told us

## Strengthened partnership working

Despite the significant pressures faced by services during the first wave, and in most cases because of them, many of our members have shared that COVID-19 has strengthened partnership working. This appears to have been particularly notable at neighbourhood and place levels, with organisations across health and care coming together to address shared challenges.

> "The COVID-19 response, as in many areas, has really propelled forward joint working across the NHS, social care and wider public sector teams. We have seen rapid decision making and (safe) bypassing of the rule book, which has resulted in more effective up-skilling, such as forward-based staff developing critical care skills or mental health nurses delivering end-of-life care."

Alison Lathwell, Strategic Workforce Transformation Lead, Bedfordshire, Luton and Milton Keynes ICS

## Innovation in system working

Over recent months, we have seen positive examples of innovative partnership working across almost all areas of health and care, including across the community and voluntary sectors, and between primary and secondary services. A recent briefing produced by the NHS Confederation's Mental Health Network and PCN Network, The Calm Before the Storm?'[13], sets out how primary care networks (PCNs) and mental health providers have been working collaboratively to ensure that the rising demand for care can be met in local communities.

## Concerns over accountability and coordination

The role of systems has been limited in part by the ongoing uncertainties surrounding their function and form. STPs and ICSs operate within a policy and legal framework that was developed to promote competition rather than collaboration. Members have therefore spoken about concerns around issues such as accountability and the difficulties of trying to coordinate services within a fragmented NHS.

## NHS-centric

We have also heard, particularly from system chairs and executive leads, that the rhetoric and planning around the future of system-working is far too NHS- and health-focused.

**80%** of respondents agree there should be a shared statutory duty on all partners within systems to deliver the triple aim

## What NHS leaders need

### Architecture that supports integration, partnership working and cooperation

Any reset must create a model for the NHS that supports integration, partnership working and cooperation between health and care services. This must set out clear roles for ICSs in areas such as transformation, regulation, reporting and governance, as well as how PCNs fit into wider system working.

### A fit-for-purpose financial framework

A future model of system-working must be underpinned by the right financial framework. This must recognise that to foster collaboration within systems, commissioning needs to move away from transactional relationships (such as those created through payment by results) and towards an approach based on shared incentives, risk-sharing and evaluation based on outcomes rather than activity. We welcome that health service finances will be system managed for the remainder of the year and hope that this represents the start of a long-term shift towards increased financial control for systems.

### Incentives for partnership working

The NHS must look to incentivise partnership working between health services and local authorities at place level. Only by working as true partners can we collaborate in a population health approach that tackles the wider determinants, by aligning our strategies and using the NHS as an anchor institution to drive local economic growth. At neighbourhood, place and system levels, this means joined-up multidisciplinary working between the NHS and all of its local public service partners.

It would be very unfortunate if local government were to get the impression that they are junior partners within systems – or that systems are simply a vehicle for managing the NHS more effectively

Independent Chair, STP

28

In October 2020, we will publish the results of a consultation with our provider trust, CCG, PCN and ICS members on what system working should look like in the future. This will ensure that our members' concerns are conveyed directly to NHS England and NHS Improvement and government as they determine national policy and legislation in this area.

NHS Clinical Commissioners, which is part of the NHS Confederation, continues to lead discussions on the evolving role of commissioning within system working, recognising that the important functions CCGs fulfil need a home within an ICS.  Creating A New Normal for CCG Business As Usual: Preparing for System by Default in 2020/21 describes this shift in commissioning.[14] The NHS Confederation's PCN Network and Mental Health Network continue to support this work.

"In many ways COVID-19 has been a demonstration of integration in action and there is strong commitment from partners to work together for our local population. This for me is one of the positives we can take from this period. We have all been forced to rip up the old ways of working and I am adamant that we cannot look back – we must continue to build on our partnerships collaboration and commitment to that which matters most; ensuring the people of north east London have equitable access to comprehensive high quality health and care services."

Jane Milligan, Accountable Officer for the seven north-east London CCGs

# LETTING LOCAL LEADERS LEAD

# 06

## The issue

We can address the form and function of a reset, by giving leaders clarity on what system working and integration mean for health and care in the future. But during the first wave of the crisis, we saw different kinds of leadership cultures and values that should be encouraged.

Much of what was good was based on local public sector and NHS leaders coming together at pace to radically redesign services for their communities. When contrasted with the slow and variable national approaches to guidance, PPE and test, track and trace, the difference makes a strong argument for a less centralised health and care system.

At the same time, the suspension of the regulatory, assurance and reporting environment in which the NHS operates enabled a leaner, lighter and more agile way of working. Services were transformed in days, rather than years, and frontline clinicians from trusts to primary care were empowered to innovate and redesign services.

The major gains were made by NHS leaders, local government colleagues, voluntary and community groups working together. COVID-19 has demonstrated that when power is decentralised it results in an increase in the pace of decision-making, innovation and improved outcomes for people patients and communities.

**91%**
of respondents believe there must be much more flexibility and freedom for local NHS bodies to listen to and co-produce local services with communities

**80%**
of respondents feel that ICSs should have increased autonomy and greater local discretion over how national priorities are implemented

30

# What NHS leaders have told us

## Decentralising power and accountability

The UK has one of the most centralised health systems in the world. The learning from the first wave of the pandemic should be used to trigger a conscious handing over of power, accountability and control to local health and care systems.
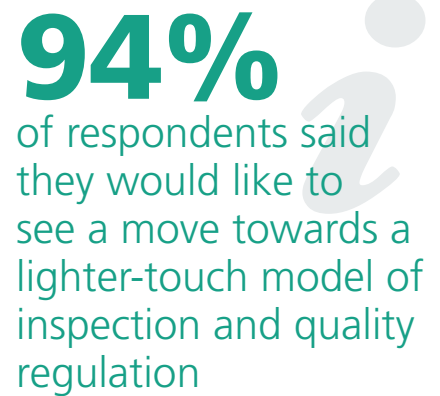
## Retaining a lean, light and agile culture

The lean, light and agile culture that the NHS has developed over the last six months has been a hallmark of the pandemic response. The health service changed rapidly with the relaxation in governance, assurance, reporting, regulation and tariff, giving leaders and clinicians the space to transform patient care. NHS leaders are hesitant about reverting to old ways of working and have expressed the need to move away from a prescriptive architecture to one that is permissive and empowering.

We are not asking for regulation and oversight to be abandoned but for proportionate, risk-based, intelligence-led assurance.

## Stripping away duplication, streamlining assurance

There is now a widespread acceptance that the 2012 Health and Social Care Act, and the way we choose to interpret it, has left a confused architecture for the NHS that wastes time, effort and money. The emergency response to COVID-19 has provided a glimpse of how the NHS could be if duplication in reporting and assurance were stripped away and the system united behind a common cause. This aim, clarity and simplicity in how the NHS is organised, regulated and assured is key to retaining this culture.

**94%**
of respondents said they would like to see a move towards a lighter-touch model of inspection and quality regulation

31

# What NHS leaders need

## Greater autonomy

Local leaders should be given greater autonomy to make decisions about health and care. In every place, at every level, health and care leaders should be trusted and empowered more.

## Reduced reporting and assurance

We welcome the Secretary of State's review of bureaucracy and his commitment to reduce unnecessary reporting and assurance. We will support his leadership in this area in support of a lighter, leaner more agile NHS. That said, we are conscious that we have heard similar sentiments before and the broad direction over the last decade has been towards more, not less, regulation.

## Suspension of inspections

We are asking for traditional forms of Care Quality Commission inspection to be suspended until the lessons from the pandemic have been learned and we are through winter, and welcome moves towards light touch and right touch inspection at this time

## Proportionate and risk-based regulation

We will support the Care Quality Commission's consultation in autumn 2020, and specifically argue for regulation that is proportionate, risk-based and which works in support of system working, integration and whole patient pathways.

## Health devolution

NHS leaders have an opportunity to build on the central role the NHS has in communities as an anchor institution. Health devolution is important if we believe in a population health approach that recognises the key importance of the wider determinants.

## Playing a role in economic and social recovery

It is vital that NHS leaders as place champions are interlocked with the success of their place. Our five-point plan, The Role of Health and Care in the Economy,[15] sets out five steps local NHS and social care organisations can take to play a leading role in place-based economic and social recovery.

## Playing a role in addressing climate change

With the next phase of the national Net Zero NHS strategy due for publication shortly, there is an other opportunity for local leaders. In doing so, they can move beyond a high-level understanding of the NHS's role in addressing climate change to one that sees it as a vital part of resetting health and care.

Action should also form part of a wider place-based approach than simply the NHS, involving a range of public and industry partners and focused on mitigating the impact on the environment. It should also realise the wider opportunities that a new 'clean' economy can bring for communities. In particular, the level of capital investment planned in the coming years within the NHS and in wider infrastructure strategies presents a generational opportunity to embed sustainability into communities.

## Deeper relationships with communities

The health and care sector needs to develop a better understanding of the communities it serves. Leaders have talked about deeper and more authentic relationships with communities, based not on engagement or consultation, but on real insight into the problems people face in their everyday lives.

As noted in the Health Devolution's recent report: "At the heart of good health devolution should be close working relationships between clinical and civic leaders; community involvement and active citizenship; and parity of esteem between the public, private and voluntary sectors."[16]

"If you don't know your community, you can't engage and help co-design the services and responses that people actually want and need. The Morecambe Bay Poverty Truth Commission enabled senior public sector leaders to listen to how the actions of public bodies have impacted on their lives. It's helped people who live in abject poverty to stand in front of leaders of the NHS, council and Department of Work and Pensions and explain how their lives have been impacted on by government. The impact on this group of leaders, of being exposed to the reality of people's lives has been transformational."

Andy Knox, GP

# SOCIAL CARE

# 07

## The issue

The COVID-19 pandemic has highlighted the critical role that social care plays in the delivery of health and care services. But it has also exacerbated the underlying weaknesses in social care and demonstrated the need for fundamental reform. Staff shortages, a severe lack of funding, the absence of robust data and access to PPE and testing, among other issues, have exposed the need for urgent government action to fix social care.

As the NHS looks to restore services, prepare for winter and ready itself for a second surge of infections, its ability to do so is heavily dependent on a stable, well-funded social care sector. Social care reform will be vital to support the millions of people at all stages of life who rely on care and support, and the effective functioning of the NHS.

It is good to see the winter plan for social care announced on 18 September 2020, but the government needs to be bolder to see the country through this winter, and braver in tackling the long-term reform of social care.

> "The plan is a welcome start, but there is much more to do. The focus on safety and wellbeing in care homes is right, but a significant majority of people receive care and support in their own home. The next step must be to increase care at home and to ensure that they are similarly protected. This will require significant additional funding to enable people to live good lives and to not merely survive the pandemic."

James Bullion, President,
Association of Directors of Adult Social Services

> In a post-coronavirus landscape, we will need our hospitals and medical facilities to recover and thrive. More crucially, we need a wider support system that enables people to live safely and well at home

Alex Fox, Chief Executive,
Shared Lives Plus

34

NHS Reset: **a new direction for health and care**

# What NHS leaders have told us

## Short and long-term funding needed

Members have raised concerns about social care and the need for short-term funding to ward off a collapse of the social care market. They have also raised the need for a long-term funding solution for social care. Social care and the NHS are intrinsically linked – a lack of resources or investment in one has a knock-on effect on the other.

## Collaboration has been key

Collaborative working, especially at neighbourhood and place levels, will only be successful if people can easily transfer between primary, secondary, community and care services. As the Health for Care Coalition, led by NHS Confederation, stated in a letter to the Prime Minister in August 2020: "The pandemic has exposed the frailty of the social care sector, but it has also demonstrated how much the NHS relies on the care sector. Failure to invest in and reform this area puts incredible and unnecessary pressure on our health services and puts at risk our efforts to create a caring and effective NHS."

## Workforce shortages causing deep concern

NHS Employers remains deeply concerned about workforce shortages in both social care and the NHS, and the impact this has on being able to deliver an integrated care offer to communities.

> "The current crisis has, more than ever, shown us that the NHS and social care are intrinsically linked. But it has also exposed the stark divide between the two in our failure to treat them as a single system and offer parity in the value we apply to social care and the NHS."
>
> Professor Donna Hall CBE, Chair,
> Bolton NHS Foundation Trust

A detailed reflection of the discussions we have had with members is contained in our report Social Care: Time to Grasp the Nettle.[17]

> The NHS cannot do it on its own. It has taken the combined efforts of many agencies to tackle COVID-19, and joint working, to face a common threat. It has forced a new level of cooperation and trust. It has also exposed, both nationally and locally, the key importance of a more integrated approach to health and social care
>
> Michael Williams, Chair,
> Nottingham City Care Partnership

35

# What NHS and social care leaders need

## A stable, well-funded social care service

The government should provide immediate funding to help social care respond to the COVID-19 crisis and its aftermath, and address the longer-term need for a multi-year funding settlement for the sector. This must ensure that the model of delivery for social care provides the right level of support at the right time for those who need it.

## A long-term plan

A clear road map for social care is needed that runs parallel to and supports the NHS Long Term Plan.

## A well-resourced and trained workforce

The government must work collaboratively with organisations in the care sector to address the significant number of vacancies and high staff turnover rates in social care. We must acknowledge and rectify the imbalance in terms and conditions between health and social care workers.

## Outcomes-based commissioning

The social care sector, as with the health sector, must move towards a model of person-focused outcomes-based commissioning. As part of system working, both health and social care organisations should be present at early commissioning meetings across different aspects of care.

We will continue to lead the Health for Care coalition[18], a group of 15 leading organisations committed to securing a new deal for social care.

# NEXT STEPS

# 08

**COVID-19 has been – and continues to be – an unprecedented challenge for the NHS and will change the way health and care services are planned, commissioned and delivered for years to come.**

As we move into winter 2020/21 and confront a second surge, NHS leaders are working hard to increase access to services, while managing the threat of infection and keeping patients safe.

We know the road to recovery will be long, and winter will add further pressure to an already over-stretched workforce. If the NHS is to get through this period, then lessons from the first wave of the pandemic will need to be learned and put into section.

Despite the unprecedented nature of the pandemic, it has brought about greater innovation and service transformation. Over the course of nearly 50 webinars, roundtables and private meetings, we have explored with more than 2,500 senior leaders, clinicians, partners and parliamentarians the shifts in culture, regulation, reporting, assurance and behaviour that have accompanied the response to COVID-19. The challenge now is to make sure such beneficial changes are sustained for the benefit of patients and health and care staff.

Some of our NHS Reset work asks for structural change in the NHS and social care, a changing of priorities, and a change in the way that we think about health and care. But much of what NHS leaders talk about is practical – about supporting the lean, light, agile and patient-focused culture that was developed in the spring.

We have learned much from the first wave of COVID-19 and are in a better position to manage this second time round. But we must hold on to the beneficial gains and take this opportunity to re-cast services. The measures outlined in this report reflect the views of our members – NHS leaders across the system – and set out a possible direction for the NHS and a future which should lead to improving health for individuals, families and communities.

We encourage our members and partners to continue the NHS Reset conversation by sharing views on this report at
**NHSReset@nhsconfed.org**

Join the conversation **#NHSReset**

NHS Reset: a new direction for health and care

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# ACKNOWLEDGMENTS

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NHS Reset: **a new direction for health and care**

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