What do leaders want from NHS Improvement?
About this Viewpoint

Nuffield Trust Viewpoints provide a platform for UK and international health leaders to explore, discuss and debate critical health care reform issues.

In May 2015, the Secretary of State for Health announced that Monitor, the regulator of NHS foundation trusts, would merge with the Trust Development Authority, which oversees other trusts – under the oversight of a single chief executive. This single body, NHS Improvement, will have regulatory and oversight duties over all NHS providers.

This Viewpoint is published as the chief executive of the newly formed organisation takes up post, at a time when NHS trusts face historic financial pressure and an ambitious programme of change. The Nuffield Trust and NHS Providers asked leaders from across the health service and other key positions in health care policy-making for their advice to the first holder of this important position.

Each respondent was asked to set out some priority areas for the chief executive to focus on, and how they believe he or she could deliver real help to the NHS at this difficult time.

This Viewpoint forms part of the Nuffield Trust’s work programme on NHS reform. Our website brings together our research and analysis in this area at www.nuffieldtrust.org.uk/our-work/nhs-reform

Visit the publication webpage for additional materials related to this Viewpoint. The views expressed are the authors’ own, and do not necessarily represent those of the Nuffield Trust or NHS Providers.

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The new chief executive of NHS Improvement has a daunting task. They will be taking on a new role at a time when the finances of the provider sector are already in deep trouble. The Government and regulators have resorted to a range of measures to ‘improve’ NHS performance in this challenging context: letters telling providers to get a grip; tough talk on targets; headline-grabbing rows with the medical profession. These seem to suggest growing concern and uncertainty.

A leader stepping into such a demanding position might expect clarity about the purpose of the organisation, about the mandate that it has, and that there are well-understood relationships with external stakeholders. In this case, there is an urgent need to sort out these basics and get alignment between all the different NHS system leadership bodies, as well as successfully bringing together two different cultures. This has to be done at the same time as working out the long-term direction, where to focus and how change will be brought about.

To win credibility within the NHS and Whitehall, the immediate task for the new chief executive will be to gain control of the financial situation and establish discipline. This will require the ability to distinguish between the different reasons for organisations being in financial deficit – are there issues inside the organisation that need addressing, problems in the local health and social care economy or fundamental questions about the sustainability and viability of the whole system?

The NHS has not been very good at making this distinction to date, and it is far too early to judge the efficacy of the new success regime. But the response to provider problems needs to be based on such a diagnosis, to avoid the moral hazard and unfairness that can arise when those who are making progress or controlling finance feel that the system is subsidising failure elsewhere.

To a great extent the longer-term direction has been agreed by leaders in the NHS and Government, who have endorsed the Five Year Forward View, the efficiency targets it contains, and the assumptions it makes about reducing demand and new models of care. There are also associated policies such as seven-day services, the new cancer strategy and, no doubt, more ideas still in train – few with identified funding.
The question left unanswered is how these changes are to be brought into effect. Almost every tool in the policy-maker’s box has been used, refined and found to be wanting. Exhortation and threats have also been exhausted. With over 10 per cent of chief executive posts vacant and the majority of providers in deficit, the reality is that the usual sanctions will not be effective. This is now a system-wide problem affecting the significant majority of providers. And despite the good early progress of the Vanguard programme, it is unlikely that the Vanguards will develop models at sufficient speed, scale and success that can be replicated to make the required difference across the system within the lifetime of this Parliament. Their success will be realised in five to ten years, not three to five.

The absence of system leadership locally is a major issue. Regional tiers had some benefits in providing this leadership and there is a strong argument that the system now needs some form of ‘referee’ to unblock and enable where local participants cannot agree or make sufficient progress on their own. But a repeating problem is that past incarnations of these regional tiers have encouraged a belief in those who work in them that they can be helpful, or that because they appear to be above trust chief executives, they should tell them what to do. And of course, there are developments in terms of devolution which may or may not provide system leadership – these developments will present an interesting dynamic in the relationship with NHS Improvement’s leadership.

So, instead of trying for one last push as a heroic individual or returning to the bad old days of over-dominant strategic health authorities, the new chief executive must lead in a different way. Up until now, the behaviour of NHS regulators and governing bodies has seemed to reflect a certain underlying theory: that the way to improve performance is to directly tell people to make change happen, without specifying how it can be done, and then check up on whether they have done it...This is an ineffective method for achieving change.”
commissioners and providers as well as local and national leaders. It must bring clinicians in to share these aims and values – no successful change can take place without them, yet disengagement is a growing danger. It also needs a clear methodology that can be replicated at the local system level and right down to the clinical front line.

It will be the role of these leaders to deliver a large range of changes, from the transactional improvements in the Carter review to more fundamental changes such as those in the Five Year Forward View. They will also need to hold each other rigorously to account for both the changes and the new ways of behaving required. This community will only work if it is based on the principles of collaboration and partnership, not command and control. This will require urgent steps to align the multiple layers of regulation and to control the epidemic of assurance, which creates distraction and unhelpfully mixed messages.

There is, of course, a whole range of technical issues to be sorted out, including the system rules and architecture that are necessary to facilitate the change. These are well understood even if, as in the case of the unhelpful competition rules or the inappropriate failure regime, the answers are not.

One important lesson is the danger of being sucked into the Whitehall machine and losing focus on the front line. Successful trust chief executives seem to have the ability to create their own narrative instead of simply being the transmission mechanism for the centre. This is difficult at trust level, and doubly so for a national role with weekly conversations on the sofa at Richmond House. Being on speed dial from No. 11 or the Secretary of State is seductive, but hazardous. It is welcome that patient safety now has a good home in a relevant location but NHS Improvement needs to resist the tendency to pick up functions that are not central to its role.

Convincing and reassuring central leaders will, no doubt, help bring the new NHS Improvement chief executive closer to meeting their elusive but crucial goals. But, in the end, he or she must remain focused on the managers and professionals who have the power to actually deliver change. As the first contributor in this collection of essays puts it, “we need to be inspired…we are…1.3 million people, not a series of systems and processes”.
What do leaders want from NHS Improvement?
The year 2015 is a challenging time to be an NHS chief executive. The expectations of patients, families and staff are rightly high; the money available, and financial and regulatory flexibility to implement change, is low. Coupled with this, we cannot recruit or retain the workforce we need for the present, let alone the future – and there is organisation after organisation whose reason for existence is to hold up a scorecard to tell us how we are getting on.

So, what do we need from the chief executive of NHS Improvement to help us deliver even better services for our populations against these challenges?

First, we need to be inspired: inspired by someone who cares about patients, families and staff, but also who cares about us as chief executives, and wants to support us to do a better job. Just like everyone else, we work better when we feel valued. This has been starkly absent over recent years.

Second, we need a plan for the money. We all know there is little additional cash – and pretending this is not the case represents a highway to nowhere. What will the tariff/funding arrangements look like going forward? How will existing debt be restructured in a sustainable way? How will we access much-needed capital? ‘There is no money’ is not a responsible answer.

Third, we need to move away from the rigid organisational forms that are constraining us. Is the foundation trust model the right one for 2015? Can we instead be allowed to re-shape and re-form at pace, by a process that supports rather than overwhelms us, especially when it is clearly the right thing to do?

Fourth, the regulatory frameworks should be aligned. We need one definition of what ‘good’ looks like, and to be held to account for that. At the moment, no chief executive really knows the ‘rules of the game’.

Fifth, and most important of all, we need someone who believes in the NHS, and who we believe can lead us out of the most difficult position in our history. Someone with vision, passion and drive, but also the ability to turn plans into actions, and surround themselves with deliverers who can make things happen at speed.
The year 2015 is also an amazing time to be an NHS chief executive. Patients and families are more willing than ever to participate in their own care and ensure they keep fit and well. Our staff are some of the best in the world and they never give up or in. Every day is a ‘going the extra mile’ day. Whoever gains the privilege of becoming chief executive of NHS Improvement needs to recognise that we are an organisation of 1.3 million people – not a series of systems and processes – and, when all is said and done, there is more to cherish and maintain than there is that needs to change.

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With the establishment of NHS Improvement there is a real opportunity to enhance the way in which clinical commissioning groups (CCGs) and the regulator work together. CCGs across the country are developing innovative new ways to transform their local health economy and bring significant improvements to the health and wellbeing of people in their area. A regulator that supports rather than stifles innovation will be key to enabling them to do this. With this in mind, we hope the new chief executive will focus on the following priorities.

First, it is crucial that the new organisation hits the ground running. Decisions over new internal structures and processes cannot be allowed to take precedence over determining pressing issues, such as the 2016/17 tariff which impacts on the whole of the health system.

Second, we would like to see a culture shift in the way that the new regulator works with CCGs. At times, some CCGs felt that Monitor and the Trust Development Authority were reluctant to engage directly with them. This leads to the danger of the local element being missed out of the regulatory process – something that CCGs, now firmly established in their local areas, are well placed to provide. While in theory there is clear recognition that local leadership is crucial, this is often at odds with how it feels on the ground. There is a chance to change this with the new organisation.

Third, we hope that NHS Improvement will adapt and keep pace with the way that commissioning is evolving and the new models of care that are being developed. CCGs are not just looking to invest in the conventional models of care but instead are looking to find innovative new ways to transform health care for the benefit of people in their area – something that is strongly encouraged by the Five Year Forward View. These changes create a challenge for regulators, meaning that they need to move from the traditional focus on the performance of just one organisation, to looking across a whole system of health care provision instead. If the new regulator is unable to keep pace and instead insists on sticking to the status quo, then CCGs will not be able to achieve the transformational change that they are aiming for to improve the health and wellbeing of their local population.
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Finally, the new chief executive should ensure that NHS Improvement aligns itself with the Care Quality Commission and NHS England. In this way, CCGs will be able to receive a consistent opinion from regulators rather than a multitude of sometimes conflicting and confusing views.

CCGs recognise that regulation is important – but if the vision set out by the Five Year Forward View is to be realised, it must be flexible and support innovation and new ways of working. We hope that this will be the case under the newly formed NHS Improvement.
Among the many abilities that the first chief executive of the new NHS Improvement needs to possess, high-level leadership skills will be paramount. This is not just about having the respect of system organisations (important as that is) – it is the ability to understand the complex nature of the job and to command confidence among multiple partners and commentators.

This individual heads a new organisation working with foundation trusts, which are, or should be, largely self-regulating sovereign boards, and also with NHS trust providers, which operate in a different statutory framework. It will be a question of judgment as to how NHS Improvement can simultaneously respect the sovereignty of foundation trust boards while also helping boards from the trusts of the Trust Development Authority to self-regulate.

This will require high-level system leadership thinking and the ability to embed a culture and approach throughout NHS Improvement that demonstrably values and encourages systems working alongside personal accountability. The diversity of the remit will require leadership by consent, not by command.

Developing a positive culture in any new organisation is difficult and requires time and close attention. Merging two distinct existing organisational cultures within the current financial and operational context adds additional complexity. The risk is a rapid dive to a default – the lowest common denominator ‘just do it’ performance management approach. Improvement science is clear: sustained improvement and transformation is deliberative, thoughtful and collaborative; it is a journey, not a brisk walk in the park. Testing, evaluating and amending new approaches does not have to be a long, slow process but it is essential for ensuring success and rapid spread.

For NHS Improvement to be effective, the relationship with NHS England will be critical. Until they, and we, are clear how that will work and how both bodies will work separately and together on system-wide management, the pace of improvement and change will be constrained. Since 2012, we have collectively offered commentary on why things do not work and the barriers to effective system change. These impediments to change are
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something that everybody can describe, but, thus far, a sophisticated game of ‘pass the parcel’ has been played. We need to move beyond triplicate or duplicate signatures on letters towards role modelling of genuinely collaborative leadership.

The next six months will be critical for shaping the approach to the future. There is a big risk that bureaucracy, regulatory creep and demonstrating how the various arm’s length bodies have ‘grip’ on their constituents will set the wrong tone for the work that needs to be done. The context, problem and strategic direction are well articulated and the focus must now be on building an honest and credible delivery plan. This may mean having the courage to start a debate about whether current ‘no go areas’ should be opened up for discussion. Starting a transformational change conversation by listing what is beyond consideration is not a good place to start.

Building confidence at the local level is critical to sustainable improvement. To have any chance of success, NHS Improvement must work collaboratively with other organisations within and beyond traditional NHS boundaries. There is a mutuality that underpins success. Whatever statutory frameworks organisations are regulated within, boards and accountable officers are required to deliver the best solution for service users of the organisations they lead. This cannot be at the expense of the best solution for the people and communities they serve.

The Five Year Forward View sets the vision – we now need to get on with the job.
What do leaders want from NHS Improvement?

Jeremy Hunt’s announcement that he would appoint a single management team to take responsibility for Monitor and the Trust Development Authority set the ball rolling. But it left all the difficult questions unanswered.

How will the new team work? What will it do? Will it be a regulator? A system manager? A funder? On what terms? How will it relate to provider organisations? What is the future of the distinction between NHS trusts and foundation trusts? Will it seek legislative change?

These are key questions which will shape future relationships throughout the health and care system – but the new team will have no choice but to answer them at the outset. Rising demand and growing deficits mean that there will simply not be time for quiet policy analysis; the new structures will be conceived in the crucible of crisis management.

Against this background, decision-makers will need to be clear about what is important.

First, NHS providers need to be better at changing their services and working with each other as well as third-party organisations to deliver joined-up care. This doesn’t mean a frenzy of structural change; it means a relentless focus on the needs of service users. In particular, it means connecting providers of the health care, social care, housing and other services that shape people’s lives.

Second, NHS providers need to be more respectful of the opinions and priorities of individual users and collective commissioners who will increasingly look beyond the narrow confines of health care in their quest for better health outcomes.

Third, the new team needs to decide whether they are an improvement agency, a market regulator, or a provider regulator. There is an unreconciled conflict between these functions at the heart of the current legislation which creates unnecessary cost and confusion and needs to be resolved.

Fourth, the new team also needs to decide whether to maintain the distinction between NHS trusts and NHS foundation trusts. Despite rhetoric suggesting otherwise, the recent reality has been a
trend towards disempowerment of local management of all kinds within the NHS. This is a trend which needs to be reversed.

Fifth, while no-one actively seeks new legislation, it seems likely that the new team will conclude that some of the inherited structures are simply not fit for purpose. If that happens, it is important that ministers address the issue head on – rather than relying on workarounds and inertia which undermine both efficiency and goodwill.

Most importantly, the new team will need to show quickly that its primary focus is genuine service improvement. It is widely believed by both service users and professional staff that their interests have too often been the victim of a political fudge.

Access to high-quality care services is inherently political, but management of the services themselves is not. NHS Improvement should be driven by a desire to ensure that services are shaped by the real needs and demands of those who rely on them.
Hello! I hear you are heading a new quango formed out of two other quangos that few people have ever heard of. Why should I care?

Sorry, that was a bit rude. What I mean is, how will NHS Improvement make a difference that will be noticed by patients and families? How will you improve things? It’s not obvious, is it?

I could never really understand the point of Monitor. And I couldn’t see why your regulator depended on whether or not you’re a foundation trust. I understand why it might make sense to merge Monitor and the Trust Development Authority. But what is the gap your new organisation is supposed to fill?

There are many other national bodies out there, designing the system of services, setting standards, inspecting and regulating, training staff and so forth. There are all the regulators policing doctors and nurses and so on. There are all the Royal Colleges, think tanks and consultants doing leadership and improvement. There are the Vanguards and other demonstrators trying out new models of care. And aren’t all the trusts, GP practices and CCGs supposed to be continually improving things?

So I sympathise with you, inheriting this muddle! Can I give you a piece of advice? I would say your main priority should be: **insist on a really clear and simple mandate.** Don’t be an empire builder. The more you have to do, the more likely it will either duplicate or get in the way of what others are doing.

Do you mind if I go on? I have four other bits of advice, if it’s not too presumptuous. The second thing is: **once you have a clear brief from the powers that be, communicate it really clearly to everyone.** And remember, if you can’t explain your job very simply to your children or your mum, then you have to wonder why you are doing it.

Third, **ground everything your organisation does in what matters to the people who use the services.** Build that in to what you try to improve, how you find things out, how you work with trusts and local communities, and how you measure things. Ask yourself every day: what have I done that has made a difference for people and communities?
“Ground everything your organisation does in what matters to the people who use the services. Build that in to what you try to improve, how you find things out, how you work with trusts and local communities, and how you measure things.”

Fourth, work very closely with your colleagues in all those other regulators and national bodies. You all need to be pulling together and you should be adding value to what they are doing.

And finally, please be very careful with the funds you get from me and the other taxpayers. Money is tight. I want as much of it as possible spent on front-line services. You don't need an army of civil servants. There's lots of expertise you can draw on from outside – not least from us citizens. And there's lots of stuff you can probably share with the other regulators.

That's enough from me. Good luck!
NHS Improvement starts work at a crucial time for the community health and care sector. Traditionally, it is one of the most innovative parts of the NHS, working creatively with primary care, acute trusts and other health and care providers to glue together services so that they really work for the people they care for.

Community trusts have embraced the Five Year Forward View as a ringing endorsement of their approach, and the sector continues to innovate to make this a reality despite the uncertainty inherent in developing locality-specific new models of care in partnership with other health and care bodies. As trusts are sailing through this new sea of opportunity, risk and uncertainty, their regulators, including NHS Improvement, will need to adjust their compasses a little to take account of the complexity of change taking place across local health economies.

From the community trust perspective, the five key priorities for the new chief executive should therefore be as follows:

- **To take the time to understand community trusts and how they contribute to place-based population health and wellbeing.** They differ from acute trusts in how they operate and the diversity of services they provide – many adult services already run 24 hours a day, every day, and involve a range of different contracting arrangements and payment mechanisms.

- **In a rapidly changing landscape, NHS Improvement needs to take a more flexible approach to organisational form and trusts’ five-year plans.** The ‘big is beautiful’ isolationist foundation trust is not always going to be the way forward for community trusts and, as new models of care are developing, they may not be compatible with the traditional foundation trust tests.

- **To acknowledge and support a move towards capitated budgets in community health care** and adjust its approach to financial risk to take account of this. There also needs to be a more flexible approach to governance and risk to reflect the different organisational partnerships and joint ventures that community trusts will form.
“The ‘big is beautiful’ isolationist foundation trust is not always going to be the way forward for community trusts...as new models of care are developing.”

• In setting stretch targets for trusts, NHS Improvement should recognise that an increasingly important part of community trusts’ budgets come from local authority public health commissioning, which is also subject to cost reductions that impact directly on providers.

• As more care moves out of hospitals and into the community and trusts are thinking ‘whole system’, so should their regulators. NHS Improvement should develop an approach to performance that looks at system-wide service delivery and focuses less on traditional acute trust measures (payment mechanisms, service delivery models, workforce and key performance indicators). NHS Improvement should work closely with other national bodies such as the Care Quality Commission and take account of their assessments to obtain a rounded view of trust performance.

The key message to NHS Improvement must be to use the opportunity of the two organisations coming together to think creatively about how best to support trusts in achieving improvements for patients as well as holding them to account.
Becoming chief executive of a new organisation is exciting and challenging. For the new chief executive of NHS Improvement, though, the challenge is doubled as two existing organisations are brought together. Perhaps the most important role will be to see beyond the health system we have now, to a new future where transformation and integrated care is seen as the norm. This will require better funding systems and local collaborations that support, not stymie, seamless patient pathways and joined-up services. A light touch and supportive regulator is essential to this in order to remove barriers while maintaining high standards of clinical care.

That vision will be carried through in the new chief executive’s relationships with other key health service organisations and stakeholders as they forge new partnerships to improve health. Crucially, the Royal College of Physicians would like to see a strong clinical voice running through everything that the merged Monitor and Trust Development Authority do. The new chief executive must value and respond to that voice: the involvement and engagement of clinical leaders is critical if the newly merged regulator is to truly drive improvement at every level of the health service.

In addition, there are a number of specific requests that we set out in our recent report *Putting the pieces together: removing the barriers to excellent patient care*:

- The regulator must help **dismantle the barriers to joined-up care**.
- The regulator should **empower and incentivise local health economics to plan for the long term**. Only then will the NHS be sustainable in the long term. Five-year rolling funding settlements, multi-annual tariff arrangements and longer-term contracts must be standard practice.
- The regulator should **clarify competition and procurement regulations** so that competition can be an effective lever for driving up quality in patient care. We must enable commissioners and providers to prioritise the quality of the care that they deliver over and above all else – including competition. That means they must be incentivised to collaborate for better quality.
“We need a new payment model that enables local health economies to use their collective resources flexibly to deliver care in the right place, at the right time, to meet the needs of local people.”

- Working with NHS England, the regulator should **scale up its work to improve NHS payment systems**. We need a new payment model that enables local health economies to use their collective resources flexibly to deliver care in the right place, at the right time, to meet the needs of local people. Perverse incentives must be removed. Funding systems must not be a barrier to joined-up care. Tariffs must be made fit for purpose.

The new chief executive will have a fantastic opportunity to influence the quality of health care throughout the country by turning these challenges into practical improvement. Whoever it is will have our support and encouragement to do so, and we wish them well and look forward to working with them.
It is very difficult to find words of encouragement about the merger of Monitor and the NHS Trust Development Authority, except to say there will be one fewer dysfunctional organisation in a wholly dysfunctional system.

Sadly for patients, the NHS is lurching from crisis to crisis as performance slips, finances worsen and the Lansley regulated market/competition model is increasingly ignored. It has left a huge vacuum with little system leadership and precious little common sense. Certainly, these two organisations have little to be proud of.

In principle, their roles were similar: ensuring NHS provider organisations were clinically and financially sustainable. The record of both organisations has been dismal. It is hard to think of any ‘success’ they have had. Most insiders believe they just make things worse. The usual tactics of blaming and shaming a struggling organisation and sending in highly paid consultants has not worked.

To be fair, they were faced with the impossibility of reconciling safety priorities and high-quality care with financial responsibility, performance targets and growing population pressures. However, given that backdrop, struggling organisations were surely entitled to expect some support, or at least sympathy from these hugely expensive quangos that, it was assumed, had all the answers.

Instead of support, organisations were offered a culture of impossible demands, incredibly short-term expectations and overbearing and hostile interventions from very well-paid ‘experts’ who often actually had very limited experience of direct operational management. The difficult situation descended into farce when Monitor set out to police the use of agency staff by employing temporary staff.

The suggestion is that this new NHS Improvement body will be fundamentally different. It will bring support to achieve success instead of presiding over failure and exit – highly anti-competitive! It will not merely look at individual NHS organisations in isolation; it will have to look at a wider picture across a wider area, although there is no mechanism with which to do this. It will also look at
system issues such as commissioning and regulation – again, way outside its obvious remit.

This is all very sensible, and a major departure, but there is very little indication that the new body will change, though clearly its new Chairman, Ed Smith, is nobody’s pushover and I am well aware of the excellent things he has done at the University of Birmingham.

It is dispiriting that this merger essentially marks the end of the NHS foundation trust movement. The aim of some degree of financial independence has been lost in the queue for bailouts; the attempt to have stakeholder governance and organisations much closer to local communities has been overtaken by the return of strong top-down direction.

This is surely the wrong direction to go. We need greater links into communities. All NHS providers should have the foundation trust stakeholder governance model, accepting varying degrees of earned autonomy as necessary. Monitor proved to be a useless advocate for the idea of local governance; it hardly acknowledged governors at all. Instead, it was obsessed with market ideology.

Ultimately, the merger of Monitor and the NHS Trust Development Authority evidences the bizarre world we live in, where ministers are micromanaging the NHS within a context of market-orientated legislation. I suspect this new organisation will not be with us for long!

“The aim of some degree of financial independence has been lost in the queue for bailouts; the attempt to have stakeholder governance and organisations much closer to local communities has been overtaken by the return of strong top-down direction.”
The key challenges and opportunities in the current health landscape are well known. However, there are some specific issues that present significant threats and opportunities to the aim of redesigning the architecture of the health care system. The new chief executive of NHS Improvement should give priority to the following issues when creating an organisation fit for the next generation of health care provision.

A major priority must be setting out the scope and limits of NHS Improvement. This will require a major external influencing operation. The most significant element of this is building consensus among politicians and policy-makers – alongside other national bodies, including local government and, ultimately, the public – around the development of a long-term strategy for health.

Another organisation dealing with short-term political imperatives in health care delivery (very often driven by short-term crises in the acute sector) will confound the rationale and will miss the opportunity to do something transformational. Building a mandate to act based on health need rather than political expediency should be a major priority for the post holder. As part of this, the regulatory regime should be proportionate and effective, not politically expedient. A regime which is permissive and tolerates appropriate risk is important. Strong relations with Simon Stevens (NHS England Chief Executive) and the Secretary of State for Health are vital. Another pivotal partner will clearly be the Care Quality Commission. In this case it is imperative that the role and function of each organisation is both absolutely clear and also consistent with the creation of a rational, understandable system of regulation which does not lead to duplication or conflict of priorities.

A second priority must be to establish a credible financial plan for transition. The need for reconfiguration and improvement of major estates in order to enable more efficient and productive health care is significant – particularly the need to expand and rebuild some acute hospitals, close others and develop community and primary care premises fit to support new community-facing models. The need for double-running and development costs to support current clinical models of care while ushering in new models is paramount. The evidence that the current financial model will avoid collapse in certain localities is unconvincing. This needs urgent attention.
Third, and linked to the above, there is a great deal of organisational posturing across the landscape in relation to supremacy, takeover, fighting for survival and so on. **Agreeing a framework by which some stability can be brought to the provider landscape is important.** While obsessing with organisational form, we avoid giving vital attention to the development of models of care. This should include building better models of prevention and self-care which are essential for achieving better population health outcomes and a financially sustainable future. This is yet another reason to avoid succumbing to the immediacy of the acute challenge at the expense of primary and community care. Partnership working, understanding inherent weaknesses in integrated pathways and engineering them out at scale are critical in a transforming health system. Merely developing acute-led accountable care organisations (which appears to be a popular narrative) will not address these important issues or build improved capabilities.

**Getting to grips with mental health should be a major priority** for the new chief executive. The extent to which institutional blindness remains around the issue is unacceptable from both an equality perspective and, more importantly, from a financial perspective. Days lost at work, outcomes in cancer, cardiac care and other major illnesses are significantly enhanced by better mental health. One in four hospital beds is used inappropriately caring for people with a primary mental health problem such as depression and dementia. A&E attendances have a very significant self-harm population, not to mention frequent attenders who have long-term conditions such as COPD. The development of world class mental health care for those with major mental health problems should be as much of a goal as world class stroke services. Policy, regulation, tariffs and transitional funding need to take mental health into consideration from the outset rather than undertaking to ‘get to it next’.

Fifth, the chief executive needs to **act fast to influence the removal of barriers to innovation.** The commissioning landscape is a major barrier inasmuch as its fragmentation across public health, primary care, specialised services and CCG commissioning mitigates against the flow of money across the clinical pathway, which in turn inhibits innovation and efficiency.

I wish him or her the very best of luck.
Nuffield Trust is an independent health charity. We aim to improve the quality of health care in the UK by providing evidence-based research and analysis and informing and generating debate.