



BUILDING A HEALTHY NHS AROUND PEOPLE'S NEEDS

AN INTRODUCTION TO
NHS FOUNDATION TRUSTS
AND TRUSTS



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BUILDING A HEALTHY NHS AROUND PEOPLE'S NEEDS

AN INTRODUCTION TO NHS FOUNDATION TRUSTS AND TRUSTS

The NHS in England

The NHS is a constant presence in everyday life. Its hospitals, ambulances, GPs, clinics and care homes are part of our national fabric. NHS services are part of everyday conversation – it is the public service people turn to when they are in pain, vulnerable and worried – they need to trust it. The NHS employs over a million people, and has a major role in local and national business through procurement, capital investment, and research and development.

Since its inception, the three core values of the NHS have been for it to: meet the needs of everyone; be free at the point of delivery; and be based on clinical need, not ability to pay. The service now cares for one million people every 36 hours, and these values remain at the core of the NHS Constitution. The NHS is internationally renowned as “world-leading example of commitment to health and health care as a human right”¹ – a truly inspirational social construct.

We trust the NHS every day with our lives and over seven decades it has changed radically, and must continue doing so to ensure it best meets people's health and care needs. The following pages describe how secondary care services work within the NHS in England – that is, the NHS acute, ambulance, community and mental health service providers – and how they work to deliver world-class care within hospitals and community based settings:

- What are the NHS foundation trusts and trusts delivering secondary and specialised care in England?
- How are these organisations responding to people's changing needs?
- How can you get to know your local NHS?
- What are the local and national organisations that make up the NHS?
- What are the key local issues likely to be and how do these translate into national policy making?
- What are the national and local priorities for NHS foundation trusts and trusts?

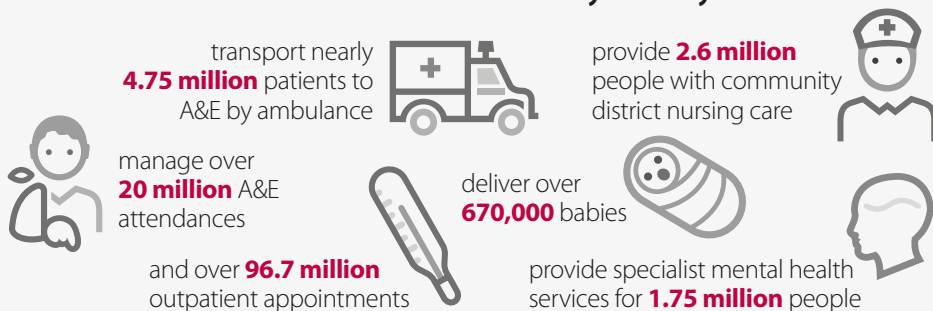
NHS foundation trusts and trusts

Secondary care in England is delivered by 240 NHS foundation trusts (FTs) and trusts. Broadly, these NHS providers fall into the following groups:

- **ACUTE**
Delivering hospital care and accident and emergency services (A&E) and in some cases specialised services such as paediatric cardiac services. Some also provide community services. Many are teaching hospitals or have ties to universities to train healthcare professionals or benefit from research.
- **AMBULANCE**
Although predominantly an emergency service which stabilises patients and takes them to hospital, ambulance services are increasingly also providing preventative and community focused care, as well as some NHS 111 services.
- **COMMUNITY**
Covering 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.
- **MENTAL HEALTH**
Usually providing specialist psychological and psychiatric care, and working closely with primary care and social care providers to support those with mental health problems as in and out patients.

NHS PROVIDERS CARE FOR 1 MILLION PEOPLE EVERY 36 HOURS

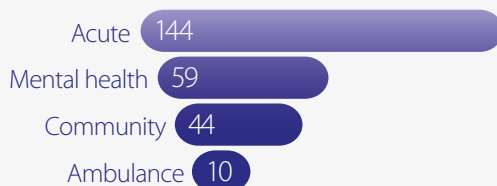
Over one million highly skilled people work in 240 acute, ambulance, community and mental health trusts and foundation trusts. Each year they:



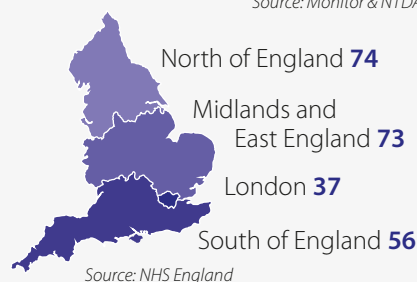
WHO ARE THE PROVIDERS?

240 providers = **151** foundation trusts and **89** NHS trusts

Services provided by FTs and trusts:



Source: trust websites



Source: NHS England

What are NHS foundation trusts and trusts?²

NHS TRUSTS

NHS trusts are public sector bodies established by parliamentary order by the secretary of state for health to provide healthcare services to the NHS. They have a board of executive and non-executive directors, and are accountable to the secretary of state. NHS trusts are expected to become foundation trusts in due course, and are performance managed by the NHS Trust Development Authority (TDA) on behalf of the secretary of state to support them in this transition.

FOUNDATION TRUSTS

- The FT model is a unique expression of local empowerment, created to devolve decision making from central government to local communities.
- FTs have a legal duty to maximise the public benefit derived from the organisation, providing and developing healthcare according to the core values of the NHS.
- They go through a rigorous approval process, after which they have greater freedoms than NHS trusts to work with their local communities and design their services around local needs. For example, they can hold a surplus which allows them to invest in new services.
- To balance their increased independence, FTs are held accountable in a unique way. Local residents, staff, patients and service users can become:
 - members: people who are actively interested in their local FT and want to influence how services are run;
 - governors: elected members who hold the FT's non-executive directors (NEDs) to account for the performance of the board, as well as representing the interests of the local community.
- In providing local services, FTs continue to work to national standards and are also accountable to commissioners, the regulators and Parliament.
- FTs provide a model of "accountable autonomy" that could be replicated across the NHS, emphasising the importance of having organisations which actively engage their staff and community in continual improvement.

TIME FOR TODAY'S MODELS OF CARE IS RUNNING OUT

Each NHS provider sector faces challenges in delivering today's care.



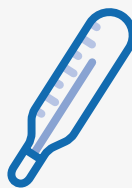
ACUTE SERVICES

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

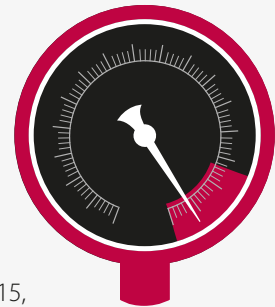
Increasing financial and operational pressures

At the same time, NHS funding is under intense and unprecedented pressure:

- a number of national targets for accessing care, as set out in the NHS Constitution, are under pressure. These include referral to treatment times and the four hour target to be seen in A&E being missed;⁶
- in recent years, funding has remained at a broadly constant level despite steady increases in demand and costs. NHS providers collectively projected a deficit of at least £850 million at the end of 2014/15;⁷
- rising demand and cuts elsewhere in the system have compounded the pressure on the NHS: social care has faced real terms funding cuts of 12 per cent;⁸
- 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 2010/11.⁹

THE SYSTEM IS ALREADY UNDER IMMENSE PRESSURE

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 collectively expected to be **£850 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**

Sources: NHSE 2014, Monitor 2014, NHS TDA 2014, BMJ 2014

MEETING THE 21st CENTURY NEEDS OF PATIENTS AND SERVICE USERS

People's health and care needs are evolving, so how we deliver services within the NHS needs to evolve too. 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.

Now, to transform care for 21st century needs, the NHS needs to develop new ways of working across health and social care, with providers and commissioners coming together to share risks and expertise.

This means empowering patients and service users in their healthcare choices, investing in prevention and wellness, and where appropriate moving care into the community and closer to home. It means reinvigorating the balanced autonomy and accountability of FTs, rallying behind direct community engagement over health and social care priorities and investment of significant public monies.

Five Year Forward View

5YFV

The NHS *Five year forward view*¹⁰ (5YFV), initiated by NHS England and published in November 2014, is a key document in setting out what the care of the future looks like and the funding levels this would require.

The 5YFV identifies three widening gaps which will need to be addressed to secure quality of care and the sustainability of the NHS in the future:

- 1 The health and wellbeing gap – without a focus on prevention, health inequalities will widen.
- 2 The care and quality gap – without reshaping care, the changing needs of patients will go unmet.
- 3 The funding and efficiency gap – without matching funding levels with system efficiencies, we will see worse services, fewer staff, more deficits and restrictions on new treatments.

It strongly focuses on preventative care – for example, by reducing obesity and problem drinking, by ensuring a good start in life for children, and by addressing lifestyle risks for dementia – to reduce the pressures on the NHS.

In addition to setting out modern approaches to services including urgent and emergency care, specialised care, maternity and care homes, it promotes new models of care:

- Multispecialty Community Providers (MCPs) – expanded GP group practices which would integrate out-of-hospital care
- Primary and Acute Care Systems (PACS) – delivering list-based GP and hospital services, together with mental health and community care, in single NHS organisations
- Networks of 'viable hospitals' – working together and collaborating in different ways to share services in some instances.

The 5YFV identifies a gap of between £8 billion and £30 billion by 2020 between what the NHS has and needs depending on how far the NHS is able to improve its own productivity.

Getting to know your local NHS providers

For the NHS to continue developing the services that patients and service users need, it is vital for local politicians to work closely with the NHS providers serving their community. NHS providers need the help of their councillors and MPs to develop plans for future provision, to communicate the need for change, and to present their challenges and priorities nationally.

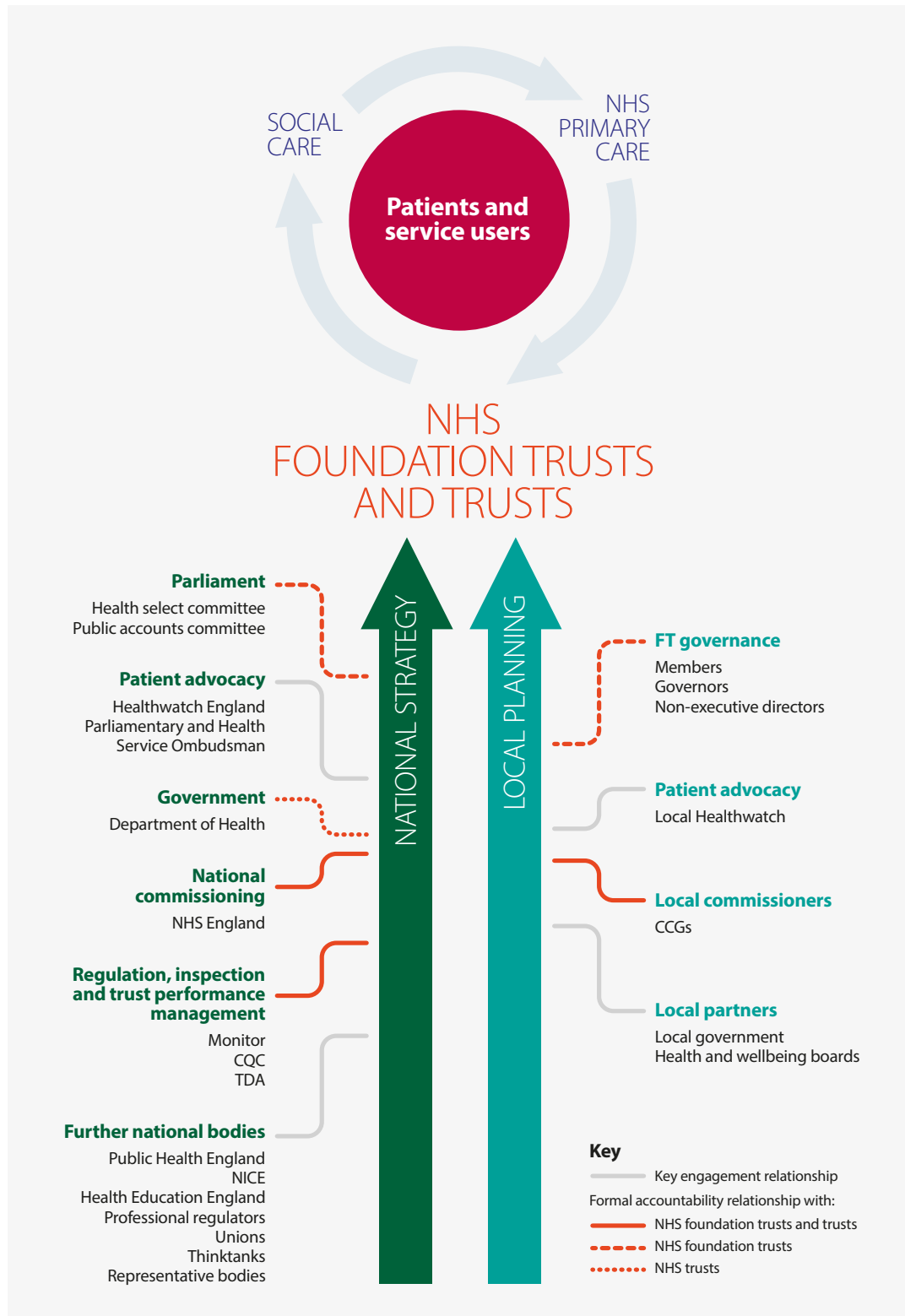
NHS providers tend to be large and complex organisations, employing significant numbers of local people, and delivering a wide range of services. To help you get to know your local NHS providers, the key areas to consider and sources of more information are set out here.

KEY QUESTIONS TO ASK STAFF AND LEADERS

WHAT TO LOOK FOR	SOURCES OF INFORMATION
<p>The basics</p> <ul style="list-style-type: none"> ● What type of services are provided? ● How many patients and service users are cared for? Over what area? ● How many people does the trust employ? ● What is the financial surplus or deficit? <p>The board</p> <ul style="list-style-type: none"> ● Who is the leadership team? How long have they been there? ● How does the trust judge and maintain quality? ● What level of challenge is there to ensure good governance? <p>Staff</p> <ul style="list-style-type: none"> ● How are staff engaged in improving care? What is their feedback? ● Are there any recruitment or retention issues? ● How are professional skills maintained and developed? <p>Trust strategy</p> <ul style="list-style-type: none"> ● How is the local community changing? ● Where does the trust expect to be in five years' time? ● What is it doing to achieve that? <p>Finance</p> <ul style="list-style-type: none"> ● What are the financial trends? How long has there been a surplus or deficit? ● What are the pressures on finances? <p>Partners and communities</p> <ul style="list-style-type: none"> ● How many clinical commissioning groups (CCGs) does the trust work with? ● What other partnerships are in place (eg with social care and primary care)? ● What is the quality of working relationships? ● How does the trust engage its local communities and (if an FT) with governors? ● What types of patient, service user and community engagement groups does the provider run? 	<p>The trust</p> <ul style="list-style-type: none"> ● Board members and staff are the key sources of information ● Board papers and minutes ● Its patient and service user groups ● Its members and council of governors (if an FT) <p>Local partners and national bodies can also provide valuable information, which together can help to create a rounded view of a provider and its local health and social care system. For example:</p> <p>Local Healthwatch representing local people using health and care services, and providing complaints advocacy</p> <p>Local commissioners (CCGs and health and wellbeing boards) can help to indicate services and quality required, and give a strategic overview of the area, working relationships and risk sharing</p> <p>Care Quality Commission (CQC) publishes quality and risk ratings, as well as provider inspection reports</p> <p>Monitor publishes financial reports of FTs, oversees competition and integration, and carries out regulatory intervention</p> <p>NHS Trust Development Authority publishes financial reports of NHS trusts, and performance manages trusts</p> <p>Health and Social Care Information Centre (HSCIC) publishes data on waiting times and other performance targets</p> <p>NHS Choices gives an overview of service quality indicators such as the Friends and Family Test</p>

How do NHS providers work with other local and national NHS organisations?

Foundation trusts and trusts, alongside their colleagues in primary care, are the visible frontline of the NHS. The diagram below sets out how NHS foundation trusts and trusts work with the other key bodies in the NHS, each of which is then further explained.



LOCAL COMMUNITIES

Patients, service users and members of the local community play a key role in shaping their local NHS services. By becoming **members** and **governors** they can directly influence an FT and hold the organisation to account. NHS foundation trusts and trusts also use a variety of means to engage with particular patient and service user groups, as well as the wider community, to seek feedback and engagement in developing services appropriately.

Organisations such as **Healthwatch England**, and their local offices, act as advocates of the patient voice, and the **Parliamentary and Health Service Ombudsman** is the final port of call to investigate complaints which have not been locally resolved.

For more information:

- Individual NHS foundation trust and trust websites
- Healthwatch England: www.healthwatch.co.uk
- Parliamentary and Health Service Ombudsman: www.ombudsman.org.uk

COMMISSIONERS

Commissioning involves working with providers and the local community to agree the outcomes required from local health services, purchasing those services, and working with providers (such as NHS trusts and foundation trusts) to monitor contracts and drive improvement.

NHS England was established in October 2012. It is legally known as the NHS Commissioning Board, and is the national commissioner with a mandate and funding from the secretary of state to improve health outcomes for people within England. It devolves much of its budget to primary care and to CCGs for commissioning secondary care services. In practice, NHS England also has a leading role in developing NHS strategy and operational policies (such as jointly setting the prices paid to NHS providers for the care they deliver).

Clinical commissioning groups are groups of GPs responsible for commissioning local health services in England. Each CCG also includes at least one registered nurse and a doctor who is a secondary care specialist. From April 2013, CCGs essentially replaced the role previously played by primary care trusts. Recently many CCGs took on additional responsibility for co-commissioning care with NHS England.

For more information:

- NHS England: www.england.nhs.uk
- Individual CCG websites

LOCAL PARTNERS

Health and wellbeing boards (HWBs) bring together partners from across the NHS, local government, the third sector and the independent sector. HWBs are supported and funded by local government, and assess the strategic needs of their locality and are responsible for developing a joint health and wellbeing strategy.

Each HWB includes at least one local **Healthwatch** representative to speak for patients. NHS providers should have some link to their HWB, either by having a seat on the board itself, or through some form of sub-group or sub-committee which informs the board.

Local government, a key partner for NHS providers, has responsibility for public health and delivers or commissions a range of social care services. Many trusts have close partnerships with these services which promote health, enable those with long-term conditions to live independently, can help to prevent unnecessary hospital admission, and assist with early discharge to enable people to recuperate or manage their condition in the community.

Voluntary sector and **independent providers** also play a significant role in enabling trusts to deliver their services effectively for their communities.

For more information:

- Individual local council websites and The King's Fund directory of HWBs: www.kingsfund.org.uk/projects/health-and-wellbeing-boards/hwb-map
- Individual local Healthwatch websites
- Individual local government websites and their representative body, the Local Government Association: www.local.gov.uk

REGULATORS AND PERFORMANCE OVERSIGHT BODIES

Proportionate, risk based regulation is fundamental to building confidence in the NHS, assuring standards of care for patients and the public and ensuring the continuity of services. A number of regulators oversee NHS providers.

Monitor has a number of responsibilities, including:

- evaluating if an NHS trust is suitable for authorisation as an FT;
- ensuring NHS FTs are financially viable, well governed and able to ensure continuity of their services. Its main tools in doing so are a provider licence (which includes conditions to which FTs must adhere) and risk ratings; and
- sector regulation. Its responsibilities here include:
 - applying certain licence conditions to all providers registered with the CQC
 - setting the prices which providers are paid for their care (in partnership with NHS England)
 - enabling integrated care
 - preventing anti-competitive behaviour
 - supporting commissioners to maintain service continuity.

The Care Quality Commission registers and regulates providers of health and social care to ensure they meet the fundamental standards of quality and safety. The CQC monitors and inspects these services to ensure they meet minimum standards by assessing whether services are safe, effective, caring, well led and responsive to people's needs.

The NHS Trust Development Authority is not a statutory regulator, but its responsibilities are in some respects similar. It is the oversight body of NHS trusts, monitoring trust finance and performance. Unlike a regulator, it also performance manages NHS trusts to support them in the process to become a foundation trust.

Professional regulators oversee professional standards, maintain registers of qualified professionals and handle complaints about individual professionals. Key examples include the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC).

For more information:

- Monitor: www.gov.uk/government/organisations/monitor
- The CQC: www.cqc.org.uk
- The TDA: www.ntda.nhs.uk
- The professional regulators include:
 - The GMC: www.gmc-uk.org
 - The NMC: www.nmc-uk.org

FURTHER NATIONAL AND INDEPENDENT BODIES

Health Education England (HEE) is the national leadership organisation for education, training and workforce development in the health sector. Its regional subcommittees (local education and training boards, or LETBs) are responsible for the training and education of NHS staff, both clinical and non-clinical, within their area.

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. It also develops quality standards, performance metrics and information services for providers and commissioners.

Public Health England (PHE) protects and improves England's health and wellbeing by advising local and national government and supporting people to protect their own health. It also reduces health inequalities and develops answers to public health problems.

Medical colleges set standards and supervise training within their field, as well as influencing national health policy. Examples include the Royal College of Physicians, the Royal College of Surgeons, and the Royal College of Emergency Medicine.

Trade unions particularly active in the NHS include the British Medical Association (BMA), Unison and the Royal College of Nursing. As well as undertaking local support for their members, at a national level the BMA represents doctors in contract negotiations.

Trade associations and thinktanks – such as NHS Providers and The King's Fund respectively – help develop policy based on research and member feedback.

For more information:

- HEE: hee.nhs.uk
- NICE: www.nice.org.uk
- PHE: www.gov.uk/government/organisations/public-health-england
- Medical colleges include:
 - Royal College of Physicians: www.rcplondon.ac.uk
 - Royal College of Surgeons: www.rcseng.ac.uk
 - Royal College of Emergency Medicine: www.collemergencymed.ac.uk
- Trade unions include:
 - British Medical Association: bma.org.uk
 - Unison: www.unison.org.uk
 - Royal College of Nursing: www.rcn.org.uk
- Trade associations include:
 - NHS Providers: www.nhsproviders.org
 - NHS Confederation: www.nhsconfed.org
- Thinktanks include:
 - The King's Fund: www.kingsfund.org.uk
 - Health Foundation: www.health.org.uk
 - Nuffield Trust: www.nuffieldtrust.org.uk

POLITICAL OVERSIGHT

Parliament holds the secretary of state for health to account for delivery of health policy within England, and for the performance of the NHS. FTs are also directly accountable to Parliament and lay their annual reports and accounts before it. As well as carrying out scrutiny of the Department of Health, in the 2010 Parliament the health select committee began holding annual hearings with those arm's length bodies – such as Monitor and the CQC – which are directly accountable to it. The public accounts committee also regularly reviews the sustainability of the NHS.

Department of Health has, since the Health and Social Care Act 2012, adopted a role of industry sponsor and patient champion. In doing so, it focuses on strategic policy development and holding to account the department's arm's length bodies, executive agencies and NHS regulators.¹¹

For more information:

- Department of Health: www.gov.uk/government/organisations/department-of-health
- Parliament: www.parliament.uk
- Health select committee: www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee
- Public accounts committee: www.parliament.uk/business/committees/committees-a-z/commons-select/public-accounts-committee

NHS issues from local and national perspectives

In working with constituents and your local health and care system, a wide range of concerns and questions will be raised. Some of the most common issues are outlined below, followed by the broader national policy questions they imply.

The subsequent pages set out the priorities of the NHS provider sector in addressing these national issues, and so support the local delivery of high quality care.

LOCAL HEALTHCARE ISSUES	DRIVING NATIONAL POLICY MAKING
<p>LOCAL HEALTH SYSTEMS: Do services meet the needs of patients and service users?</p>	
<ul style="list-style-type: none"> ● What do local and national performance indicators – such as waiting times, patient and staff feedback – show? ● What feedback, complaints or concerns do patients and service users tend to raise? ● Can people access the services – such as GPs and A&E – that they need? Are there alternative services to A&E in place so people don't have to attend hospital if they don't need to? ● How are mental health needs supported? Do they receive a level of attention similar to physical health needs? ● Are services being shaped around local demography? How will services change? ● Is the community engaged with the future of their health and care services? ● Do NHS services – such as GPs, district nurses and hospitals – coordinate care around patients and service users? Are NHS and social care services similarly coordinated? ● Do services offer continuity of care by being available seven days a week? ● Can patients be discharged safely and in a timely way following an episode in hospital? 	<ul style="list-style-type: none"> ● What is driving national performance trends? ● Are we using the right tools for improvement? ● Can the NHS make better use of competition and choice to increase quality? ● Is there parity of esteem for how physical and mental health are funded, commissioned and delivered? ● How will we build new care models which better integrate health and social care services? ● Do the national policy frameworks allow enough flexibility for local discussion, innovation and collaboration? ● Is there unmet need? Are local and national commissioners working together and with providers effectively? ● Do we have the right organisational models to deliver the care people need?

LOCAL HEALTHCARE ISSUES

DRIVING NATIONAL POLICY MAKING

NHS WORKFORCE: Who delivers and leads frontline care?

- | | |
|--|---|
| <ul style="list-style-type: none">● Are there enough staff to deliver care and manage the organisation?● Can local services attract and retain the right staff? If not, what are the issues they are facing?● Are staff looked after by their employers? Can they raise concerns and be confident they will be addressed?● Are staff appropriately rewarded for their work?● Are staff engaged and empowered in their roles? Do clinicians and managers work closely together?● What are the ambitions of the board of directors for the organisation? Is there a stable leadership team? | <ul style="list-style-type: none">● How should staffing numbers be determined?● What are the training and education needs for the coming years?● Is the national pay bill affordable? Do terms and conditions reflect performance? Do we need greater local flexibilities in how pay, terms and conditions are agreed or should the system remain at a national level?● What skills do NHS leaders need? How do we create a national pipeline of future leaders? |
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NHS FUNDING: What funding and resources are required to meet care needs?

- | | |
|---|--|
| <ul style="list-style-type: none">● Is there adequate funding to pay staff and suppliers, to maintain infrastructure and service levels, and to invest in improvement and future services?● What will organisations do if they are underfunded? Could care be compromised? Are any services at risk?● What funding sources do organisations have? Can they increase their funding?● Are trusts using their resources and carrying out procurement efficiently? What waste could be reduced? Is there any further scope for efficiencies? | <ul style="list-style-type: none">● What further efficiencies could the system make?● Are payment systems working properly to get funding to the frontline?● How is risk shared across local health and care systems?● What level of funding is necessary to stabilise and secure services in the short term?● What is the likely long term funding requirement? |
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REGULATION: What assurance is there for the quality and safety of care?

- | | |
|---|---|
| <ul style="list-style-type: none">● What level of intervention in local NHS providers is there by the TDA, the CQC and Monitor?● Is there a consistent regulatory view of the quality and sustainability of local care?● How are local services responding to the regulators' views?● Are NHS providers leading their own improvement plans? | <ul style="list-style-type: none">● Is there an appropriate balance between the autonomy of local organisations and their local and national accountability?● What level of oversight do regulators need and have?● Are the regulators operating in a proportionate and risk-based manner?● What level of control over service continuity and reconfiguration is needed? |
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Delivering 21st century care: what do NHS providers of care need?

NHS foundation trusts and trusts are striving to provide world-class care in the right place at the right time. To meet 21st century health and care needs, this means reshaping NHS services.

NHS providers need to be able to invest time and resources in new models of integrated care which meet 21st century needs, but they are facing an unprecedented combination of factors:

- they need to ensure existing demand for care – which is growing by four per cent a year – is met;
- at the same time, they need to radically change their services at pace and scale; and
- funding pressures are growing with the majority of providers reporting deficits and less able to invest in maintaining and developing their services.

Rising to these challenges 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.

The specific priorities for NHS providers as they move towards sustainable 21st century models are set out below, covering local health systems, the workforce, funding and regulation.

THE SOCIAL AND ECONOMIC CONTRIBUTION OF NHS PROVIDERS

- **The NHS ranks first among comparable countries for quality, access and efficiency¹²**
- **Over the last 10 years, quality of care has improved against a range of measures including patient experience and outcomes**
- **FTs alone contribute £30 billion to the economy through employment¹³**

LOCAL HEALTH AND SOCIAL CARE SYSTEMS

NHS providers are experts in delivering the care their local communities need and progress is being made in developing integrated models of care – that is, models where health and social care, secondary and primary care and physical and mental healthcare are better coordinated.

This is not least through “vanguard sites”, which are the first to develop the new models of integrated care set out in the 5YFV. The process for developing the sites is also a positive development in NHS culture, emphasising change led by the frontline, the need to understand the specific needs of local areas, and on sharing learning. The programme will also offer support for “fast followers”, and many further NHS providers are considering how best to work with their partners to integrate care.

Nevertheless, there remain a number of factors though which, if addressed, would allow the sector to consistently deliver the highest quality care.

NHS providers – even though they tend to carry the greatest financial and clinical risks in a local health and social care system, and despite their expertise in delivery – are inconsistently involved in developing strategic plans for the area. Care also needs to be taken to ensure that the requests and direction of the national bodies is not at the expense of local priorities.

Ensuring the structural stability of the NHS is also vital. The NHS has been reorganised 20 times in 41 years, with performance unavoidably affected by such extensive upheaval.¹⁴ It must be recognised that nothing works until it has had time to work.

As NHS providers and their local partners move towards integrated, seven day services, there will be far-reaching change over an extended period. Local political support will be vital in helping to communicate the case for change and ensuring that patients and service users are confident in their continuing and improving care.

THE GOVERNMENT AND PARLIAMENTARIANS NEED TO:

- ask NHS providers and local health and care systems what help they need;
- commit to no administrative reorganisation of the NHS;
- create a duty for local commissioners (health and wellbeing boards, local authorities and CCGs) to take account of provider views;
- support the development of commissioners, holding them to account via NHS England for working with providers to deliver high quality services; and
- develop payment systems and performance measures which support integration across health and social care systems.

WORKFORCE

The NHS depends on over a million people to care for patients and service users. Its workforce faces 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.

At the same time, patient needs are evolving. Episodic clinical care is giving way to round the clock integrated health and social care. We know that delivery of more NHS services over seven days means better, more consistent care for patients. More staff, with a more complex mix of skills, are needed more of the time. Responding to this means looking at a range of issues, including leadership, job roles, pay, terms and conditions, and working cultures.

Firstly, greater focus is needed on supporting leaders to develop and perform. There is a clear correlation between high performing healthcare organisations and the longevity of their senior leadership. Yet the average tenure for a provider chief executive remains stubbornly low at just over two years. NHS leaders – with their role widely regarded to be one of the most difficult leadership roles – need to be supported and given the time and space to develop their organisations. The pressures faced by a chief executive of an NHS FT or trust include:

- operating in a safety critical industry with highly visible results;
- not having control over significant aspects of their organisations (such as the services they must provide and how much they are paid);
- acting as an umbrella organisation for a range of dissimilar activities such as district nursing and walk in centres;
- existing in a system where other parties – including the government, statutory bodies, unions and medical colleges – can have a significant impact on the organisation; and
- increasingly complex managerial requirements, with more emphasis on cultural leadership and oversight of dispersed clinical management.

Across NHS provider organisations, it is key to develop and empower staff, and ensure positive working cultures, as the level of staff engagement has a direct correlation with the quality of patient care. Diversity needs to be a central concern: the strong connection between the treatment of black and minority ethnic (BME) staff and the care that patients receive is now beyond doubt. At board level, we know that diverse teams make better and safer decisions.

RACE EQUALITY IN THE NHS

Research on NHS staff and patient surveys in 2012 by Michael West found:

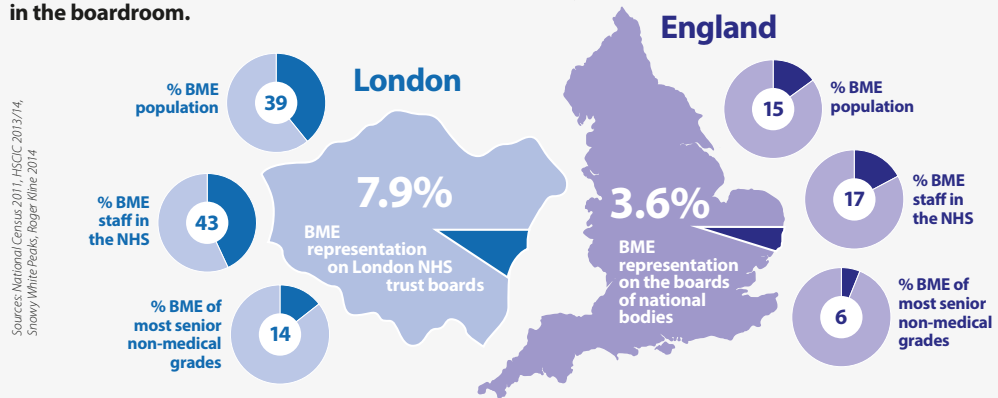


The experience of black and minority ethnic NHS staff is a good barometer of the climate of respect and care for all within the NHS. Put simply, if BME staff feel engaged, motivated, valued and part of a team with a sense of belonging, patients were more likely to be satisfied with the service they received.

Source: NHS Staff Survey and Related Data West, M et al 2012

WORKFORCE REPRESENTATION

Black and minority ethnic (BME) people are significantly under-represented at senior levels in the NHS, particularly in the boardroom.



RECRUITMENT

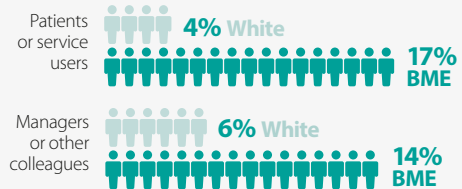
% of shortlisted BME applicants who are then appointed



Source: Discrimination by appointment - Public World 2013. Based on a sample of 30 trusts and data between 2010 and 2013

WORKING CULTURE

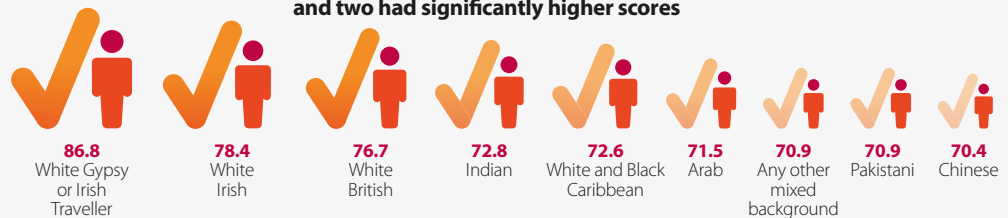
% of staff that have personally experienced discrimination at work from



Source: NHS staff survey 2013

PATIENT EXPERIENCE

In the 2012 adult inpatient survey, of 18 ethnic groups six had significantly lower patient satisfaction scores than white British patients and two had significantly higher scores



Sources: Adult inpatient survey 2012, The relationship between cancer patient experience and staff survey results, Macmillan Cancer Support 2013

In addition, there is a need to ensure greater flexibility in how providers deliver a modern package of pay, terms and conditions for their staff. Pay constitutes between 60 and 85 per cent of an NHS provider's expenditure and the existing conditions on which the pay bill is based can no longer keep up with today's resourcing requirements. That's besides the extended demands of integrated care models and seven day services. Equally, terms and conditions do not fairly reflect performance, they leave little room for tailoring to individual or organisational needs, and they hinder the ability of staff to move between health and social care settings.

It is critical that politicians, policymakers, NHS organisations and staff work together to find a way forward in each of these areas. As they do so, it is as important to recognise that working in the NHS usually means taking on a difficult and pressured role. This must not be under-appreciated and any successful change needs to happen hand in hand with staff to avoid unsettling and destabilising the workforce.

THE GOVERNMENT AND PARLIAMENTARIANS NEED TO:

- recognise that success depends on stable leadership and seek ways to support directors and develop talent at every level;
- ensure appropriate levels of funding for training and education;
- allow NHS providers to develop the roles of the future and set their staffing requirements according to clinical need; and
- act as a facilitator to reviewing national pay frameworks, in order to ensure activity and performance are fairly rewarded.

FUNDING

The NHS budget has remained broadly flat in real terms for five years, and the NHS provider sector has remained within its budget despite increasing demand and costs. But this is not a sustainable trend. In 2014/15, NHS providers project a deficit of at least £850 million despite significant additional support from the Department of Health to individual organisations and health economies. This means that performance targets (such as waiting times) are likely to be missed and consistent quality of care is at risk.¹⁵

NHS providers need to be paid a fair price for the services they are commissioned to deliver in order to sustain and invest in the quality of care that patients and taxpayers alike expect. While some savings could potentially still be realised – for example, from shared back office functions or more effective procurement – they wouldn't be sufficient to allow NHS providers to break even or to move to new care models.

The shortfall is exacerbated by NHS funding being confirmed annually. This creates uncertainties which make it harder to invest and increases transactional costs (as contracts need to be renegotiated each year), which overall diverts resources away from patient care and reduces value for money.

NHS providers are determined to transform to NHS and move to 21st century models of care which will safeguard both patient interests and the service's cost-effectiveness. Achieving this goal depends on an immediate stabilisation plan, including adequate funding and the ability to make better use of funding. This needs to be urgently addressed as the funding challenges that NHS providers are facing are mounting and the longer they are left, the harder they will be to correct.

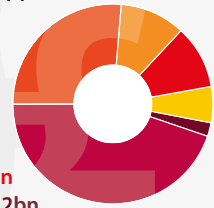
If the service achieves efficiency savings of 2-3 per cent (£22 billion) by 2020/21, the 5YFV sets out a best case scenario of an £8 billion funding gap.¹⁶ However, this depends on a well-planned and risk-managed approach, where the government works with the NHS to establish what can be done, what funding would be required, and what timescales would be realistic.

NHS providers then need the autonomy to work with their local partners and invest funding appropriately, being held accountable for the results.

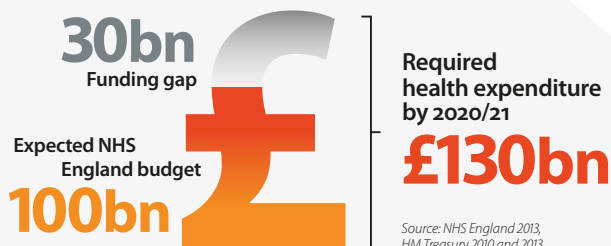
THE NHS BUDGET TODAY

Total budget for NHS England in 2013/14
£95.6 billion

Acute **£43bn**
Mental health **£10bn**
Community **£10bn**
Ambulance **£2bn**
Specialised services and primary care **£25.4bn**
Other **£5.6bn**



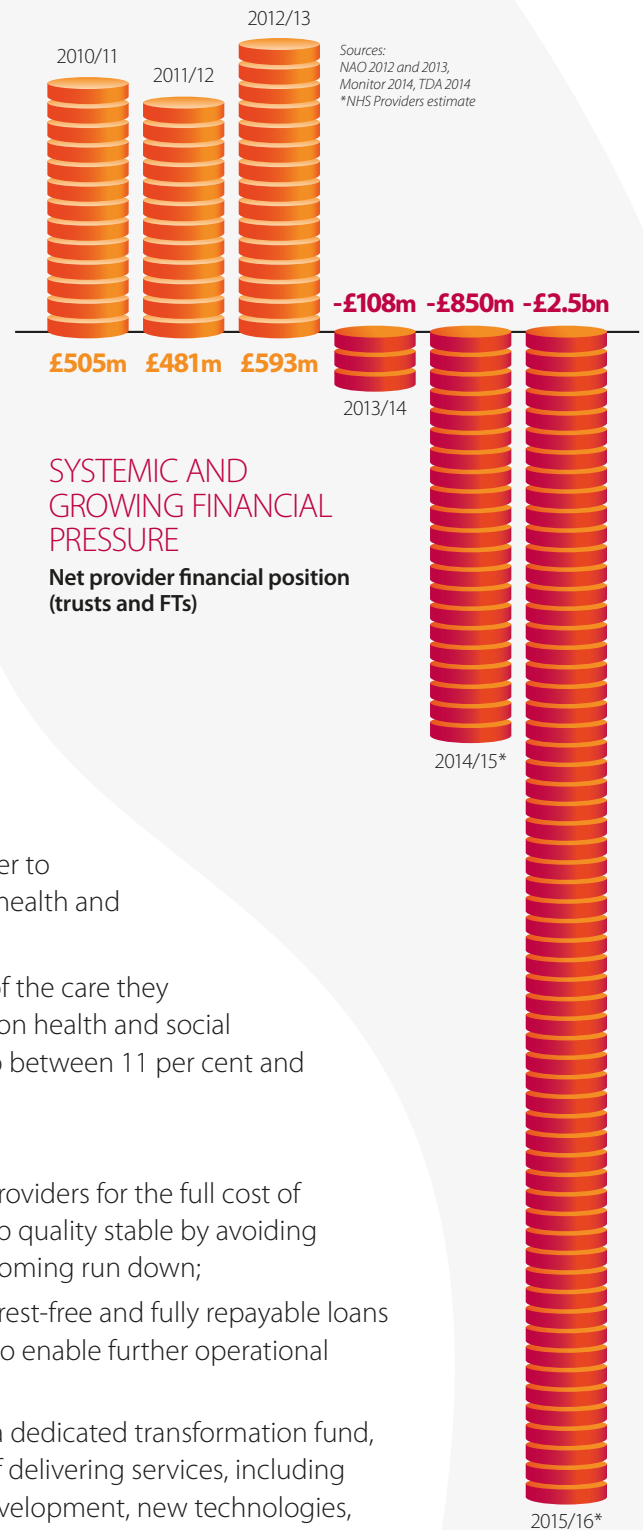
Source: NHS England 2013/14



Source: NHS England 2013, HM Treasury 2010 and 2013

THE MINIMUM FUNDING GAP FACING THE NHS

Since the formation of the NHS in 1948, health expenditure has increased by around **4%** annually in real terms. However, since 2010/11, government expenditure on health has increased at only **0.1%**. If this trend continues, and the NHS budget remains flat in real terms, this will have fundamental implications for provider sector finances and the care they are able to deliver to patients.



SYSTEMIC AND GROWING FINANCIAL PRESSURE

Net provider financial position (trusts and FTs)

THE GOVERNMENT AND PARLIAMENTARIANS NEED TO:

- commit to upholding the core values of the NHS;
- maintain the NHS ringfence, and ringfence social care funding in order to recognise the interaction between health and social care;
- pay NHS providers for the full cost of the care they deliver, increasing public spending on health and social care from its first spending round to between 11 per cent and 12 per cent of GDP by 2025;¹⁷
- enable NHS providers to:
 - invest to maintain – by paying providers for the full cost of the care they deliver, and so keep quality stable by avoiding infrastructure and resources becoming run down;
 - invest to save – by agreeing interest-free and fully repayable loans against business plans, in order to enable further operational efficiency savings; and
 - invest to improve – by creating a dedicated transformation fund, in order to enable better ways of delivering services, including through clinical research and development, new technologies, and new care models;
- create a mechanism (such as Office for Budget Responsibility for Health) for regular assessment of health and social care spending needs and the amount of tax this requires, as a means of generating a better public debate on these issues;
- create a multi-year settlement for the NHS in line with the parliamentary term.

REGULATION

Regulation gives public assurance that services meet agreed standards and can highlight areas for development. Regulators can sanction and check whether required improvements have been made, but they cannot directly improve quality of care on the ground. It is NHS providers themselves that use their clinical and organisational judgement to continuously improve patient care, identifying and responding to local needs while meeting national standards.

For these reasons, it is important that regulation is proportionate (avoid creating an excessive burden which distracts from providing care) and risk-based (focused on assuring the safety of care).

Regulatory intervention needs to be carried out with clear objectives to avoid contradictory requirements or duplication. For example, there have been instances where the CQC's requirement for some trusts to increase staffing levels – because of an understandable focus on enhancing care quality – has led to financial investigation and intervention by Monitor.

It is equally important that regulators focus on the particular needs of a local health system. It may be that issues are centred on a particular trust. Yet it may also be that the whole local NHS is struggling, with commissioners, providers and social services alike unable to balance meeting their community's needs with the current set of services and levels of funding.

Finally, regulation cannot be a substitute for local leadership and it cannot drive cultural change. It rightly remains the responsibility of NHS provider boards to lead their own improvement. Only then can they be held properly accountable for the results.

THE GOVERNMENT AND PARLIAMENTARIANS NEED TO:

- support the principles of good regulation as being independent, proportionate and risk-based;
- work with regulators to facilitate solutions where local health and social care services are collectively struggling;
- encourage regulators to:
 - work together to minimise their burden on NHS providers and avoid distracting from patient care; and
 - ensure their own value for money and the sustainability of the regulatory framework;
- facilitate improvement led by the NHS provider sector.

REGULATION OF NHS PROVIDERS

IN HEALTHCARE, REGULATION IS FUNDAMENTAL IN...

- Assuring patients and the public that agreed quality standards are met
- Giving NHS provider boards information to drive improvement
- Building confidence in the health and care system

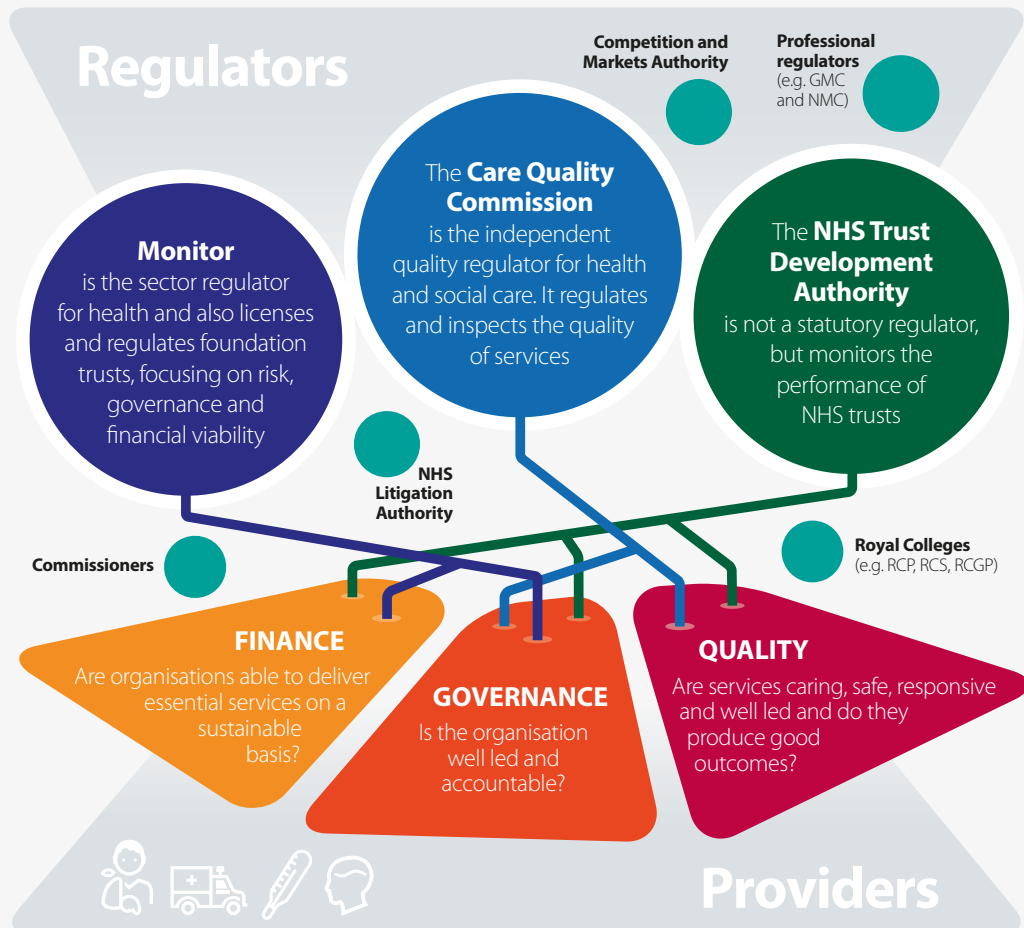


NHS PROVIDER BOARDS HAVE A KEY ROLE TO PLAY

- Showing strong local leadership and accountability, working with local partners and driving continuous improvement
- Encouraging learning cultures and empowering their staff
- Learning from each other through benchmarking and peer review

WHAT ARE THE ROLES OF THE MAIN BODIES REGULATING NHS PROVIDERS?

NHS providers operate within a complex regulatory framework. There are three main regulators of NHS foundation trusts and trusts, but many other bodies exercise regulatory or monitoring functions that also affect NHS providers.



HOW MUCH DOES REGULATION COST?

- The combined budget of Monitor, CQC and TDA (2014/15) is £232.8m – roughly equivalent to running the South Western Ambulance Service for one year (£225m)
- NHS providers and other regulated bodies also dedicate considerable resources to ensuring compliance with agreed standards

Sources: HSJ May 2014, SWASFT annual report 2013/14

HOW SHOULD REGULATION DEVELOP?



- 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

About NHS Providers

NHS Providers is the membership organisation for NHS foundation trusts and trusts. We represent every variety of trust, from large acute and specialist hospitals through to ambulance, community and mental health trusts.

We help our members to deliver high quality, patient focused, care by enabling them to learn from each other, acting as their public voice, developing evidence-based policy, and representing members with key stakeholders and policymakers.

We derive our strength from the scale, diversity, experience, expertise and effectiveness of our members, speaking with a united and uniquely informed voice on the issues that matter.

In the last Parliament, our work included:

- sustaining our focus on the unprecedented financial challenges facing NHS providers, and arguing for a realistic view of the level of funding required to maintain quality standards;
- representing our members on key implementation groups for the 5YFV, including the new models of care, workforce advisory and prevention boards;
- continuing our campaign for parity of esteem across acute, ambulance, community and mental health services, focusing on fair funding, specialised services and the roll out of new access targets for mental health.

We provide regular parliamentary briefings and submissions, and can also assist if you have any specific questions about our work or your local health services. For example:

- sharing data and analysis from our surveys of NHS providers;
- giving our view on topical health policy issues;
- helping to answer questions about health in your local area;
- introducing you to our networks – forums for NHS provider leaders to share ideas and meet senior healthcare leaders.

If you would like any further information, please:

- contact Ferelith Gaze, public affairs manager:
020 7304 6873, ferelith.gaze@nhsproviders.org
- see our website: www.nhsproviders.org

Endnotes

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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 focused, care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has 222 members – more than 93 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.



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