PROVIDING FOR THE FUTURE

BUILDING A HEALTHY NHS AROUND PEOPLE’S NEEDS

A programme for the next Parliament

IN DEPTH
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A PROGRAMME FOR THE NEXT PARLIAMENT

Building a healthy NHS around people’s needs

Our vision is of an NHS providing world-class care in the right place at the right time. Of an NHS responsive to local needs and continuously improving experiences and quality of care. Of an NHS where communities, patients and service users know they have control and choice in decisions about their health. There are strong foundations for this vision.

Over the last ten years, quality of care has improved against a range of measures including patient experience and outcomes. The NHS is internationally renowned for its “world-leading … commitment to health and health care as a human right”, and ranks first among comparable countries for quality, access and efficiency. Its workforce is compassionate, highly-qualified and ambitious. NHS providers are pioneering innovative ways of working and delivering care, and collaborating with commissioners and colleagues in primary and social care.

Confronting major failings in care, such as those at Mid Staffordshire, has had a profound effect, creating an impetus for cultural change across the NHS. Culture does not change overnight, but the people who serve in the NHS aspire every day to deliver their best and help those in need. It is the responsibility of NHS provider boards, working with their local and national partners, to enable them to do this.

The UK rightly values healthcare as an investment in national wellbeing which creates unparalleled social and economic benefits. NHS providers also play a key role in their local economies as major employers, and in local and national business through procurement, capital investment, and research and development. Foundation trusts (FTs) alone contribute £30 billion to the economy. The NHS is a prized national institution and consistently rates as the public service that people are most proud of and most want to protect.

The case for change

Yet fully realising this vision means far more than the NHS simply working harder, being more efficient and continuing as it is. It must transform, and it must do so urgently. The NHS cannot stand still.

England’s population is growing, ageing and living longer. People in deprived areas experience multiple health problems 10 to 15 years earlier than those in more affluent areas. People with serious mental illnesses are at risk of dying 10 to 20 years earlier than the rest of the population – this is comparable to or worse than the reduction in life expectancy caused by heavy smoking. Around 80 per cent of deaths from major diseases are related to lifestyle risk factors such as poor diet, smoking and alcohol misuse. Meanwhile, expectations around the effectiveness, accessibility and experience of care are rising as was recognised in the recently published Five Year Forward View.
The changing social and clinical landscape has significant implications for NHS care. Tackling health inequalities alone would have a considerable positive impact. More people are living with one or more long-term condition and need personalised support across physical, mental health and social care. The NHS must make difficult decisions to prioritise the significant and long-term investment that clinical advances require. Moreover, the NHS cannot focus solely on providing a cure – it must recognise the impact of people’s lifestyles on their health, and help to promote wellness and prevent illness. The social, economic, employment and housing aspects of this challenge mean that preventative care is not something the NHS can do alone: it is a wider societal endeavour.

The challenge of achieving radical and urgent change coincides with an extended period of intense financial pressure. In recent years, NHS funding has remained at a broadly constant level despite steady increases in demand and costs. NHS providers have made extraordinary efforts to find efficiencies of £20 billion between 2010 and 2014 without damaging quality of care. Further substantial increases in productivity can only be achieved with upfront investment in new ways of working, and even then, these would not be sufficient to make up the NHS’s funding shortfall.

NHS providers now collectively project a deficit of at least £500 million by the end of 2014/15. The pressure on the secondary care sector is compounded by rising demand elsewhere in the system, including for primary and social care, which itself has faced real terms funding cuts of 12 per cent. There is growing concern about the impact that ever tightening resources will have on quality of care, as some of the access targets and commitments laid down in the NHS Constitution entered national breach this year for the first time. Having made substantial investment to improve the NHS in the past decade, there is now a risk that it will slip backwards in the coming decades.

There is an immediate shortfall in NHS funding for 2015/16 of £2 billion which, if current trends continue, will grow to £30 billion a year by 2020/21. The demographic pressure alone on the NHS means that, if its current real terms budget is only maintained rather than increased, by 2018/19, age-adjusted health spending on each person would be 9.1 per cent lower than in 2010/11.

Meeting these 21st century needs means reshaping NHS services. Change is not new to the NHS. Throughout its extraordinary history the NHS has evolved and innovated, and it has strong foundations for the future. Yet it is facing an unprecedented combination of the need for radical service change at pace and scale; demand for existing care growing unremittingly; and funding pressures threatening its sustainability and ability to invest.
Challenges NHS providers face in existing care models

**ACUTE SERVICES**
Hospital based provision, including specialised care, remains a crucial element of effective, world class clinical intervention and care. However where there is insufficient capacity in community based provision, including primary and social care, additional demand can be placed on the acute sector inappropriately, including on A&E.

**AMBULANCE SERVICES**
Use of ambulance services to access other health and care services in non-emergency situations can prevent timely responses for those patients most in need. It also under-utilises the skills of paramedic and ambulance crews who could move beyond stabilisation and conveyance to hospital and increase their clinical treatment capabilities.

**COMMUNITY SERVICES**
Community services cover a wide spectrum of care including home visits, treatment for minor injuries and outpatient services. They play a key role in helping people live independently, offering services closer to home and managing demand. Yet they are underfunded and face staff shortages, meaning community capacity is often insufficient.

**MENTAL HEALTH SERVICES**
Despite some progress, parity between mental health and physical health services has not yet been achieved. Only 26% per cent adults with mental health issues receive care, spending on mental health is growing more slowly than on acute services and lack of capacity means service users might leave their local area for specialised provision.
New and locally driven models of care

NHS providers – those FTs and trusts providing acute, ambulance, community and mental health services – can be the engines of transformation. They are at the heart of their local communities unlike any other part of the service: not only do they provide highly visible frontline of care, but through the FT model, they maintain a unique connection to their communities.

Being an FT means the freedom to decide how to meet local needs and independence from central government control, with this autonomy balanced increased accountability to the community, as represented by governors and members. In providing local services, FTs continue to work to national standards and are also accountable to commissioners, the regulators and parliament. FTs are public benefit corporations, and provide a model of accountable autonomy that could be replicated across the NHS. They embody the lesson that the best organisations have empowered boards which understand their locality and engage their staff and community in continual improvement.

NHS providers need to be able to invest time and resources in new models of integrated care which meet 21st century needs. This will require new ways of working across health and social care, with providers and commissioners coming together to share risks and expertise. It will mean empowering patients in their healthcare choices, investing in prevention and wellness, and where appropriate moving care into the community and closer to home. It will mean reinvigorating the balanced autonomy and accountability of the FTs, rallying behind direct community engagement over health and social care priorities and investment of significant public monies.

To move to new models of care, NHS providers, local health and social care systems and national bodies need to work together to:

● invest to transform the NHS into a sustainable 21st century service
● support an empowered and affordable NHS workforce with the right skills and in the right numbers
● ensure improvement is owned and led by providers, underpinned by regulatory assurance that the system is working in the best interests of patients and service users
● enable autonomous and accountable NHS providers to drive new models of care, in partnership with their local health and social care system.
The population is growing, ageing, and leading lifestyles which affect their health.

- From 2003 to 2013 the population grew by 7.3% with the number of people aged 80+ increasing by 17.4%.
- One in four experience poor mental health in their lifetime.
- People with multiple long-term conditions expected to rise from 1.9 million in 2008 to 2.9 million in 2018.
- The gap in healthy life expectancy between the richest and poorest areas is 17 years.


With growing demand on services but minimal additional resource, NHS providers are feeling the pressure.

- In the first quarter of 2014/15, emergency admissions increased by 7% and ambulance journeys by 6%.
- NHS providers are collectively expecting to be over £500 million in deficit by the end of 2014/15.
- Staff shortages led to a 60% increase in spending on locum A&E doctors 2009 to 2013.
- Over-regulation risks diverting staff time away from patient care and local accountabilities.
- FT status gives providers the independence to respond to local health needs but only a handful of NHS trusts have been authorised as FTs since January 2013.


WHAT ARE THE SOLUTIONS?
To move to new models of care, local health and social care systems and national bodies need to work together to:

- Invest in a sustainable 21st century service.
- Support an affordable and empowered workforce with the right skills in the right numbers.
- Enable autonomous and accountable NHS providers to drive new models of care in partnership with their local health and social care system.
PROVIDING FOR THE FUTURE

People’s health and care needs have changed, so the NHS needs to change. The NHS has a wealth of compassion, talent and ambition. But that is not enough for it to be able to realise its full potential. NHS providers need a new way of working with those it cares for and with the national bodies which oversee the service.

Delivering high-quality care in the right place at the right time for each individual means NHS providers must be freed up to use their capabilities to their full extent. It means significant additional investment, as well as more staff with the right skills empowered to use their expertise. It means a renewed partnership with local communities, with patients and taxpayers having a sense of their rights and responsibilities for a healthy NHS. It means the centre helping create confidence and the conditions for local health and social care systems to thrive.

This is a cross-party programme for the next Parliament to enable NHS providers to play their full part in delivering a healthy, 21st century NHS.

PRIORITIES FOR NHS FUNDING

**Invest to transform the NHS into a sustainable 21st century service**

1. Allocate sufficient funding to protect the core values of the NHS.
2. Mobilise a robust, public discussion on NHS funding and priorities.
3. Pay NHS providers for the full cost of the care they deliver.
4. Make resources go further through multiyear funding and planning frameworks.
5. Enable the NHS to invest in efficiency, improvement and innovation.

PRIORITIES FOR THE NHS WORKFORCE

**Support an empowered and affordable NHS workforce with the right skills and in the right numbers**

1. Lead cultural change by example and support staff engagement.
2. Recognise that the NHS relies on dynamic, capable and diverse local leadership.
3. Make pay, terms and conditions fit for purpose.
4. Base staffing decisions on local clinical judgement not blunt national targets.
5. Let NHS providers drive workforce planning.

PRIORITIES FOR NHS REGULATION

**Ensure improvement is owned and led by providers, underpinned by regulatory assurance that the system is working in the best interests of patients and service users**

1. Recognise that NHS providers must be responsible for their own improvement.
2. Insist on independent, proportionate and risk-based regulation.
3. Develop regulatory assurance that takes local context into account.
4. Facilitate tailor-made solutions in distressed local health systems.
5. Hold the regulators to account for providing value for money.

PRIORITIES FOR THE NHS PROVIDER SECTOR

**Enable autonomous and accountable NHS providers to drive new models of care, in partnership with their local health and care system**

1. Ensure the strategic leadership role of NHS providers within local health and social care systems.
2. Demand higher standards of local and national commissioners.
3. Support the autonomy of NHS providers to focus on local needs.
4. Embed high-performing cultures through meaningful accountability relationships.
5. Realise the full potential of the FT model as an agent for achieving local health priorities.
PRIORITIES FOR NHS FUNDING

Investment in a sustainable 21st century service

Patients should experience seamless working between primary and secondary care and social care, with high-quality provision and continual innovation in clinically and financially sustainable settings. Achieving this vision relies on realistic levels of investment being made on an ongoing basis, with funding flowing efficiently through the system.

NHS finances now

The NHS cares for over one million patients every 36 hours. To deliver this care in 2013/14, NHS providers had a collective budget of approximately £75 billion (including specialised care) – a sum easily comparable to the turnover of any one of the very largest FTSE 100 companies – with the total NHS budget accounting for 6.4 per cent of GDP in 2013/14. For five years NHS providers have consistently met increasing demand despite rising costs and a flat budget. This is an extraordinary achievement, especially as NHS spending had in previous years grown by an average of 4 per cent, but it is not sustainable.

There are already clear signs that the NHS is working under intensifying financial pressure. In 2014/15, NHS providers project a deficit of at least £500 million and the pressure on resources is now impacting on a number of quality indicators, including waiting times and staff morale. This difference between patient needs and available funding is currently reconciled through the payment system, with sustainability increasingly subverted to affordability.

While some savings could potentially still be realised – for example, from shared back office functions, more effective procurement and more efficient partnerships – these are unlikely to be at a level which releases funding for transformational change. Moreover, given that new models of care are not tried and tested, the NHS cannot depend on them to deliver savings. The funding shortfall is exacerbated by the national planning and funding cycles not aligning, creating structural inefficiencies and uncertainties which hinder long-term investment.

The longer that the NHS is under-funded, the harder it becomes to sustain the core values set out in the NHS Constitution – a system based on clinical need and not ability to pay. The payment system needs to fairly reimburse NHS providers for the care that they provide; efficiency requirements need to be set at realistic levels; NHS providers need the freedom to plan ahead; and, as a system, the NHS needs to invest in new models of care.
The scale of transformational need and investment must not be underestimated – it is far greater than the sum of the headline-grabbing NHS funding questions of efficiency, procurement, pay and private finance initiatives. Addressing each of these issues would help, but it is not realistic to expect these will close the funding gap or drive a revolution in care. There must be an honest acceptance of both the need for significantly more money from government and the need for NHS providers to do better with it.

To provide for the future we need to invest to transform the NHS into a sustainable 21st century service

1. Allocate sufficient funding to protect the core values of the NHS

The NHS must meet the needs of everyone; be free at the point of delivery; and be based on clinical need, not ability to pay. These core values of the NHS, set out in the NHS Constitution, are inviolable – once eroded, there is no way back. The longer that the NHS is under-funded, the harder and more expensive it will become to sustain, as investment in future services will be perpetually diverted to back-filling existing needs.

The UK spends appreciably less on health and social care than comparable countries. The UK spends 9.3 per cent of its GDP (and US$3,300 per person) on public and private healthcare, in contrast to comparable countries such as Germany, Denmark, the Netherlands and Canada where spending is around 11 per cent (and where health spend is over US$4,500 per person). The UK is also at the lower end of the spectrum on social care spending.

THE GOVERNMENT NEEDS TO:

- Maintain the NHS ringfence to protect the minimum funding settlement, and ringfence social care money to recognise the interaction between health and social care.
- Increase public spending on health and social care from its first spending round, in line with the recommendation of the Barker Commission, to between 11 per cent and 12 per cent of GDP by 2025.

EACH POLITICAL PARTY NEEDS TO:

- Make an explicit commitment to upholding the core values of the NHS and rejecting approaches which undermine these, such as new or significant co-payments or charges for NHS care.

2. Mobilise a robust, public discussion on NHS funding and priorities

Current debates about NHS funding and performance are clouded by inaccuracies and political point scoring. In particular, there is a damaging tendency to obscure the links between finance and quality, and between changing patient needs and new service patterns. Yet the scale of challenge facing the NHS is clear: at best, as the NHS moves to new models of care and makes 2-3 per cent efficiencies annually, NHS England expects the annual shortfall to grow to £8 billion by 2020.
Political choices about funding need to be made, and new models of care will lead to highly visible changes in every community. The public needs to be engaged in and convinced of the need for change before plans are formulated.

In 2001 and 2002, the Wanless reports established the links between public expectations of the NHS, the impact of underfunding and the scale of investment required. A similar mechanism is needed now to facilitate an honest public debate about the trade-offs between NHS funding, provision, and performance.

THE GOVERNMENT NEEDS TO:

● Create a mechanism for regular assessment of health and social care spending needs and the amount of tax this requires. This would help to generate a better, more transparent public debate between politicians, the health sector, and the public on these issues. One way of delivering this would be to create an Office for Budget Responsibility (OBR) for Health or to repeat the Wanless exercises as originally intended.

3. Pay NHS providers for the full cost of the care they deliver

The provider payment system is increasingly and inappropriately used as a means to deliver on specific policy intentions or as a blunt tool to make the NHS superficially affordable through enforced efficiencies and transferring unsustainable levels of risk to providers. Payments therefore become disassociated from costs and NHS providers are prevented from shaping services around need, while the incentive for commissioners to improve is diminished. The payment system needs to pay providers a fair price for the services they are commissioned to deliver in order to sustain, and invest in developing, the quality of care we all expect. The system must also appropriately balance need across acute, ambulance, community, and mental health services.

NHS PROVIDERS NEED TO:

● Ensure they have maximised the efficiencies available to them, including procurement, estates, and productivity, recognising this requires centrally supported investment.

MONITOR AND NHS ENGLAND NEED TO:

● Work with NHS providers to establish the payment system as founded on the following core principles:
  ● recovering the cost of delivering care and securing a reasonable margin to maintain and improve services
  ● payments are allocated primarily through a rules-based system – with payments structured around factors such as patient volume, capacity, and/or capitation as appropriate – and geared towards long-term planning
  ● non-recurrent funding is brought into normal tariff arrangements to improve NHS providers’ ability to plan
any efficiency requirement must be realistic – evidence consistently identifies a maximum annual efficiency gain of 2 per cent
penalties for quality shortfalls are separate from the payment system, as levying financial fines cannot improve patient care.

THE GOVERNMENT NEEDS TO:

- Fully fund and phase in any in-year policy requirements (that is, new service developments beyond those in the Mandate), as to do otherwise demands resources are reallocated at short notice, and undermines planning and investment.

4. Make resources go further through multiyear funding and planning frameworks

NHS funding is not going as far as it could. Investing for the greatest benefit to patients and service users means NHS providers need confidence in the future, but this is undermined by misaligned planning and funding frameworks. The NHS budget is confirmed annually, along with the government’s ambitions for the service, but NHS providers (and separately commissioners) are required to submit two- and five-year plans, while new national priorities can be imposed mid-year without adequate funding or integration with existing priorities. This can divert money from patient care, increasing transactional costs with plans and contracts renegotiated every year, resulting in reduced value for money. Commissioners and NHS providers alike need to be able to invest in long-term innovation, service improvements and strategic developments without bearing excessive risk.

NHS PROVIDERS NEED TO:

- Take a leadership role in discussions with commissioners and local health and social care system partners to discuss transforming care in the patient interest, and sharing risk.

THE GOVERNMENT NEEDS TO:

- Work with the arm’s length bodies (ALBs) to align NHS planning and funding frameworks so that they become synergistic rather than antagonistic.
- Establish a multiyear settlement in line with the parliamentary term. This would enable funding to be used as effectively as possible, being set against risk managed business plans and translated into the detailed operation of the NHS.
Enable the NHS to invest in efficiency, improvement and innovation

The NHS relies on an extensive infrastructure and world-leading clinical expertise to deliver high quality patient care. Maintaining these, as well as maintaining the NHS’s relevance and capacity for innovation, requires continual investment and long-term planning. Cost inflation and the slowdown in funding have left NHS providers less able to invest in either existing services or transformational change. NHS providers need a realistic, long-term funding settlement and investment mechanisms in order to be able to:

- invest to maintain: operating existing services on a day-to-day basis and keeping quality stable by avoiding infrastructure and resources being run down
- invest to improve: finding better ways of delivering services (distinct from finding ways to increase service efficiency), including through clinical research and development, and through estate redevelopment
- invest to save: making efficiency savings and enabling NHS providers to become more productive, for example, through trusts sharing back office functions, introducing technology or merging organisational structures
- invest to transform: radical change to services, such as moving to new models of care.

NHS PROVIDERS NEED TO:

- Ensure they have maximised the efficiencies available to them, including with regard to procurement, estates and productivity.

THE GOVERNMENT NEEDS TO:

- Enable NHS providers to:
  - invest to maintain: by paying NHS providers for the full cost of the care they deliver
  - invest to save: by creating a dedicated, self-replenishing, central fund to enable the NHS to realise further operational efficiency savings, agreeing interest-free and fully repayable loans against business plans
  - invest to improve: by creating a substantial transformation fund, so that the NHS can achieve the radical changes to service delivery it needs make in order to safeguard its fitness for purpose and sustainability.
THE NHS ARM’S LENGTH BODIES (ALBs*) NEED TO:

● Ensure that payments to NHS providers do not subvert sustainability to affordability and, at a minimum, encompass both operational cost recovery and strategic renewal.

● Be satisfied that prices are reasonable and, if there is a difference between what is reasonable and what is affordable, source sufficient funding from the government as well as working to improve commissioning and demand management.

● Support NHS providers who plan long-term efficiency profiles, rather than putting a premium on significant savings being delivered within each year.

● Recognise that innovation carries the risk of failure and that this can only be managed, it cannot be entirely avoided.

● Support transformation by being ready to adapt their approaches to, for example, new investment profiles or models of care.

* NHS arm’s length bodies in this document indicates a group of arm’s length bodies: NHS England, Monitor, the Care Quality Commission (CQC) and the NHS Trust Development Authority (TDA).
PRIORITIES FOR THE NHS WORKFORCE

An empowered and affordable workforce with the right skills in the right numbers

Over a million people in England work for the NHS, caring for its patients, making the service run smoothly and looking for ways to deliver better outcomes every day. They face considerable pressure, working on the frontline to help complex mental and physical needs and working behind the scenes to ensure that safe care is affordable and deliverable. As care needs evolve, how and where patients are cared for – and the roles and skills of those delivering care – must also change. The future of a high quality NHS depends on NHS providers being able to deploy a suitably skilled, motivated workforce in the right numbers, to the right places, at the right times.

The NHS workforce now

As care moves into new settings, the NHS workforce will need new skills and flexibilities. It will also need an in-built capacity for continued evolution to ensure it can always support patient needs. This applies at every level of an organisation: NHS provider leaders have a highly responsible role and operate in a pressured, complex and shifting landscape. Their ability to engender confident, well-run organisations at a time of radical change will be crucial to the success of future care delivery.

Significant and imminent reforms to the workforce are needed to enable this degree of transition. Yet the provider voice in designing and determining the roles of the future has been undermined. The autonomy of Local Education and Training Boards (LETBs), through which NHS providers should be able to set out the clinical skills and posts they will need, has been diminished in favour of the increasingly centralised direction of Health Education England (HEE). The weight of importance placed on clinical judgement in staffing decisions is further reduced by an excessive focus on national nurse to patient ratios, which rob NHS providers of their judgement to match appropriate staffing levels and skill mixes to patient need.

Moreover, there are widespread recruitment and retention difficulties with today’s care models, which will lead to difficulties for tomorrow. For example, although the number of A&E consultants has increased over the last five years, this has not been sufficient to cope with current demand, let alone the upcoming requirements of delivering increased cover on a late hours and seven-day service basis. At the current rate of training, supply of A&E consultants will not meet demand before 2020.28 Already, NHS providers are looking abroad to fill nursing vacancies, but still an imminent and chronic shortfall is expected – the most likely scenario is expected to see a 47,500 shortage of registered nurses by 2016.29
As well as leading to longer waiting times and a poorer patient experience, staff shortages significantly increase costs and diminish investment capabilities. On average, an emergency department spends £600,000 a year on locums, equating to around £120 million a year across England. The problem is not confined to A&E though: across the service there are signs of deteriorating morale, and in a 2013 survey, over 75 per cent of NHS providers reported recruitment and retention problems across both clinical and non-clinical staff.

Furthermore, we need to radically overhaul NHS pay, terms and conditions. The pay bill is becoming unaffordable, while the current terms and conditions do not adequately match reward with performance, or enable smooth transitions between health and social care. With pay constituting between 60 and 85 per cent of an NHS provider’s expenditure, a sustainable balance must be found, where the national staff costs of delivering new models of care such as seven day services are adequately resourced and quality of patient care can be maintained. This must be resolved: if the workforce becomes unsustainable, livelihoods and lives will be lost.

The NHS is a service wholly dependent on the skills and dedication of its staff. While the government, NHS ALBs, unions, professional colleges and regulators will – rightly – always be a presence in employment relations, NHS providers need to reclaim their relationship with their workforce. It is only then that clear focus will be brought to improving employee engagement and ensuring positive working cultures; finding a reasonable balance in pay, terms and conditions; and empowering each individual in their professional judgement and development. It may be that radical solutions are necessary to achieve this, but at the heart of any change, there needs to be a mutual recognition that each is working towards sustainable, high quality care.

To provide for the future we need to support an empowered and affordable NHS workforce with the right skills and in the right numbers

1. Lead cultural change by example and support staff engagement

Patient experience is significantly influenced by frontline staff’s own experiences in the workplace. Where an organisation inspires and enables its workforce, staff are more likely to go the extra mile, feel confident to raise and resolve issues of concern and seek opportunities for continuous improvement. Such staff engagement cannot be nationally mandated – it needs the active involvement of employees at every level, creating shared responsibility for learning and improvement. Legislation cannot endow an organisation with a working culture, it cannot make people welcome difficult truths, it cannot create a self-reinforcing instinct for dedication, honesty and collegiate trust. Culture change and improvement is an ongoing process, and NHS providers, staff, patients and service users alike need to engage in this to maintain momentum.
THE BOARDS OF NHS PROVIDERS NEED TO:

- Listen to staff and patients, share organisational learning, and create positive working cultures by encouraging, for example:
  - empowered staff able to use their expertise
  - information sharing and open communication
  - constructive and timely responses to the concerns staff, patients and service users raise
  - a coaching and enabling role for middle management
  - collaborative problem solving rather than blame cultures.
- Reinforce local community involvement in developing an open and collaborative NHS working culture by encouraging member engagement, a greater presence for volunteers, and support for carers.

THE GOVERNMENT AND THE NHS ALBS NEED TO:

- Resist the fallacy that engagement can be nationally mandated.
- Lead by example as pressures and attitudes bear down through a system, so that the centre embodies the culture it would want to see from board to ward, listening to the service and valuing honesty and candour.
- Recognise organisational autonomy as being key to empowering NHS providers and ensuring the sector takes ownership for improvement.
- Foster locally led improvements and solutions to care delivery.
- Consider the impact of national targets and priorities on provider engagement, to ensure clinical judgement is not overridden by excessive upward reporting.

2. Recognise that the NHS relies on dynamic, capable and diverse local leadership

The NHS workforce – its leadership and managers in particular – are too often denigrated. The correlation between high performing healthcare organisations and the longevity of their leadership have been repeatedly identified, as has the importance of managed transitions to preserve achievements. Yet the NHS presents one of the most difficult leadership challenges, comprising a highly complex and safety critical operation under intense scrutiny. The average length of tenure for an NHS provider chief executive is 700 days. NHS leadership is a high pressure role, and fulfilling it cannot depend on a few extraordinary individuals. The NHS needs to do more to attract talented individuals to board positions, ensure a diverse and representative workforce and to create a pool of current and potential leaders at every level who are appropriately supported by the entire NHS system. Effective boards – and therefore organisations – are comprised of able people empowered to perform.
THE NHS PROVIDER SECTOR NEEDS TO:

- Invest in developing a diverse and capable leadership. Potential and new leaders – at every level and in every service – need to be supported in their roles, with ongoing professional development for established leaders to share good practice.

- Reinforce good practice, recognising that the key to board effectiveness – and so to provider effectiveness – is ‘not rules and regulations, it’s the way people work together.’

THE GOVERNMENT AND THE NHS ALBS NEED TO:

- Facilitate the stability of NHS leadership to ensure able people have time to perform and achieve results. A succession of leaders set up to fail will lead to considerable harm to the organisation, its staff and its patients.

- Give leaders the space and support they need to perform and create the conditions for success. Where new requirements are made of them, this should follow an assessment of the reasonable expectation of an organisation to implement them given existing priorities. The leadership environment needs to be simplified so that leaders can exert autonomy, be properly governed and then be judged on the outcomes, rather than a distracting focus on inputs.

3. Make pay, terms and conditions fit for purpose

The current pay, terms and conditions for the NHS workforce were designed for a different time and a different health service. Episodic clinical care is giving way to round the clock integrated health and social care. More staff, with a more complex mix of skills, are needed more of the time. The current pay, terms and conditions are standing in the way of these new models of care. The pay bill can no longer keep up with resourcing requirements – let alone the extended demands of integrated care models and seven day services – while terms and conditions are also inflexible and do not fairly reflect performance. With staff pay accounting for between 60 and 85 per cent of a provider’s expenditure, it needs to be allocated as efficiently and effectively as possible.

NHS PROVIDERS NEED TO:

- Take the lead in optimising pay, terms and conditions by engaging staff in the need to define local and sustainable solutions. Reforms are difficult to achieve through nationally negotiated agreements, especially in the short term, where these are definitely required. Unless employers and employees work together, this situation is likely to worsen as financial pressures on the service continue.

THE GOVERNMENT NEEDS TO:

- Give national support through:
  - fundamental reviews of doctors’ contracts and of the basis of Agenda for Change, to develop a new model to reflect today’s workforce needs
  - support in achieving value for money from the pay bill through, for example, creating a more facilitative environment for NHS providers to adapt national pay frameworks to meet local needs, as well as ensuring clinical excellence awards and incremental programmes reflect individuals’ activity and performance
national discussions and strategic change management with unions on the future workforce and realistic expectations and needs given external pressures

- transferrable and/or harmonised terms and conditions between health and social care to reflect that as services integrate, the workforce will increasingly be viewed as a pooled resource.

- Give local support through:

  - investment in management capacity and capability to redesign services while keeping afloat operationally, to align job planning with activity, and to manage performance
  
  - greater promotion of the need motivate and empower staff in order to improve performance, and in turn improve recruitment and retention issues
  
  - supporting good practice and highlighting where improvements have been made, particularly in trusts undergoing significant organisational change which will be concurrently managing a wide range of complex and competing issues.

4. Base staffing decisions on local clinical judgement not blunt national target

Sufficient staffing is a driver of care quality, but prescriptive staffing ratios are not a panacea. Setting staffing numbers in isolation of clinical need can dilute the skills base in both the short term – as less experienced staff will cost less – and in the long term – as boom and bust recruitment bubbles are created, with senior staff needed but unaffordable. Instead, the key is in the trust assuring itself that the right staff – motivated and empowered, with the right mix of skills and experience – are in place to deliver the required care.

**NHS PROVIDERS NEED TO:**

- Establish clinically-led staffing mixes, with close monitoring of outcomes and rapid adjustment as necessary.
  
- Emphasise safety from ward to board, with board oversight of staffing decisions alongside longer-term assessment of trends and of where improvements can be made.

**THE GOVERNMENT AND NHS ALBS NEED TO:**

- End the distracting obsession with absolute staffing levels as being able, on the one hand, to indicate poor care and, on the other, underwrite good outcomes.
  
- Be supportive of clinical judgement and focus on assurance that good governance mechanisms are working to ensure good patient outcomes.
5. Let NHS providers drive workforce planning

The clinicians and managers developing models of care on the ground have the best insight into current and future workforce needs. With NHS providers already reporting recruitment and retention problems, and as the integration of health and social care progresses, designing the new roles and skills required cannot be satisfactorily achieved centrally. An overemphasis on national level workforce planning is a false economy, with serious clinical and financial consequences. For example, in recent years a mismatch between the supply of and demand for staff has contributed to increased use of locums and agency staff – this can vastly increase the cost of resourcing a given post and is a significant contributor to provider deficits and potentially to poorer patient experiences. NHS providers must have a strong voice in workforce planning and commissioning of education and training, with central support for creating a flexible workforce and overcoming structural barriers to recruitment.

HEALTH EDUCATION ENGLAND NEEDS TO:

- Preserve the autonomy of LETBs to lead workforce planning locally, with providers making a leading contribution so the needs of local patients can be effectively met.
- Make it easier to retrain and move between specialisms, for example, moving from surgery or a generalist physician role, or between emergency care and general practice.
- Support development of generalist roles to respond to the increasing proportion of patients with multiple needs, such as older people and those with co-morbidities.

THE GOVERNMENT NEEDS TO:

- Help ensure sustainable staffing and effective deployment by, for example, echoing the recruitment and retention initiatives of the education sector. There, high quality graduates have been attracted to shortage subjects such as science and maths through grants, and to the profession itself through Teach First. Similar approaches could be developed in the NHS with, for example:
  - trainees being encouraged to spend their first one or two years post-qualification in emergency care
  - education grants for those willing to go to NHS providers with hard-to-fill vacancies
  - a streamlined process for nurses to return to the profession after a career break.
Patient safety and public confidence in the NHS are crucial. For this to be possible, the regulatory regime must be independent, transparent and risk-based. The necessary counterpart is a provider sector where each organisation’s board takes ownership of its own development and supporting the sector as a whole to improve. It is only through provider-led improvement that we can be sure of a sustainable, well-led NHS capable of continual evolution to meet patient needs.

NHS regulation now

Proportionate, risk-based regulation is fundamental to ensuring public confidence in the NHS and to assuring standards of care. However, in other high-risk industries, such as aviation and nuclear power, the focus on assuring safety critical systems and the tension between regulatory intervention and organisational autonomy has encouraged each industry to lead its own improvement. The same is not yet true of the NHS, where regulation is becoming increasingly prescriptive and interventionist without a clear patient benefit. At the same time, the improvement model in the NHS is very top-down and centrally driven, as opposed to providing central support, enablement and facilitation for sector led improvement.

The Health and Social Care Act 2012 established Monitor as the provider sector regulator (responsible for enabling integrated care and safeguarding choice and competition) and economic regulator (jointly setting prices for NHS funded care with NHS England). These powers were in addition to Monitor’s existing role to authorise and regulate FTs. This combination created a set of potential conflicts of interest within Monitor for instance the need to balance provider regulation with wider sector responsibilities, and the need to implement competition policy while enabling integration.

The standing of the Care Quality Commission (CQC) has also changed. A series of care scandals brought CQC’s approach under considerable scrutiny. Now under new leadership, it has developed specialist inspection teams with a risk-based surveillance framework guiding when, where and what to inspect. Although inspections have improved, the consistency and objectivity of CQC judgements, and the size and calibre of inspection teams, has not yet been established.

Increased regulatory risk aversion has also hindered embedding NHS provider autonomy and accountability. Most recently, a deadline of April 2014 was set for an all-FT provider sector, with the NHS Trust Development Authority (TDA) responsible for supporting the transition of NHS trusts towards FT status. Yet around a third of NHS providers remain in the authorisation pipeline.
Overall, the rate, cost and burden of regulatory intervention and reporting are growing at pace, with NHS providers vulnerable to multiple levels of uncoordinated and overlapping scrutiny. There is also an increasing tendency to try to use legislation and regulation to drive cultural change. While well-intentioned, these are blunt tools and the working ethos of an organisation can only be led on the ground by NHS provider boards. Over-regulation risks undermining NHS provider autonomy and accountability, and can act as a resource-intensive distraction from providing high-quality care.

The system cannot rely on regulatory compliance and performance management as a route to clinical and financial sustainability. For regulation to create confidence in future care, its focus must be on assuring the NHS’s quality and governance mechanisms, and on minimising the burden and distraction created by regulation, while provider boards lead organisational improvement.

To provide for the future we need to ensure improvement is owned and led by providers, underpinned by regulatory assurance that the system is working in the best interests of patients and service users

1. Recognise that NHS providers must be responsible for their own improvement

Regulation provides public assurance that services meet minimum standards and highlights areas for development. Regulators can sanction and check whether required improvements have been made, but they cannot directly or sustainably improve a provider’s performance. Regulation cannot engender innovation, and intertwining regulation with performance management creates stasis rather than the foundations for continual improvement. As the CQC has acknowledged, it ‘is not an improvement agency, but is an agent of improvement’. NHS provider boards need to learn from local government, and the focus on safety critical systems and processes present in high-risk industries, and lead their own improvement, in order to enable a better balance between organisational autonomy and regulatory assurance.

NHS PROVIDERS NEED TO:

- Drive improvement at every level of an organisation, with the board wholly responsible for achieving this.
- Share good practice, working openly and credibly to create confidence throughout the system.
- Establish a framework for improvement including, for example:
  - formal and informal peer-to-peer working, with NHS providers better able to create mentoring relationships and seek peer review
  - facilitation of local networks, including provider-led centres of excellence throughout England, in order to share expertise in clinical, financial, managerial and leadership roles
  - collaborating with partners in their local health and social care systems to develop the frameworks and standards that will build in continuous improvement to benefit patients and service users
continual engagement with commissioners and others in local health and social care systems to discuss standards and requirements.

THE GOVERNMENT AND THE NHS ALBS NEED TO:

- Step back from performance management, recognising that this cannot embed good practice or behavioural change, and may also stymy innovation.
- Promote a regulatory system focused on assurance that boards are leading their organisations effectively, and so ensure the integrity of provider autonomy and accountability.

2. Insist on independent, proportionate and risk-based regulation

The centrality of the NHS to everyday life and the political narrative drive risk aversion and regulatory overreach. Consequently, the timing of regulatory requirements may be tied primarily to political imperatives, or demands may increase in intensity to demonstrate a firm response. Yet this does not take account of the causes of problems, and as regulation is inevitably retrospective, it cannot prevent poor care or impose good care. The greater the expectation of this being the case, the more the conditions for failure are created, where provider resources are diverted towards regulatory compliance and away from patient care. Regulation needs to be honest about what it can achieve and where attention is most effective. To date, it has failed to do this and undermined the credibility of both NHS providers and the regulatory regime.

THE NHS, ITS ALBS, THE GOVERNMENT AND PARLIAMENT, NEED TO:

- Insist on adherence to the letter and spirit of the principles of good regulation, with independent, proportionate and risk-based regulation as key to upholding the patient interest. This means regulation should:
  - set appropriate standards and provide a credible source of evidence for whether these have been met
  - work transparently, objectively and consistently, acting as one means among many of helping to build public confidence in the service
  - have the confidence of NHS providers in the effectiveness and objectivity of the process and framework
  - be streamlined, balancing the needs of regulation against the burden of the process
  - result in measurable outcomes-based results that are cost effective and provide value for money for NHS providers and the wider public
  - not be used as a means to performance manage
  - not stifle or prevent innovation and the development of new service patterns
  - recognise that NHS providers vary both within and between sectors, and so be sector-appropriate in its methods, as well as ensuring overall parity of conduct.
MONITOR, THE CQC AND THE TDA NEED TO:

- Align behind a single, clear objective of NHS assurance.
- Assert their independence from political interference and ensure they regulate as best supports the long-term patient interest.
- Ensure they do not dilute provider autonomy and accountability so that they themselves can fulfil their duties to set, require and assure clear minimum standards.

3. Develop regulatory assurance that takes local context into account

There is a disproportionate focus on individual NHS provider performance as a means to regulate patient care. This means, at times, NHS providers are held accountable for problems beyond their control in their local health and social care system, while other participants are not encouraged to come together to solve system-wide issues. This provider-centric approach has also meant that regulators do not take full account of issues within a local health system which may be outside of an NHS provider’s direct control. In pricing, all too often sustainability has been subverted to affordability – financial flows and incentives are misaligned, with NHS providers in deficit despite commissioners holding surpluses.

Regulators need to recognise where change in a local health and social care system is required, including at commissioner level, to serve the interests of patients and service users. This needs to be facilitated by clearer frameworks governing change – uncertainty over competition rules, for example, can hinder NHS providers’ investment in service innovation and impede collaboration to develop new models of care, including mergers and acquisitions.

MONITOR NEEDS TO:

- Prioritise its role as a sector regulator, including taking steps to:
  - help align incentives across local health and social care systems and hold all participants in local health and social care systems – including local commissioners and primary care – to account to ensure they are well governed and working in the patient interest
  - facilitate new patterns of service delivery, including working with local health and social care systems, politicians and the public to communicate the reasons for change, the expected benefits and the necessary investment
  - set sustainable prices. At present, Monitor and NHS England seek to reconcile the cost at which NHS providers can deliver care with the price commissioners can afford to pay. Too often, they try to resolve the difference through excessively high efficiency factors. This undermines NHS providers’ financial sustainability, for which Monitor then negatively judges them
  - continue to develop competition rules which are clear and fit for the healthcare market, which recognise it is one possible tool for improving patient care, and which need to cohere with other tools. There should only be an imperative for competition where this will enhance service provision; it should not be expected or enforced by default
establish suitable checks and balances on its involvement in facilitating the smooth functioning of the sector to ensure it retains provider confidence and avoids regulatory powers being used to implicitly or explicitly coerce local parties into accepting Monitor’s preferred approach.

THE GOVERNMENT NEEDS TO:

- Resolve the conflict of interest within Monitor presented by its regulation of both foundation trusts and the sector, potentially by overseeing a separation of powers within Monitor.

4. Facilitate tailor-made solutions in distressed local health and social care systems

At present, the only way to relieve a distressed local health and social care system or provider is through the extreme mechanism of the provider failure regime. The changes to service design which are then made tend to be externally imposed rather than developed through local consensus. This gives the new configuration poor levels of local acceptability, while the reputation of the provider – if it continues to operate – is damaged and its ability to attract and retain talented people is diminished. This is a time consuming and wasteful process. Crucially, it does not guard against further later failure because it does not address the causes. NHS providers and their local health and social care systems are under increasing clinical, financial and operational pressure without a contingent regime to ensure sustainability issues are addressed early, appropriately and quickly. The regulatory system must support a sustainability regime built around tailor-made solutions.

MONITOR AND THE TDA NEED TO:

- Engage with NHS providers and local health and social care systems to understand the underlying causes of issues and so help to create the conditions for them to thrive and avoid failure. For example:
  - help to address structural financial issues within NHS providers which may benefit from PFI debt being moved off the balance sheet or from longer term loan conditions
  - avoid NHS providers being pushed into failure because of lack of funding for service transformation. This requires support for health systems and NHS providers in obtaining upfront funding for service on the basis that it engenders long-term efficiency and avoids the far greater distress and expense of failure
  - acknowledge that the NHS is not a mature or perfect market and there will be times when the public interest requires services to continue despite lack of market viability. It could then develop the requisite changes to enable sustainability and equilibrium such as tariff adjustments and renegotiated commissioner requested services (CRS)
  - facilitate locally led resolution to structural issues in local health and social care systems including, for example, service reconfiguration and funding to achieve this, in order to avoid increasing levels of distress and eventual provider failure.
THE GOVERNMENT AND PARLIAMENT NEED TO:

- Ensure the speed and effectiveness of response to unavoidable provider failure by ensuring the trust special administrator or other appropriate mechanisms are sensitive to the causes of failure and adjust their interventions accordingly.

5. Hold the regulators to account for providing value for money

The combined budget for Monitor, the CQC and the TDA is £232.8 million for 2014/15. This is a substantial proportion of the NHS budget – equivalent to around 7,500 nurses – which needs to create a clear net benefit for patients, the public and those regulated. Moreover, their grants in aid and the fees NHS providers pay regulators have risen at a time of shrinking budgets and rising costs elsewhere in the NHS – costs which include the burden presented by regulation. Regulators themselves are no less accountable for their use of public money than NHS providers.

MONITOR, THE CQC AND THE TDA NEED TO:

- Work seamlessly to minimise their burden on NHS providers without necessarily being merged. NHS providers need to be able to reasonably manage regulatory requirements, in terms of quantity and complexity:
  - NHS providers must not be subject to multiple levels of scrutiny for the same aspect of service delivery, and so be vulnerable to double or triple jeopardy
  - NHS providers should only have to submit a given information set once. The regulators – along with the Department of Health and NHS England – must seek and work from a single, agreed set of information. It is their responsibility to set out the objectives of data collection, design information requests and ensure the scope is proportionate to the need. As far as possible, NHS providers should be able to submit data to regulators in the same format in which they collect it for their own governance purposes
  - any requests made must be better coordinated. NHS providers have, for example, been required by Monitor to provide two- and five-year plans, as well as separate detailed financial data, at the same time as preparing for a CQC inspection with teams totalling up to 80 people to host
  - back office functions could be merged. Sharing these would reduce costs and encourage a shared culture, mirroring the expectations on commissioners and NHS providers.

- Ensure their own value for money and avoid detracting from patient care. For example:
  - regulators should focus on provider and sector strategy and governance, and on minimising obstacles to transformation, rather than maintaining an operational focus and reporting burden
  - the CQC needs to create a sustainable inspection model which does not rely on ever-expanding teams of specialists. This will take clinicians away from the frontline, cause undue delays in inspections, and increase the cost of regulation. Instead, smaller teams need to get a clear understanding of provider quality and then go to the board to assure the provider has the capacity to maintain and improve standards.
● regulators need to encourage honesty in discussions with provider leaders, rather than encouraging the answers they want to hear and then blaming NHS providers when results do not match expectations

● each regulator must recognise that part of the burden of regulation is the reputational damage of a poor report. Problems should not go unsaid, but NHS providers need to have a greater voice in setting out how they will lead improvements

● the TDA must ensure it fulfils its valid function in reasonable time and within scope, confirming a timeline for the authorisation of trusts.

PARLIAMENT NEEDS TO:

● Hold the regulators more strongly to account, including an assessment of the impact that their individual and combined presence and requirements make on NHS providers’ ability to perform.
PRIORITIES FOR THE NHS PROVIDER SECTOR

Autonomous and accountable NHS providers driving new models of care in partnership with local health and social care systems

The NHS is complex, dispersed and heterogeneous. It is in truth a set of systems united beneath the banner of a national public service. It works because of the expertise and dedication running throughout its constituent organisations, with a governing mechanism provided by the twin pillars of autonomy and accountability, underpinned by robust risk regulation. The FT model embodies this approach, which weaves empowerment, responsibility and answerability into the everyday and devolved functioning of the NHS. It is this mechanism which, when fully realised, drives high performance in every locality.

The NHS provider sector now

The FT model is a unique expression of local empowerment. The model – which includes a legal duty for FT boards to maximise the public benefit derived from the organisation – gives NHS providers greater independence to work with their communities and ensure their services are designed around local needs. This autonomy is balanced by accountabilities to their community, via members and governors, and to commissioners, regulators and parliament.

Yet NHS provider autonomy has been diluted by regulatory performance management, and the balance between its many accountabilities has been undermined to the detriment of local involvement. Moreover, the pipeline for authorisation of NHS trusts as FTs has stagnated, further diluting the strength of accountable autonomy.

At the same time, NHS providers face significant operational upheaval. They not only need to manage their operations and sustain quality in a difficult financial environment, but they must also consider radical options for delivering integrated, seven day services. This is right for patients and service users, and it requires far-reaching change over an extended period, with commissioners and NHS providers across all sectors investing considerable time and resources in working together.

Yet a number of local barriers to change exist, including lack of alignment of financial incentives across local health and social care systems. There is also considerable variation in the capability and capacity of commissioners and health and wellbeing boards. In particular, local, national and specialised commissioning are disjointed; the areas covered by CCGs are too small; and there is little instinct to engage fully with NHS providers.
At a regional and national level, the burden of financial risk and regulatory attention are focused on provider operations to the detriment of a wider system view. There is no mechanism to avoid or relieve distress in local health and social care systems, and little realistic appreciation of the time and resources which need to be devoted to changing service patterns. There is also a persistent dichotomy at the heart of any discussion about the future configuration of the NHS: NHS providers are under pressure both to change their services and keep them the same, with politicians nationally siding with change, and locally siding with the status quo.

Transformation cannot be externally enforced – it can only be enabled and encouraged by creating the conditions for constructive locally-led change. NHS provider boards need to be confident their autonomy will be upheld and they careful exercise accountability. In the absence of this confidence, change becomes a gamble: you cannot invest in your own success or that of your peers if you are not sure of the lines and weight of responsibility.

To provide for the future we need to support an empowered and affordable NHS workforce with the right skills and in the right numbers

1. Ensure the strategic leadership role of NHS providers within local health and social care systems

   There is no NHS without NHS providers. Yet there is considerable variation in how well commissioners and health and wellbeing boards engage NHS providers, who tend to be brought in to implement designs, rather than being able to play a key role as strategic partners. This is despite NHS providers’ clinical expertise, knowledge of delivering care and capability for innovation. It also reinforces the often disjointed and institutionally focused nature of local health and social care systems.

   NHS providers need to be enabled to undertake the collaborative, strategic leadership role that their skills, knowledge and resources equip them to play. The system must enable NHS providers to work with their local health and social care system partners, patients and the public to make the necessary changes. At present, where significant service change is needed, the issue often stagnates until it becomes a crisis or highly politicised and, in the worst case scenarios, exacerbates provider distress and prompts national intervention. An NHS for the 21st century requires radical change, achieved through everyday working relationships in the locality.

   **NHS PROVIDERS NEED TO:**

   - Play a leadership role within their local health and social care systems, working with commissioners, to develop 21st century services, collaborate and share risk appropriately.

   **LOCAL HEALTH AND SOCIAL CARE SYSTEMS NEED TO:**

   - Build effective relationships with NHS providers and actively involve them in discussions to design, implement and improve services.
   - Come together to explore solutions to a wide spectrum of issues –
from developing new service patterns to resolving issues which do not lie within any one organisation but across the network.

- Collaborate to promote the needs of the wider local health and social care economy over institutional advantage.
- Engage meaningfully with communities and politicians to make the case for change and develop new models of care.

THE GOVERNMENT AND NHS ALBS NEED TO:

- Create a duty for health and wellbeing boards, local authorities and CCGs to take account of NHS provider views.
- Address the national-level barriers to integration and new models of care, including:
  - insufficiently aligned arrangements for NHS providers and commissioners to share risk
  - payment mechanisms and incentives which do not support integration across the system and performance metrics which are focussed on institutions not pathways
  - lack of an evidenced business case for the benefits to patients of integration
  - an inappropriate expectation that integration will achieve rapid significant efficiency savings
  - performance metrics which are focused on institutions rather than pathways
  - a regulatory regime which is slow to respond to issues across a local health and social care system
  - lack of clarity about the interaction of competition law with integration policy.

THE GOVERNMENT AND ALL POLITICIANS NEED TO:

- Commit to working with the current NHS structure and enabling it to function, and explicitly confirm that no restructure will take place at any point during the next Parliament.
- Help localities make the case for change, seeking to understand and communicate the potential benefits even while challenging local health and social care systems in order to assure the robustness of plans. If politicians want high quality health services for their constituents, they must play their part in enabling NHS providers to deliver the right services.

2. Demand higher standards of local and national commissioners

Although some CCGs have begun to add significant value, there is considerable variability in their effectiveness across the country. They do not always exercise the full breadth of their rights and responsibilities, and neither are they held accountable for doing so. Commissioners and health and wellbeing boards alike have yet to build consistently transparent and constructive relationships with NHS providers. For example, a 2014 survey found that only half of NHS providers were involved in the
development of their local Better Care Fund plans, with only 2 per cent considering they had been fully involved. Moreover, too few are undertaking the strategic commissioning role that was envisaged for them. Too many are focusing very narrowly on contracting and procurement or duplicatively second guessing providers. Specialised commissioning, including its coordination with local commissioning, has fallen short in ensuring timely and accessible care, particularly in relation to child and adolescent mental health services. The cost of specialised services is growing annually by 7 per cent, and the drivers of demand and expenditure are not yet properly understood. Provider engagement is critical as proposals for service changes are progressed, which may include a combination of specialised centres, networks around lead NHS providers and co-commissioning with CCGs.

This underdeveloped capability has an adverse impact on improving care and sustainability. For commissioning to be an effective part of the system, there needs to be a move away from short-term transactional approaches towards strategic service design which consistently accounts for patient need and the provider perspective.

LOCAL HEALTH AND SOCIAL CARE SYSTEMS NEED TO:
- Recognise the commissioning process as a whole local health and social care system activity, with ongoing provider engagement, even while local commissioners need to remain responsible for final commissioning decisions.

NHS ENGLAND AND MONITOR NEED TO:
- Hold local commissioners to account for the quality of their commissioning and the outcomes achieved.
- Increase the transparency of CCGs’ and health and wellbeing boards’ activities, as well as how they will be held to account and what the consequences will be, to an extent equivalent to the wealth of provider information the public can access.
- Help align financial and clinical incentives across local health and social care systems.

NHS ENGLAND NEEDS TO:
- Invest in the development of commissioning capability and ensure commissioning is better coordinated, outcomes focused and at appropriate scale, and concentrate on strategic commissioning as opposed to second guessing providers.
- Clarify its intentions for commissioning of specialised services and engage NHS providers fully developing plans in order to ensure appropriate and sustainable provision.
- Ensure joined up commissioning at every level.
- Work with the government to ensure local commissioners can achieve appropriate scale to be efficient and effective.
3. Support the autonomy of NHS providers to focus on local needs

The focus for NHS providers must be on local and organisational priorities. Yet increased regulatory risk aversion and intervention, and a national focus on blunt performance targets, means the provider sector’s attention has increasingly been drawn towards the centre. This diminishes their ability to pursue a coherent strategy based on community needs. NHS providers need to be able to use their clinical and organisational judgement to continuously improve patient care, identifying and responding to local needs while meeting national standards.

NHS PROVIDERS NEED TO:

- Assert their autonomy to use their judgement in providing high quality care, including in using the freedoms of FT status to do so.
- Invest in their own capability to ensure that autonomy and probity go hand in hand, so that improvements or corrective measures are transparently implemented and communicated.

THE GOVERNMENT AND NHS ALBS NEED TO:

- Recognise the importance of organisational autonomy in order to preserve accountability. In doing so, the centre would support board capability and organisational effectiveness.
- Focus on seeking evidence of good corporate governance in the exercise of autonomy. This would assure the regulators of a provider’s capacity for sustained improvement and success.

4. Embed high performing cultures through meaningful accountability relationships

An organisation can only be held to account if it has been in control of its operation. Too often, NHS providers’ autonomy and accountability are diluted by centrally mandated requirements. This undermines the links between patient needs, provider services and care quality. The balance between, and integrity of, the multiple accountabilities held by NHS providers needs to be restored with greater focus on local accountability.

PATIENTS, CARERS, FAMILIES AND COMMUNITIES NEED TO:

- Tell local NHS services what they would like to see and what would help them.
- Help to design a 21st century NHS by getting involved in proposals for new services and engaging with the objectives, costs and benefits.
- Exercise their right to choose services based on quality.
- Become members, governors and non-executive directors (NEDs) of FTs.
NHS PROVIDERS NEED TO:

- Ensure local communities can see and participate in informal and formal accountability mechanisms, from newsletters and open days to membership and governor engagement.
- Demonstrate to local communities that the organisation welcomes any feedback as a learning opportunity, is investing in its improvement, and is committed to resolving any problems.
- Further build up the roles of FT non-executive directors and governors to ensure they are capable of consistently presenting strong challenge to the board.

COMMISSIONERS AND LOCAL HEALTH AND SOCIAL CARE SYSTEMS NEED TO:

- Play their part in holding providers – both NHS and private – to account, recognising that their duties continue throughout the life of a contract and they need to assure themselves that the service they have commissioned is meeting the defined quality standards.

MONITOR, THE CQC AND THE TDA NEED TO:

- Where practice falls below the minimum standard, hold NHS providers to account in a way that is meaningful for organisational improvement and does not damage patient care. This means avoiding financial penalties, removing leaders only where they are the cause of problems, and not instituting solutions which dilute the organisation’s future accountability.

THE GOVERNMENT NEEDS TO:

- Work with the NHS to ensure it has the resources and autonomy it needs to be able to use its clinical judgement and be held accountable for the care it provides.

PARLIAMENT NEEDS TO:

- Hold the government and the NHS ALBs to account for creating a clinically and financially sustainable NHS.

5. Realise the full potential of the FT model as an agent for achieving local health priorities

The FT model is unique: it is designed to give boards independence in responding to local needs, and hold them accountable for decision making within their locality. But the strengths of this model are at risk. Only a handful of NHS trusts have been authorised since January 2013 and NHS trusts still comprise around a third of the NHS provider sector.47 This is damaging and wasteful, leading to greater complexity and bureaucracy, hindering improvement and innovation. The uncertainty must end – ultimately with FT status for all NHS providers, whether they continue in their current form or join with others to achieve this.
THE NHS PROVIDER SECTOR NEEDS TO:

- As part of the sector’s commitment to leading its own improvement, ensure all trusts are actively engaged in the FT application process and are supported in doing so.
- Use the freedoms which come with FT status to their fullest extent to demonstrate the model’s benefits for the NHS, for community engagement and, above all, for patients and service users.
- Support trusts for which standalone FT status is unlikely to be a viable option by continuing to explore the FT model as a way of preserving good governance and accountability while allowing for a range of organisational forms.

THE TDA, CQC AND MONITOR NEED TO:

- Continue to support and develop the FT model.
- Publish the trajectory for each NHS trust in the pipeline to achieve foundation trust or another appropriate status.
- Address barriers to progression, wherein:
  - for those trusts close to authorisation, Monitor and the TDA should commit supporting authorisation as quickly as possible, while recognising that a rigorous, standards based, process must remain the gateway to FT status.
  - for those trusts where financial hurdles alone – such as a substantial PFI burden or above average costs because of location or demography – would prevent authorisation, Monitor and the TDA should consider tailored solutions such as differential tariffs or moving debt off the balance sheet.
  - for those trusts facing long-term unsustainability, Monitor should facilitate trusts working with their local health and social care systems and other trusts to identify solutions such as mergers, service reconfiguration or new organisational forms.
Endnotes


30 Department of Health and College of Emergency Medicine, ‘Emergency medicine taskforce interim report recommendations,’ 2012 (http://secure.collegeremedymedic.ac.uk/Share-Floors/Policy/10%20priorities%20for%20Emergency%20Medicine)

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39 The Independent, ‘NHS spends £2.5bn on agency staff to meet rising demand,’ October 2014 (http://www.independent.co.uk/life-style/health-and-families/health-news/nhs-spends-2.5bn-on-agency-staff-to-meet-rising-demand-9816894.html)


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NHS Providers is the new name for the Foundation Trust Network (FTN)
TO READ ABOUT
NHS PROVIDERS’ PROGRAMME
FOR THE NEXT PARLIAMENT
PLEASE VISIT OUR WEBSITE

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

NHS Providers has 226 members – 94 per cent
of all NHS foundation trusts and aspirant trusts –
who collectively account for £65 billion of annual
expenditure and employ more than 928,000 staff.

NHS Providers is a signatory to the 2015 challenge,
co-ordinated by the NHS Confederation and signed
by 21 health and care bodies.

http://www.nhsconfed.org/~/media/Confederation/Files/