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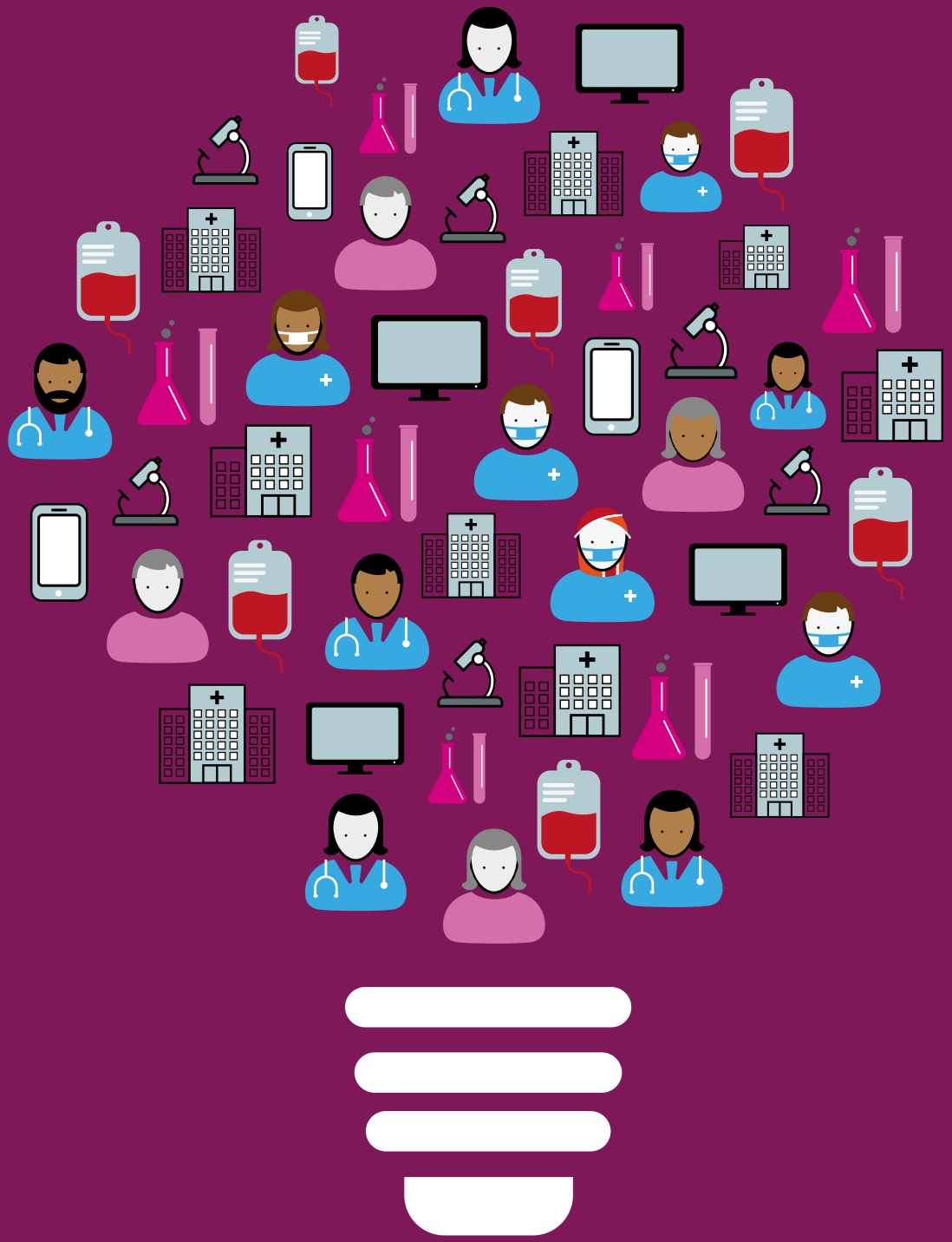

The NHS Winter Crisis

About *Reformer Thoughts*

Reformer Thoughts brings together the opinions of leading experts from academia, business and government; frontline practitioners and public service users, to provide readers with valuable insight into the challenges shaping the policy debate. The series aims to give a platform to innovative ideas and facilitate an open and informed conversation about how we can improve public services.

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Reform is established as the leading Westminster think tank for public service reform. We are dedicated to achieving better and smarter public services. Our mission is to set out ideas that will improve public services for all and deliver value for money.

We work on core sectors such as health and social care, education, home affairs and justice, and work and pensions. Our work also covers issues that cut across these sectors, including public service design and delivery and digital public services.

We are determinedly independent and strictly non-party in our approach.

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Introduction
NHS winter pressures: Lurching from crisis to crisis?

Fears over the NHS coming under strain in winter are not new. Every year dire media headlines warn about capacity issues, large-scale staff shortages, worsening A&E performance and its consequences for frontline staff, patients and their families.

Whilst the NHS has coped well with winter pressures this year, this seems to be the result of a combination of factors, including a milder winter and extra government funding for hospitals to invest in infrastructure and mitigation planning. However, the latest NHS performance figures paint a bleak picture of the current state of A&E departments across the country, reigniting concerns about the long-term sustainability of services in the face of rising demand. It is not surprising that, in the eyes of some commentators, the annual NHS winter crisis is now an "all year-round crisis".

An historic funding settlement of £20.5bn by 2023 for the NHS was announced last June, followed by the publication of the NHS long-term plan earlier this year. The plan sets out bold ambitions for delivering joined-up, world-class care. It also contains specific measures to tackle winter pressures, including expanding and improving urgent and emergency care services and targeting investment to support those at higher risk of hospitalisation, especially patients suffering from respiratory diseases.

A recent report by the National Audit Office has warned that despite greater investment, substantial deficits remain in some parts of the system and that short-term cash injections to NHS Trusts risk hindering transformation. This was echoed by a previous report from the Public Accounts Committee which declared that the "NHS is still very much in survival mode" and called for a more strategic approach to system change, long-term planning and better and joined-up services for patients.

There is increased recognition that winter crises are not the result of isolated capacity issues in A&E, but symptoms of more systemic problems. The NHS does not operate in a vacuum and tackling these challenges will require a multi-agency approach and integrated thinking, particularly with adult social care. Achieving the goals proposed by the long-term plan will therefore require action that goes beyond simply keeping services afloat but builds capability for the system to deliver integrated care, improve quality and harness innovation.

Tackling the winter crisis

This *Reformer Thoughts* series brings together healthcare professionals to discuss what can be done to alleviate winter pressures on the NHS. The blogs address the multifaceted nature of winter crises, touching on the challenges posed by workforce supply issues, funding and a lack of joined up approaches in primary and secondary care. It is suggested that digital technologies could play a greater role in helping the NHS manage capacity and demand for care in the long-term. They stress the need to reform the way health and social care services are delivered and funded, as well as the specific challenges facing services such as mental health and community nursing. This series presents a forward-looking assessment of the NHS and suggests that much can still be done to prevent winter crises from recurring.

Claudia Martinez
Research Manager at Reform

"There is increased recognition that winter crises are not the result of isolated capacity issues in A&E, but symptoms of more systematic problems"

The NHS Workforce: in Crisis?

As the NHS enters another period of crisis, some would say the 18th month of a perpetual winter crisis, my concerns focus around staffing and workforce. This is of utmost importance as in my view the people who work within the NHS are its vital lifeblood and without them there would be no NHS.

The workforce can be broken down in two main ways, the current 'team' and how to retain them and then the everyday worrying gaps in those numbers for both medical and non-medical staff.

Staff retention is a relatively unrecognised issue that is hard to quantify. From the Royal College of Physicians (RCP) 2018 census of consultants and trainee doctors it was noted that 33 per cent of consultants currently in post will reach retirement age in the next 10 years and in the age group currently aged over 60 nearly 50 per cent have reduced their hours significantly in the last 12 months. Replacing a consultant is not quick or easy – at present 45 per cent of advertised consultant posts are unfilled due to a lack of suitable applicants and it takes on average 14 years from entering medical school to becoming a consultant.

Gaps in the workforce cause significant issues with 53 per cent of consultants saying rota gaps occurred frequently/often, with significant patient safety issues in 20 per cent of these despite on average working 10 per cent above contracted hours. Worryingly a third of trainee physicians said that if they could start again, they would take a medical job outside the NHS or a job outside medicine, quoting rota gaps as the major factor.

Nursing workforce issues have long been widely reported - official NHS Workforce statistics data confirms the total number of nurses in the NHS as 285,500 which is only 7,000 more than in 2009 and this is despite the massive rise in need in the NHS. Hidden in this is the over 10 per cent reduction in community nurses and the staggering 40 per cent reduction in nurses specialising in learning difficulties/disabilities over this timeframe. Ian Dalton was quoted in the summer acknowledging that there are over 40,000 unfilled nursing posts in the NHS (at 11.6 per cent vacancy rate). The currently unknown effect of Brexit is looming with one think tank, the Cavendish Coalition, forecasting possible further 5,000-10,000 nursing vacancies (on top of existing ones) by 2021.

In efforts to make the service safe, trusts are forced into using expensive bank and locum staff – 13,000 doctors and 64,000 nurses were employed in this fashion costing the NHS an incredible £207 million in September 2018. There are massive variations in reported spends with one hospital (Bart's Health NHS Trust) showing a spend of nearly £10 million with others (e.g. King's College Hospital NHS Foundation Trust) spending under £100,000 in the same period.

In conclusion, as the NHS faces ever mounting pressures from demand, the internal pressures created by staffing gaps are of equally high importance not only for care but also finance and any long-term plans must address this so that working in the NHS again becomes a career people will choose.

Dr Nick Scriven FRCP (London)
Consultant Physician and President, Society for Acute Medicine

"At present 45 per cent of advertised consultant posts are unfilled due to a lack of suitable applicants"

Staffing the NHS: Why we need to invest in the community workforce

In a time of rising demand in healthcare it's unsurprising that the perennial issue of winter pressures comes onto the radar. The recent publication of the NHS Long Term Plan tried to tackle many different subjects but included relatively little on demand and no concerted effort to understand it.

One of the areas that it did focus on was keeping people out of hospital. The Long Term Plan offers an ambitious aim: to integrate GP, community and health and social care with increased investment. This idea is not new but it is often seen as the answer to the overloading of the acute sector. One of the reasons it never quite seems to work out is because of the challenge of providing acute care outside of hospital.

The workforce supply issues we currently face in the acute sector pale in the light of the decline of the community workforce, and there is no better example than district nursing. In England district nurses have almost halved in just a few years. They provide a range of services such as palliative care and the management of long-term conditions in the community - the kind of care that, if unmanaged, means the default is hospital. District nursing is some of the most complex work we have ever observed. Not only does it consist of complex case management but the effective network and brokering ability of this group is extensive. They seem to conjure up solutions to problems and have many alternative strategies to the emergency department. They are also a salutary example of the decline of the expert front line decision maker. Community nursing is a good example of this decline. Disinvestment in the specialist district nursing qualification, a division of labour model of task delivery, the rise of "tick box care" which nurses find frustrating, inflexible employment models and an ageing workforce have all contributed to their decline. The Queen's Nursing Institute which researches the community workforce, found that there had been a 10 per cent drop between 2016 and 2017 of those taking the specialist qualification.

In order to meet increasing demand in both acute and community settings, the policy response to workforce is to develop a cheaper, less qualified, more flexible worker. More hands for less money. Various types of assistive personnel, such as associate professionals, are being introduced whilst the experienced, expert, decision-making workforce declines.

A workforce of low cost interchangeable widgets has long been the holy grail of workforce planners. A less qualified workforce is a very risky proposition in healthcare. The panacea of a "widget workforce"-worker who can fill any gap, in an increasingly high-risk, high-expectation, complex safety critical field is an illusion if good outcomes such as admission avoidance are key. Other safety critical industries have tried and then reverted back to the valuing of front-line expert decision makers.

If we want to salve the issue of winter pressures in the acute sector then sustainable and safe alternatives need to be found. Investing in the community workforce could be a significant part of that solution.

Alison Leary
Professor of Healthcare and Workforce Modelling at London South Bank University and The University of South Eastern Norway

"The workforce supply issues we currently face in the acute sector pale in the light of the decline of the community workforce"

Primary Care Networks as a response to the winter healthcare crisis.

General practice sits at the heart of the NHS and is often the first port of call when illness strikes. The service delivers accessible, whole-person care to local communities but in recent years has felt the impact of chronic underfunding, an increasingly complex workload and falling GP numbers.

Little surprise therefore that when winter comes an already stressed system is further stretched leading to the healthcare crises that feature regularly in newspaper headlines.

The decision to prioritise investment in general practice in the NHS long-term plan (LTP) is a welcome first step. However, funding alone will not be sufficient to avert the winter crisis and to address the other deep-seated problems currently affecting healthcare delivery in primary care. The LTP has called for the establishment of Primary Care Networks to strengthen collaboration between practices allowing pooling of staff and resources. Properly funded networks are a key innovation for meeting contemporary service requirements and the extra demands that winter brings.

Tower Hamlets where I work as a GP has a diverse population with some of the worst health inequalities in the UK. Yet, the CCG delivers excellent health outcomes for all, with a top three ranking nationally against IO of the Quality Outcome Framework (QOF) clinical measures. Central to this success story has been the long-standing establishment of eight borough-wide GP networks with more recent federation of all 36 practices in the Tower Hamlets GP Care Group. In 2015 network activity was strengthened when Tower Hamlets became a "vanguard" for the new care-models programme of the NHS Five Year Forward View, aimed at improving health and wellbeing of the local population through partnership between the Care Group, CCG, local authority and local acute and mental health trusts, as well as key partners in the voluntary services.

These collaborations have worked to relieve pressure on services in a variety of ways. For example, confusing arrangements for accessing urgent care, which led to clogging of local A&E departments, have been simplified by the introduction of the new NE London-wide III service. This has potential to provide 24/7 advice for patients with signposting to the appropriate emergency service. Most importantly, a GP hub now operates in each network providing additional "overflow" appointments as well as more choice of times to be seen. A&E can now book those patients better seen by their GP directly into appropriate appointments either with their own surgery or a hub as well as registering un-registered patients with local practices. Use of telephone triage by practices has further improved service delivery by directing patients to appointments with the correct healthcare professional, the emphasis moving from first-come-first-served to access based on clinical need.

The effectiveness of streamlined healthcare through networked practices depends on patients obtaining access to the appropriate healthcare professional. This is not always the GP. Reception teams are being upskilled to triage calls to the appropriate professional, including allied health professionals: nurses, pharmacists, physician associates and others, many employed through networks to ensure services are maximised across all Tower Hamlets practices.

Naureen Bhatti
GP Tower Hamlets, Vice-chair Tower Hamlets, LMC Board member, Tower Hamlets GP Care Group

"Failure to address issues outside the control of the NHS will continue to place significant extra pressure on front-line health services and impact on the success of any innovations"

These innovations have been underpinned by a strong quality improvement programme, EQUIP and multi-professional protected learning time through the community education provider network (CEPN). Technology is being used to bridge the gap between acute, primary and community sectors through the Communicate and Educate initiative which allows healthcare professionals to join the numerous educational events virtually, improving staff morale and ultimately benefitting patient outcomes.

Network collaborations such as those we have pioneered in Tower Hamlets are already having a profound impact on quality of care and are key to our response to the winter healthcare crisis. However, while extra primary care funding from the LTP is welcome, it falls short of the historic average and of what the experts estimate is needed. This will be further exacerbated if social care and public health continue to be underfunded given the background of rising poverty with widening socioeconomic inequality. Failure to address issues outside the control of the NHS will continue to place significant extra pressure on front-line health services and impact on the success of any innovations.

Beyond 'Blue Monday': Why the divide between mental and physical health is artificial and unhelpful

Pressures on NHS hospitals during the winter have become a staple of media concern and political anxiety in recent decades. Fears about the impact of flu epidemics or very cold weather stalk health policymakers, not just in winter but all year round as the NHS and its partners seek to avoid getting overwhelmed.

One area of the NHS that does not experience the same seasonal variations in need or demand is mental health services. While much is made every January of so-called 'Blue Monday', mental health difficulties can affect people at any time of the year and the triggers for emotional and psychological distress tend to be quite different.

But could the NHS, if it was more cognisant of the impact of mental health on the wider health and care system, weather the storm of winter pressures a little more easily?

There is a growing realisation in both mental and physical health services that the separation of body and mind that has been perpetuated for centuries may in fact be both artificial and unhelpful. It is now clear that our mental and physical health are inextricable: that difficulties with one often affect the other, and that people with the most serious and ongoing health needs very often have problems with both.

Having a long-term physical condition, for example, doubles our risk of experiencing depression. And if someone with a long-term condition also has a mental health problem, they are likely to experience more ill health, more complications, more hospital admissions and an earlier death. The cost of (mostly unnoticed, let alone treated) poor mental health among people with long-term conditions is estimated nationally to be around £10 billion: close to £1 in every £10 of NHS spending.

We also know that people living with long-term mental health problems have much poorer physical health than average. A person living with schizophrenia can expect to live for 15-20 years fewer than average, most of which is a result of poor physical health. People living with a severe mental illness have higher rates of almost all long-term physical health problems as well, yet until recently these were barely recognised by the NHS and seldom treated.

In each case, the pernicious links between poor mental health and poor physical health contribute to a situation where health care costs (and pressures) rise while people's quality of life suffers. Taking effective action to address these issues could help to reduce costs, improve lives and give the NHS a little more breathing space. For people with long-term conditions, this could include offering emotional support when it's needed, more actively enquiring about wellbeing and providing structured support for those with the most complex needs. For people with mental health problems, it could include help with diet and physical activity, shared decision-making about medications with known effects on physical health, and tailored help with smoking cessation.

But to make a really big impact, we also need to look for much longer-term solutions. There is growing evidence that our psychological wellbeing early in life has a profound impact on everything that

Andy Bell
Deputy Chief Executive, Centre for Mental Health

"The separation of body and mind that has been perpetuated for centuries may in fact be both artificial and unhelpful"

follows, including both mental and physical health. And poor mental health during childhood is strongly related to economic and social inequalities. So investing in local authorities to take effective action in communities to prevent poor mental health, and developing policies nationally that will reduce risk factors such as poverty, homelessness and discrimination, will in time make a marked impact.

There is growing acknowledgement that for too long health policy has prioritised physical over mental health, health care over social care and treatment over prevention. The arrival of Integrated Care Systems could bring about a sea change in this situation, or it could repeat the same patterns under a different guise. The challenge for the whole system will be to commit to rebalance itself and use resources very differently to bring about better health for the long term for everyone's benefit.

Action is needed now on adult social care

Winter always represents a particularly challenging time of the year for councils arranging social care and support. The Government has recognised this and has attempted to address this with much-needed extra funding for under-pressure local services over the winter period. But these are one-off injections and not a sustainable solution.

However, the pressures faced are not simply confined to the winter period; they are all year round. Adult social care is in crisis and the current system is unsustainable and will buckle under the weight of demand unless the Government acts.

Councils want to ensure that people are able to live the life they want to lead and are able to access the right care in the right place at the right time. With people living longer, increases in costs and decreases in funding, this is becoming more and more difficult.

While one-off funding injections may help curb the severity of immediate pressures, they are only short-term and the problem has become year round.

Councils have proven that they can make the most of new funding, managing to reduce Delayed Transfers of Care by 37 per cent since July 2017, a figure that is all the more impressive when compared with the NHS which has managed to reduce delays by 13.6 per cent.

However, that example also reveals another serious problem within the social care system. It is important that future social care funding avoids top down, target chasing control, as this hinders local health and social care leaders who are best placed to develop their own plans and care and support services.

If we are to really relieve winter – and all year-round – pressures, we need a much greater emphasis on treating the causes of these pressures, not just the symptoms.

The NHS Long Term Plan does attempt to address some of the health problems affecting the social care system with a much-needed focus on prevention, early support and reducing health inequalities as well as promising investment in primary, community and mental health services.

However, it is a plan for the NHS rather than a comprehensive plan for the wider health and care system so, inevitably, it offers only part of the solution to the health, social care and wellbeing challenges facing our communities.

The social care system helps support people's independence, strengthens communities, reduces pressures on the NHS, supports around 1.5 million jobs and contributes as much as £46 billion to the UK economy. It needs to be properly supported.

Councils have protected social care relative to other services. But the service still faces a shortfall of £3.6 billion by 2025. This is what is needed simply to keep on providing existing support at current levels and would not meet the cost of changing the current model of provision, or include the funding needed to tackle under met and unmet need.

It was therefore disappointing that the Government chose not to also launch its long-awaited adult social care green paper and proposals for the sustainable funding of these services and represents a serious missed opportunity.

The Government needs to be bold in the upcoming Spending Review and urgently invest in these essential services, which protect health, prevent sickness and are the surest way to reduce hospital admissions.

The Government must also use its upcoming green paper to make a serious case for national tax rises, including either increases to Income Tax and/or National Insurance to provide long term sustainability for the vital social care services that are central to helping people to live fulfilling, independent lives.

Further delays will only deepen the crisis in adult social care. Action is needed now.

Cllr Ian Hudspeth
Chairman of the Local Government Association's Community Wellbeing Board

"We need a much greater emphasis on treating the causes of these pressures, not just the symptoms"

Combining tactical and strategic healthcare innovation

Innovative technologies, especially digital healthcare solutions, can be presented as a panacea for the NHS. This is an oversimplification that can create a drive towards solutions being defined and delivered with problems fitted only in retrospect.

Key to our ability to innovate away from winter pressures, is improving our capability to articulate, define, and measure driving factors. This knowledge can then be used to prototype, pilot and scale solutions that speak to these root causes.

In the short term, technical change should be used to break the negative cycle where we are so busy dealing with immediate problems that we cannot raise our heads and look beyond the horizon. Careful use of tactical solutions can provide breathing space that lets us address this bigger picture. In Salford's work as a Global Digital Exemplar site we have approached this by focusing on efficacy as well as efficiency. Improving our clinical documentation by applying user centred design to our EPR has made this a more "usable, useful and used" tool. Enabling clinical staff to have a better experience whilst delivering more reliable care and also creating valuable structured data (that supports operational decisions), helps us to capitalise on existing digital investments and infrastructure. The same principles have been applied when leveraging digital communication tools that support specialist services in finding new ways of working that allow them to deliver safe remote management advice. This improves working experiences and supports provision of safer patient care closer to home.

Simple technical changes can support rapid improvements in patient flow by improving communication between teams. Interest in leveraging NHS data sets to predict patient length of stay will only add value if this information can be converted into more timely discharges. In Salford we have piloted a simple task management app to streamline communication between ward flow facilitators and capacity management teams. This has allowed a proactive, responsive approach to addressing discharge barriers. This, in conjunction with clinically sponsored quality improvement work, is bringing discharge times forwards and creating capacity within the system.

The axiom *"Prevention is better than the cure"* should not only apply to physical and mental health. Strategic investments in technology can enable healthcare organisations to work to this principle and deliver 'control center' models. This approach combines technology, analytics and change management to drive improvement. Accurate reporting empowers staff by communicating information throughout an organsiation; predictive modelling supports early decision making, with the combined outcome being improved matching of capacity to demand. Here, we have already seen benefits by matching staffing levels to patient acuity, but this is just the first step towards balancing how the skill mix of our staff is best used to help patients.

Finally, innovations must be rigorously tested and evaluated. To enable this, we have developed the model of a 'digital factory'. Here, any member of our organsiation can explore their service challenges and problems with a team who are expert in digitally enabled change. Potential solutions can be rapidly identified, tested and (if deemed appropriate) integrated to allow testing in a 'dummy' environment. This gives staff ownership of the solution and associated change, and offers protection against the imposition of reactive technical solutions that do not meet long term needs.

Jim Ritchie
Program director Digital Control Center, Consultant Renal Physician and Divisional Chief Clinical Information Officer, Salford Royal Foundation Trust

"Technical change should be used to break the negative cycle where we are so busy dealing with immediate problems that we cannot raise our heads and look beyond the horizon"


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Conclusion
Resolving the Winter Crisis requires integration, innovation and staff

The NHS has enjoyed a rare winter out of the headlines this year. Indeed, compared to the worst ever winter pressures recorded in 2017-18, this year has seen some positive changes.

Thorough preparation and earlier funding injections – combined with a dose of mild weather– has led to some welcome improvements. Compared to last year, for example, there have been fewer A&E closures and ambulance delays.

However, a closer look at the statistics suggests the NHS remains vulnerable to winter pressures. Despite the mildest of winters, average occupancy rates have remained above safe levels and performance against four-hour targets reached a 15-year low in January 2019. Against a long-term trajectory of rising demand from patients with increasingly complex conditions, contributors to this series have all stressed that creating a sustainable NHS requires more than quick fixes and short-term funding boosts.

As highlighted by both Dr Nick Scriven and Alison Leary, efforts to create a sustainable health service must first tackle the challenges facing the NHS' most valuable asset: its staff. This will require not only recruiting more staff but retaining and upskilling existing staff. These challenges are closely related, and nowhere is this more apparent than in the context of district nursing. Since 2009, district nursing numbers have fallen by almost half, with knock-on negative impacts on staff wellbeing and quality of care. If the NHS is to achieve its vision to shift healthcare delivery away from hospitals and into community settings, it must also deliver a complementary workforce strategy that reverses the decline of NHS staff working in the community.

Contributors to this series also raised the issue of integration in various ways; from the need to improve collaboration between GP practices, to the need to think about mental and physical health, as well as health and social care, as two sides of the same coin. However, the goal of delivering joined-up care in the community as a way to relieve pressure on hospitals is not new, yet successive governments have failed to successfully deliver on this ambition. The case of Tower Hamlets discussed by Dr Naureen Bhatti highlighted ways this goal can be achieved on the ground, where the introduction of a London-wide III service and the use of telephone triage has enabled faster access to appropriate services and reduced A&E presentations.

Finally, a sustainable health service is one which embraces the digital era. Jim Ritchie urged the NHS not to introduce technology for technology's sake, which results in "solutions being defined and delivered with problems fitted only in retrospect." Instead, the NHS should adopt a stepped approach to technological innovation, where digital solutions are prototyped, piloted and rigorously evaluated with respect to local needs.

To improve the long-term resilience of the NHS, policymakers must look to address the root causes of winter pressures through improving integration across public services and investing in the workforce and technology. This series has featured many ways this is already taking place at a local and regional level; the challenge is now how to embed relevant innovations across the NHS.

Imogen Farhan
Researcher at Reform

"Creating a sustainable NHS requires more than quick fixes and short-term funding boosts"

Related content

To mark the NHS's 70th birthday, *Reform* produced a video that argues the NHS is at "a defining moment" which will "flip healthcare on its head". The film describes how this will not only result in a new way of providing care but also a new type of patient.