No extra money for NHS, Theresa May tells health chief

theguardian.com/politics/2016/oct/14/no-extra-money-for-nhs-theresa-may-tells-health-chief

Denis Campbell 10/14/2016

Theresa May has told the head of the NHS that it will get no extra money despite rapidly escalating problems that led to warnings this week that hospitals are close to breaking point.

The prime minister dashed any hopes of a cash boost in next month's autumn statement when she met Simon Stevens, the chief executive of NHS England, senior NHS sources have told the Guardian. Instead she told him last month that the NHS should urgently focus on making efficiencies to fill the £22bn hole in its finances and not publicly seek more than the "£10bn extra" that ministers insist they have already pledged to provide during this parliament.

She told him the NHS could learn from the painful cuts to the Home Office and Ministry of Defence budgets that she and Philip Hammond, the chancellor, had overseen when they were in charge of those departments, according to senior figures in the NHS who were given an account of the discussion.

Senior Whitehall sources have confirmed that Hammond's statement on 23 November will contain no new money for the NHS, despite increasingly vocal pleas from key NHS organisations and the public's expectation of extra health spending if Britain voted to leave the EU.

NHS Providers, which represents 238 NHS trusts, last week accused ministers of perpetuating "a bit of a fantasy world" on how well the NHS is doing after the worst-ever performance figures for key waiting time targets for A&E care, planned hospital operations and cancer treatments led to warnings that it was starting to buckle under the strain of unprecedented demand.

Health experts warned that the NHS would have to ration treatment, shut hospital units and cut staff if it gets no extra money soon.

Nigel Edwards, chief executive of the Nuffield Trust health thinktank, said: "If the government has firmly decided not to revisit NHS funding, this underlines that the health service faces four very difficult years. In particular, balancing the books in 2018 and 2019 when funding will flatline looks all but impossible with the current level of services.

"If more money from tax or borrowing is ruled out, the only choices left may be even less attractive, including reducing access and services, closures and reductions in staff," he said.

Jeremy Hunt, the health secretary, and Jim Mackey, the chief executive of the health service's financial regulator, NHS Improvement, also attended the 8 September meeting, which was Stevens' and Mackey's first encounter with the prime minister.

"No 10's message at the meeting was quite blunt and stark, that there will be no more money. Theresa May and Philip Hammond say that they presided over big efficiency programmes at the Home Office and MoD and didn't whinge about it. Their view is that the NHS is already doing very well, but that's head in the sand stuff," said one NHS insider who was among those briefed on the meeting.

NHS leaders privately fear that May's remarks indicate that she will be much tougher on the service's pleas for more cash than David Cameron and does not appear to appreciate the extent of its deepening problems. She is said to be sympathetic to the view of many senior Treasury officials that, as one NHS source put it, "always giving the NHS more money is throwing good money after bad, like pouring water on to sand".

May's stance raises questions over the future of Stevens, who is preparing to give evidence on the NHS's finances to the Commons health select committee on Tuesday. The NHS boss, who had a close relationship with Cameron and George Osborne, has recently irritated No 10 by publicly questioning the accuracy of the

government's claim – which May repeated at prime minister's questions on Wednesday – that the NHS will receive £10bn extra by 2020.

He told the public accounts committee last month: "The government would record it as £10bn. The health committee recorded it a little differently. There is an apples and pears issue there."

Stevens has welcomed the fact that the £8bn boost Osborne pledged during last year's general election campaign was "frontloaded" to give the NHS £3.8bn more this year, a rise of 1.7%, as he had requested. But he highlighted that the service had not got the sums it needed for 2017-18, 2018-19 and 2019-20. On current plans, it is due to receive increases of just 0.6%, 0.2% and 0.1% respectively, even though demand for core NHS services such as A&E care is rising at 3% or 4% a year.

Chris Ham, chief executive of The King's Fund thinktank, said that any policy of providing no more money was unwise, "simply not credible" and would threaten standards of NHS care. "If these accounts are true, then it is clear that Downing Street does not yet fully understand the impact on patients of the huge pressures facing the NHS.

"The view from the top of government appears to be that the NHS has been given the extra money it asked for and should deliver what is expected of it. But this misses the point that demand for services is rising rapidly and the NHS is managing with the lowest funding increases in its history," he said.

A Downing Street spokesman said he could not comment on what May, Stevens and Mackey had discussed because it had been a private meeting .

NHS

Doctors accuse Tories of deception over 'extra £10bn for NHS' claim

Government used accounting tricks to give impression of support but budget will only be up by £4.5bn by 2020-21, BMA claims

Jeremy Hunt, the health secretary. Government is leaving patient care underfunded, union says. Photograph: Tom Nicholson/Rex/Shutterstock

Denis Campbell Health policy editor

Monday 21 March 2016 00.01 GMT

This article is **7 months old**

Doctors' leaders have accused the Conservatives of deceiving the public by giving the NHS less than half the extra £10bn ministers regularly cite as proof of their support for the service.

The government has used a series of accounting tricks to wrongly give the impression of generous backing when in reality it is leaving patient care underfunded and refusing to face up to the NHS's deepening financial crisis, a report from the British Medical Association claims.

Former Lib Dem minister David Laws said on Sunday that Downing Street dismissed the NHS boss Simon Stevens's bid for the £15bn-£16bn more he believed the NHS needed as "mad" and unaffordable and told him to make do with much less instead.

The BMA has joined the row over the integrity of the government's approach to NHS spending with a highly critical analysis of persistent claims made and figures cited by ministers including David Cameron, George Osborne and the health secretary, Jeremy Hunt.

The doctors' union points out that the Department of Health's budget to fund health in England will only have gone up by £4.5bn by 2020-21 compared to the current financial year, well below the £10bn extra the government has pledged to increase it by.

"This continued and repeated misuse of figures is nothing more than a political deception that is damaging to the long-term future of the NHS," Dr Mark Porter, the BMA's chair of council, told the Guardian. Its report seeks to expose what it calls a worrying "mismatch between the cosy political rhetoric and the practical reality of an NHS facing an unprecedented funding crisis".

Dr Mark Porter, head of the BMA. Photograph: Frank Baron for the Guardian

Warning that quality of care could suffer because of disguised underfunding, Porter said: "The government's promise to inject an extra £10bn into the health service will actually see less than half of that amount reach frontline services, with the rest diverted into what the chancellor describes as 'Whitehall budgets', such as the National Institute for health and Care Excellence (Nice).

"This leaves resources for patient care well below the £8bn demanded by the NHS Five Year Forward View to sustain effective patient care." NHS England recently posted its worst performance statistics against its key treatment waiting time targets and there are

growing concerns that care is being compromised due to money problems, understaffing and relentless demand.

The BMA bases its claim on joint projections by the King's Fund, Nuffield Trust and Health Foundation thinktanks. They found that Osborne's spending review last November means that the Department of Health's budget will rise by just £4.5bn during this parliament – to £120.9bn by 2020 – but that NHS England's share of it to pay for frontline services will go up by £7.6bn to £108.9bn.

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The increase share is due to a £3bn cut over that time to other parts of the NHS budget, such as funding for Nice, the Care Quality Commission and training and education of nurses, doctors and midwives. Critics have accused minsters of "robbing Peter to pay Paul".

The BMA calls the reallocation of the department's budget "incredibly shortsighted". It warned: "Budget cuts in all of these areas will results in increased costs for the NHS and the taxpayer in the future."

In a key moment in last year's general election campaign Osborne pledged that if re-elected the Tories would increase NHS funding by £8bn by 2020-21. Ministers have since added last year's £2bn rise in the Department of Health's budget to that and claimed to be giving the NHS even more than it had asked for even though Stevens's bid for extra funding was for the five years of this parliament.

In his new book about the coalition, Laws claims that Stevens made clear to Downing Street his view that the NHS needed an extra £15bn or £16bn over that period in order to keep running smoothly while also transforming how it cares for patients.

However, Laws writes, in extracts serialised in the Mail on Sunday: "No 10's reaction was: 'You've got to be joking.' Stevens was told there was no way the PM and chancellor would sign up to an 'impossible and excessive' commitment this size. He was told: 'Get it down to a more deliverable sum.'"

The Five Year Forward View – Stevens's blueprint to reshape the NHS and close the £30bn gap in its funding expected to have emerged by 2020-21 – was published in October 2014. Stevens indicated that the service could cope with an £8bn rise and would find £22bn of efficiency savings. Laws claims that was because Downing Street had made clear to him that any more than £8bn would be unacceptable to them.

There is little hope that

It is an open secret at NHS England that its leadership – Stevens and other key figures, including

the NHS can avoid a financial crash

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the chairman, Prof Sir Malcolm Grant, and the medical director, Prof Sir Bruce Keogh – think the £8bn is far too little and that the £22bn savings target is unachievable.

NHS England sought to limit the impact of Laws's disclosures by maintaining that it stood by its belief, stated in 2014, that the service "would need in the range of £8bn to £21bn real terms annual growth by 2020". It denied that Stevens had been subjected to political pressure.

"We stand by this analysis and were not 'leant on'. David Laws was not part of these discussions, and has no first hand knowledge of them," a spokeswoman said.

The BMA also accused ministers of not providing additional funding to pay for the seven-day NHS they want to create by 2020 and of repacking monies it has announced for technology, mental health and GP services to give the impression that it is additional to the £10bn.

Heidi Alexander, Labour's shadow health secretary, said: "It's clear David Cameron isn't being straight with the public about the state of the NHS's finances and his promise of extra funding has completely unravelled. Money earmarked to improve patient care is instead being sucked into repairing hospital deficits and paying for extra pension costs."

A Department of Health spokesman rejected the BMA's report as "misleading". He said: "We are committed to the NHS and absolutely clear the £10bn we've promised is being made available to NHS England for frontline patient care, not 'Whitehall budgets'. This is much more than the funding the NHS called for in its own plan for the future."

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David Laws

Conservatives' pledge to protect NHS 'entirely disingenuous'

David Laws' book says the promised £8bn-a-year was half the figure Downing Street had been told was needed

David Laws on the BBC's Andrew Marr Show on Sunday. He said No 10 'leaned on' NHS England to accept the £8bn figure. Photograph: Jeff Overs/BBC/PA

Peter Walker and **Denis Campbell**

Sunday 20 March 2016 13.34 GMT

This article is **7 months old**

The Conservatives' key pre-election pledge to protect the NHS with £8bn extra spending a year was entirely disingenuous as the government had been told the service required at least double that amount to keep going, according to a book by a former minister.

Downing Street was informed by an official report that to stay afloat the NHS would need £16bn a year extra in government spending above inflation by 2020, but dismissed this as "mad" and ordered the figure to be halved, according to David Laws.

The book by the former Lib Dem MP, who was chief secretary to the Treasury for little over a fortnight in 2010 before resigning over wrongly claiming £40,000 in expenses and was later a junior minister in the coalition, is being serialised in the Mail on Sunday.

The £8bn a year pledge was a primary plank of the Conservatives' 2015 election campaign, and designed to ward off Labour claims that the party could not be trusted to properly fund the health service. The figure was explained at the time as being arrived at after a report by Simon Stevens, the chief executive of NHS England, found there would be a £30bn a year funding gap for the service by the end of the decade. Stevens said this could be made up from £22bn a year in efficiency savings, leaving £8bn a year for the government to make up.

But Laws' book reportedly explains: "Stevens' original estimate was that the NHS needed £15-16bn extra [from the government]. No 10's reaction was, 'You've got to be joking.'

"Stevens was told there was no way the PM and chancellor would sign up to an 'impossible and excessive' commitment this size. He was told, 'Get it down to a more deliverable sum.'"

According to the book, this pressure resulted in the supposed possible efficiency savings increased to "totally unrealistic" levels.

Laws added: "The Stevens report was changed for cynical political expediency. I am not blaming Stevens: he was put under huge pressure."

This sleight of hand was not highlighted by the Lib Dems at the time because Nick Clegg discovered "the fiddle" some time after the Stevens report was published, Laws said, by which time countering the £8bn-a year-figure would have caused confusion and a major row.

NHS England denied on Sunday it had been "leaned on" to accept the £8bn figure, but indicated that it might press for that sum to be revisited and increased before the 2020 general election.

A spokeswoman said: "The NHS five-year forward view in October 2014 clearly and independently said that the NHS would need in the range of £8bn-£21bn real-terms annual growth by 2020, depending on levels of efficiency, capital investment and transformational funding. We stand by this analysis and were not 'leaned on'. David Laws was not part of these discussions, and has no first-hand knowledge of them."

The NHS spokeswoman added: Stevens had been more vocal than any of his predecessors in arguing the case publicly for extra investment in the NHS and the service is "going hammer and tongs" to make itself as efficient as possible.

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Treasury chief secretary David Laws to repay £40,000 expenses

- Lib Dem 'hatchet man' David Laws apologises
- Newspaper reveals rent claim paid to partner
- Laws facing calls to step down from Treasury role

David Laws: ‘My motive throughout has not been to maximise profit but to protect our privacy’ Photograph: Guardian/Martin Argles

Patrick Wintour, political editor

Saturday 29 May 2010 12.06 BST

This article is **6 years old**

The chief secretary to the Treasury, David Laws, is fighting for his political life after agreeing to pay back £40,000 in expenses he claimed to pay rent on a room in the home of his long-term partner.

In a setback for the government, Laws, a Liberal Democrat, said he would "immediately" pay back the housing costs and refer himself to the parliamentary standards commissioner, John Lyon.

The Daily Telegraph reports that Laws claimed up to £950 a month for five years to rent a room in two properties owned by his partner, James Lundie, who works for a public relations firm. Parliament's rules are open to interpretation on the issue of defining a partner.

His political allies rallied to his defence today. But Downing Street's support has been muted and the former parliamentary standards commissioner called for him to stand aside for the duration of an inquiry.

Laws said the situation arose because he wanted to keep the matter of his sexuality secret. "I have kept this secret from everyone I know for every day of my life. That has not been easy, and in some ways it is a relief not to have to go on misleading those close to me about who I am," he told the Times.

Tory colleagues have referred to Laws as "the hatchet man" necessary to cut the deficit and he was widely praised in the Commons for his dispatch box performance when he justified £6bn of spending cuts. But any suspicion that he has been even inadvertently abusing the expenses system could damage him politically.

Laws, MP for Yeovil, has expressed his deep regret and announced that he would "immediately" pay back tens of thousands of pounds claimed for rent and other housing costs between 2006 and 2009.

The Telegraph said it was not intending to disclose that Laws was gay, but he had chosen to do so.

"James and I are intensely private people," Laws said in a statement. "We made the decision to keep our relationship private and believed that was our right. Clearly that cannot now remain the case.

"My motivation throughout has not been to maximise profit but to simply protect our privacy and my wish not to reveal my sexuality."

According to the Telegraph, between 2004 and 2007, Laws claimed between £700 and £950 a month to sub-let a room in a flat in Kennington, south London.

This flat was owned by Lundie, who was also registered as living at the property. Lundie sold it for a profit of £193,000 in 2007. He then bought a house nearby for £510,000. The MP began claiming rent for the "second bedroom" in this property. His claims were £920 a month. Lundie also lived at the property. Laws registered his main home as in his Yeovil constituency.

The arrangement continued until September 2009, when parliamentary records indicate that Laws switched his designated second home and began renting another flat at the taxpayer's expense. His partner remained at the Kennington house.

Since 2006, parliamentary rules have banned MPs from "leasing accommodation from a partner".

Laws – a millionaire former City banker – claimed he had breached no rules saying in a statement: "At no point did I consider myself to be in breach of the rules which in 2009 defined partner as 'one of a couple ... who, although not married to each other or civil partners, are living together and treat each other as spouses'.

"Although we were living together we did not treat each other as spouses – for example, we do not share bank accounts and indeed have separate social lives. However, I now accept this was open to interpretation ... I regret this deeply, accept that I should not have claimed my expenses in this way and apologise fully."

A spokesman for David Cameron did not defend Laws to the hilt instead saying: "The prime minister has been made aware of this situation and agrees with David Laws's decision to self-refer to the parliamentary standards commissioner."

Sir Alistair Graham, former chairman of the Committee on Standards in Public Life, called on Laws to step down while an inquiry is carried out. "I would have thought the minimum that should happen is that he should step aside from the role of Chief Secretary to the Treasury as he's in such a sensitive position until the parliamentary commissioner for standards has carried out an investigation and reported to the House of Commons committee on standards and privileges," he told Sky News.

Friends of Laws came to his defence. Jeremy Browne, a Foreign Office minister and Lib Dem colleague of Laws, told Today on BBC Radio 4: "I've known David for about 15 years and I can tell you categorically that this is a human story, it's not a financial story. He is a deeply private man and he has a personal wish not to have his life put up in lights.

"I think it should be possible to be in politics and serve your country and still maintain a private life at the same time."

He stressed that Laws had given up a lucrative City career to go into politics, and could have claimed far more in expenses if he had stated openly that he was part of a couple.

Lord Ashdown, the former Liberal Democrat leader, joined the efforts to shore up Laws's position. He said the affair was a "terrible personal and public tragedy" and warned against a "witch hunt".

"He is a man who is deeply private. I can tell you he is Mr Integrity. I've known him for a long time – he took over my constituency from me."

Ashdown told Sky News: "Whether or not this infringed the rules because they infringed the term 'partnership' as it is meant in the rules is a matter for the parliamentary commissioner to decide on."

He stressed that Laws could have made "huge amounts of money" outside politics. "He represents the very best in our politics, and you should be careful – we should all be careful – about taking that down in the manner in which this public witch hunt is in danger of doing."

· This article was amended on 4 June 2010. The original referred to the parliamentary standards commissioner as John Lyons. This has been corrected.

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Healthcare Network

NHS Five Year Forward View will need support from clinical staff to succeed

Richard Vize

Having the backing of NHS leaders isn't enough: for this ambitious plan to succeed, we need the commitment of the clinical frontline

‘Unless clinical leaders take ownership of Forward View and see its potential for improving care and securing sustainability, it will fail.’ Photograph: Team Static/fStop/Alamy

Thursday 19 February 2015 12.29 GMT

As the implementation phase of the NHS Five Year Forward View begins, the whole programme risks falling victim to its own early success. It has been so well received that too little attention has been paid to selling the message to clinical staff.

At the King’s Fund on Wednesday, NHS England chief executive Simon Stevens revealed that there have been 268 applications to become “vanguard” areas, developing new models of care such as multi-specialty community providers (MCPs) and integrated primary and acute care systems. Fifty hospital systems want to form integrated organisations funded with a capitation budget, while 170 GP-led consortia want to expand into secondary and community care services, some in collaboration with hospital consultants.

NHS Five Year Forward View: a

Intriguingly, applicants will get a chance to comment on each other’s bids, in what Stevens likened to a

shopping list without the prices

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Eurovision-style process, to maximise the chances of selecting sites which are going to provide the most useful models for the rest of the country.

Backed up by a £200m fund, the vanguard areas offer the exciting prospect of rapidly developing new models of care that improve health and are financially sustainable. NHS England is not interested in schemes with elegant governance; the message is to get the change working at the clinical frontline and backfill the paperwork later.

But at the end of the vanguard process, the vast majority of the NHS will be unchanged. As the Audit Commission found with local government in the 1980s, the difficulty is not encouraging the best or tackling the worst, it is galvanising the bulk of the system which is already performing adequately to make a step change.

At the same debate, King's Fund chief executive Chris Ham highlighted the immense difficulties in changing the system to permit and promote service redesign on a massive scale. Its prosaically titled report Implementing the NHS Five Year Forward View: Aligning Policies with the Plan stresses the need for national and local NHS bodies to stop thinking as organisations and start thinking as systems – sharing sovereignty locally to reform entire health economies, and nationally to provide a coherent strategy for change.

There need to be big changes in the way the national bodies think and work. The Care Quality Commission needs to look at the experiences of people receiving services from several providers. The NHS Trust Development Authority must get a lot better at supporting solutions for whole systems rather than propping up individual organisations. There will have to be reforms to the operation of competition to ensure that collaboration and integration are not impeded by dogma.

Ham provided a timely reality check to assumptions that the Forward View has wide support. On the contrary, he suggested, those who are motivated by its philosophy and creativity are "deviants"; the overwhelming majority of clinical staff are simply not interested – at least so far.

NHS Five Year Forward View: the pressure's on to test new models of care

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The Forward View and its primary author, Simon Stevens, have been so well received by the senior ranks of the NHS that there has seemed little need to sell the message. In the absence of the row that traditionally accompanies any move to reform the NHS, there has been too little emphasis on proselytising among the unbelievers. This weakness

now has to be addressed.

Part of the problem has been the focus on money. With the three main parties falling over each other to offer the NHS more billions of pounds, even as they condemn social services to more devastation, the impression is too easily given that relief is at hand. Whatever the downsides of a funding shortage, it certainly focuses minds on efficiency and effectiveness.

The debate over the NHS now needs to shift from funding to service models. Unless clinical leaders take ownership of the Forward View, recognise the need to think and work differently, and see its potential for improving care and securing sustainability, it will fail.

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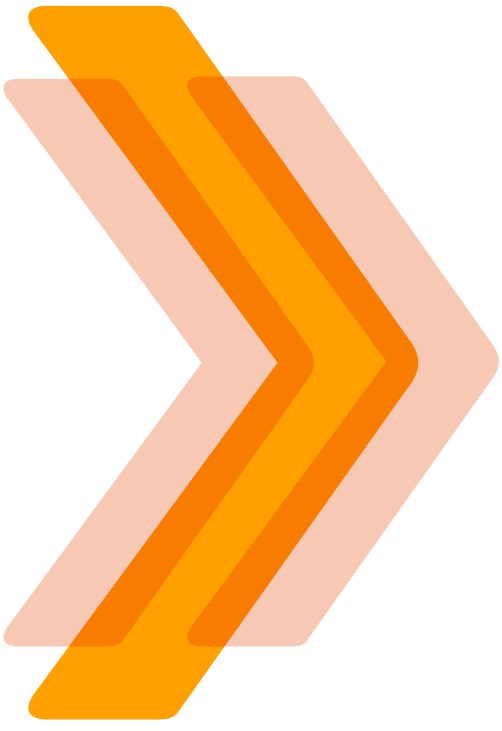
The King's Fund

Ideas that change health care

Implementing the NHS five year forward view: aligning policies with the plan



Authors

Chris Ham

Richard Murray

February 2015

Introduction

The *NHS five year forward view* (Forward View), published by NHS England and other national NHS bodies (2014), sets out a shared view on how services need to change and what models of care will be required in the future. Its key arguments are that much more attention should be given to prevention and public health; patients should have far greater control of their own care; and barriers in how care is provided should be broken down. This means putting in place new models of care in which care is much more integrated than at present.

The Forward View differs from many other plans for the NHS in arguing that England is too diverse for 'one size fits all' solutions. Instead of setting out a blueprint for the future, it outlines a number of care models that may be adapted in different areas to put in place services fit for the needs of local populations. The emphasis is on 'diverse solutions and local leadership, in place of further structural distraction' supported by 'meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied' (p 4).

Many of the ideas in the Forward View draw on work by The King's Fund and others (see, for example, **Ham *et al* 2012**). Part of its purpose is to highlight the level of funding needed to implement new care models and what the NHS itself needs to do to fill the funding gap. This includes making substantial improvements in productivity, seen by some observers as unlikely to be achieved.

While the direction set by the Forward View has been broadly welcomed, it risks suffering the same fate as previous policy documents unless serious attention is given to the policy changes needed to support local leaders to make new care models a reality. The purpose of this paper is to outline some of the changes necessary to avoid reform being both slow and, in many cases, falling well short of the kind of future described by NHS England and its national partners.

It focuses on the following areas in which The King's Fund has particular expertise, particularly how:

- services are commissioned and paid for
- the NHS is regulated
- improvements in care are delivered by local leaders
- a transformation fund could contribute.

In writing the paper, our aim has been not only to describe why changes are required but also to make practical proposals on what should now be done to remove barriers to the development of new care models and how implementation of these models can be supported. Changes are also needed in other areas, such as workforce and information technology, but these are outside the scope of this paper. Implementing the changes we outline entails the fundamental redesign of policies on commissioning, regulation and payment systems, as well as the support provided to NHS organisations.

One of the challenges in acting on the ideas outlined here is the fragmentation of responsibility for the NHS at a national level. It is therefore all the more important that the guiding coalition – to borrow John Kotter's phrase – brought together by NHS England remains in place and works hand in hand with ministers and Department of Health officials in working through these ideas. The NHS desperately needs high-quality and consistent system leadership at the centre to avoid conflicting signals being given by different national bodies, and more positively to give confidence that there is a clear and shared direction for the NHS.

System leadership is equally important at a local level, where organisational changes following from the Health and Social Care Act 2012 have left a vacuum that commissioners and providers are seeking to fill through partnership arrangements of various forms. At a time of growing pressures within the NHS, the absence of a designated system leader places the onus on commissioners and providers to agree how this vacuum should be filled. Much then hinges on the quality of relationships between organisations and their leaders and their willingness to seek common cause to deal with the challenges facing the health and care system, as we discuss further below.

How services are commissioned and paid for

Innovations in commissioning and contracting

Our research has identified innovations in commissioning in a number of areas of England designed to support new care models, with a particular focus on the use of prime contracts and alliance contracts (Addicott 2014). These approaches are intended to facilitate new forms of integrated provision for specific groups such as older people or people with defined medical needs such as cancer and musculoskeletal conditions.

Innovations in commissioning are still in development and it is too early to draw firm conclusions. What is clear is that the process of developing prime contracts, alliance contracts and related approaches needs considerable investment of time and resources as well as work to develop effective relationships between commissioners and providers. Commissioners often need expert advice from lawyers and others in taking forward these innovations, and the preparatory work also consumes substantial funds.

In stylised terms, there are choices between a focus on specific diseases, care groups and whole populations. Although there is as yet no experience in England of seeking to commission care for whole populations, Alzira in Spain is a well-known European example and there are also examples in the United States. There are choices too as to whether to include social care within the scope of services to be commissioned.

Further choices are to be made about the type and content of contract that will best support the delivery of these services. This includes the outcomes to be used to hold providers to account under the terms of the contract and the incentives in place. Outcomes and incentives are often linked, as when commissioners make some of the funding conditional on providers delivering agreed standards.

Developing outcomes that matter to those people using the services is also likely to involve engagement with patients and the public.

Innovations in commissioning create opportunities for risk-sharing between commissioners and providers. This is particularly important in a cash-limited and increasingly cash-strapped NHS where gains in one part of the system may create problems in another part. Multilateral risk-sharing arrangements between commissioners and providers are needed to manage the consequences and this is a complex undertaking not least because commissioners often lack experience of developing such arrangements.

Prime and alliance contracts often transfer risk from commissioners to providers for a range of services. This means that the providers need to have developed the relationships that enable them to work together to provide care to the required standard. Often this will involve providers working as part of a supply chain in which resources are allocated in relation to their differing contributions. Lead providers in the supply chain in effect become commissioners, raising questions as to whether the current separation between providers and commissioners is sustainable.

Even when contracts are let, there can be difficulties in securing commitment from key stakeholders, as in the musculoskeletal contract in Bedfordshire (Welikala 2014). Structuring incentives within the supply chain presents as much of a challenge as in the contract negotiated between commissioners and providers. Providers will therefore need to agree how to resolve any conflicts that arise. This will require explicit legal agreements that bind providers together and specify their different roles.

Work on the technical aspects of commissioning and contracting needs to go hand in hand with the relational aspects. Our work shows that prime contracts and alliance contracts will only work in a context in which commissioners and providers work collaboratively and openly, based on a shared understanding of what they are seeking to achieve. Among other things, this means investing in the development of system leaders. This is discussed in more detail later in the paper.

To make these points is to illustrate the complexity of innovations in commissioning and contracting and also the challenges they present. Commissioners will need practical support and opportunities to learn from each other through a community of practice as they take forward this work. They also need to be able to access

information quickly and easily from other areas that are further advanced in implementing new forms of commissioning and contracting.

Recommendation

National bodies should support NHS commissioners to implement new forms of commissioning and contracting. This should include establishing a community of practice to share learning and expertise, and offering expert legal and other advice.

Multispecialty community providers

One of the models of care described in the Forward View is the multispecialty community provider (MCP). This involves the development of federations, networks and super partnerships to enable general practices to operate on the scale required to deliver a wider range of services. These services would include those provided by some specialists alongside other professionals such as nurses, therapists, pharmacists, social workers and psychologists.

In previous work, we have argued for the use of a population-based capitated contract linked to the delivery of agreed outcomes as the best way of commissioning MCPs (**Addicott and Ham 2014**). The budgets they take on would be determined by a combination of population size and need and the range of responsibilities included in it, including funding for general practice. The scope of budgets could be expanded as emerging MCPs demonstrate their ability to work in this way.

MCPs would use their budgets to take 'make or buy' decisions. This would mean delivering services directly where possible or commissioning services from other providers. There would be a blurring of the distinction between commissioners and providers to enable GPs, in partnership with other clinicians, to deliver more integrated services in the community.

In assuming greater responsibility for commissioning and providing care, MCPs would need to demonstrate that they have the capabilities to manage the contract and deliver the expected outcomes. These capabilities include skills in contract negotiation and management, financial management, utilisation management, and the management of clinical quality. Also important is well-developed clinical leadership and access to real-time information about how the budget is used.

As multispecialty providers, MCPs would include in their membership specialists currently based in hospitals where there is scope for more care to be provided in the community. Examples include geriatricians, paediatricians and 'office-based' specialists such as diabetologists, dermatologists, rheumatologists and respiratory physicians (see **Robertson *et al* 2014**). Multispecialty medical practice holds out the prospect of savings in the cost of hospital care because of the opportunity it creates to provide proactive care in the community and rapid responses to crises.

Integrated commissioning would be needed to implement the new contract for MCPs. This means bringing together funds currently controlled by clinical commissioning groups (CCGs) and NHS England (for primary care provision), as well as some of the funds controlled by local authorities if social care is to be delivered by MCPs. Plans by NHS England to develop co-commissioning by CCGs already indicate the direction of travel, and it will be important to ensure CCGs have sufficient resources to take on these additional responsibilities.

Potential conflicts of interest also need to be managed, for example by practices involved in bidding to provide services under the terms of the new contract being excluded from the process of commissioning these services. It would also be important to develop transparent governance and accountability to avoid any suggestion that GPs are gaining inappropriately through their involvement in MCPs.

There needs to be sufficient time to implement and evaluate how an MCP contract might work, based on early testing with federations, networks and super partnerships willing and able to work in this way. As with the innovations in commissioning and contracting described above, emerging MCPs would also need expert support. This might include learning from other systems like New Zealand and the United States where models of this kind already exist.

Recommendation

NHS commissioners should work with interested and capable general practices operating at sufficient scale to establish MCPs that take control of a capitated budget to deliver integrated out-of-hospital services. National bodies should provide access to learning from relevant experience of other health care systems.

Primary and acute care systems

Another care model outlined in the Forward View is primary and acute care systems (PACS), described as 'single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services'. It is suggested that these might be formed in a number of ways including hospitals opening their own GP surgeries with registered lists and MCPs taking over the running of hospitals.

Our research into the role of acute hospitals in emerging integrated care systems in England illustrates the complexities of bringing primary and secondary care together (Naylor *et al,* forthcoming). Perhaps most important are longstanding cultural differences between GPs and their teams on the one hand and hospital clinicians on the other, as well as differences in the way that these services are commissioned, contracted and organised. Bringing mental health and other community services into PACS adds to the challenge of aligning the contributions of different professions behind a common purpose.

As small businesses responsible for running their own affairs, general practices enjoy a large measure of autonomy and flexibility in how they organise their work. Practices typically have flat structures with limited formality and, at their best, an ability to adapt quickly in response to changing circumstances. Hospitals, by contrast, are much larger bureaucratic organisations with more complex reporting lines. Further difficulties are likely to emerge as a result of existing contracting arrangements in primary care, as well as different employment arrangements between general practitioners and hospital staff.

Having made these points, some acute hospitals already run community health services following the changes that resulted from the policy on transforming community services; others have begun to work more closely with GPs either through employing GPs or creating joint ventures. In some cases, collaboration between hospitals and GPs has been helped by the parallel development of networks and federations in general practice.

The time needed to establish these arrangements and to realise the benefits should not be underestimated. The prominence of acute hospitals in the NHS means that GPs and staff running community services are sometimes fearful that they will be

the poor relations within integrated care models. Persuading GPs to take part will require discussions with one practice at a time to understand and address these and other concerns.

One option would be for PACS to be established as virtual organisations rather than as single merged organisations. This might involve acute trusts working closely with networks of general practices through joint ventures or other contracting arrangements. As with MCPs, there are major questions about how virtual PACS of this kind would be commissioned and funded, and the nature of relationships between providers within the networks.

PACS are similar in some respects to health maintenance organisations and accountable care organisations in the United States. Experience in the United States shows the potential benefits of a single organisation (real or virtual) taking responsibility for the health of a defined population with a capitated budget. These benefits include the ability to focus on the health of the population and not just the treatment of sickness, and to use the capitated budget flexibly to meet that population's need.

In the current context in England, PACS that encompass community services, GPs and social care also have the potential to speed the flow of patients into and out of hospitals to remove some of the blockages that are behind pressures in the urgent and emergency care system. To realise these benefits, PACS will need to heed the warning signs from the United States by understanding the factors that caused some integrated delivery networks to fail in the 1990s. These factors included inadequate attention to change management processes. This prevented emerging networks from emulating the achievements of long established integrated systems like Kaiser Permanente (Burns and Pauly 2012).

Both MCPs and PACS will have to run the gauntlet of rules on procurement and tendering, discussed further below. PACS in particular could fall foul of the competition regulators if they emerge as monopoly integrated providers of NHS care in their area. One way of handling this would be to tender the management of PACS for a period of 10 years or more in a form of competition for the market, analogous in some ways to the example of Alzira mentioned earlier.

As large integrated providers, PACS would pose fundamental challenges to commissioning as currently organised. In previous work (**Ham *et al* 2013**) we have argued that strategic commissioning would be needed to counteract the power of fully integrated providers whether real or virtual and to ensure they are held accountable for the delivery of defined outcomes. This includes avoiding an acute hospital mindset dominating primary and community care providers working within PACS. Innovations in care models may therefore require commissioning to be organised differently if they are to deliver on their promise.

Recommendation

Different options for PACS should be explored, recognising the cultural differences between GPs and hospital clinicians and concerns that community services and GPs could become the poor relations. These options should include PACS being established as virtual organisations as well as single organisations.

Incentives to support new models of care

Care delivered within the NHS is currently paid for through a mix of payment systems including Payment by Results for much routine acute hospital activity, block contracts for community and mental health services, and funding for specialised services provided by NHS England through a separate tariff. Many GPs are paid through a contract that combines capitation payments, pay for performance, some item of service payments, and reimbursement of costs such as for premises and staffing. Other GPs are employed on a salaried basis, while dentists and opticians work under their own contracts.

The variety and complexity of current payment systems reinforces the fragmented nature of NHS provision. These systems also contain conflicting incentives. Payment by Results was originally designed to reward hospitals for higher levels of activity, while pay for performance was intended to reward GPs for improving the quality of care provided to patients, through the quality and outcomes framework (QOF). Successive additions and refinements to payment systems such as the cut in prices paid to hospitals for emergency admissions over the 2008 benchmark and changes to the size and composition of the QOF have sought to alter the incentives for providers.

In previous work, we have argued that payment systems need to be flexible and adjusted in the light of their impact, changing policy objectives, and changes in the context in which they operate (Appleby *et al* 2012). Nowhere is this more important than in relation to Payment by Results, which was introduced at a time when the NHS budget was increasing rapidly and when a core objective was to reduce waiting lists and waiting times for hospital care by treating more patients. With NHS funding now tightly constrained, and the focus having shifted to how care can be better integrated around the needs of people with long-term conditions, much more emphasis needs to be given to payment systems that support this objective.

This has been recognised for some time and lies behind the interest in developing bundled payments and year-of-care tariffs for some forms of care. Talk about these kinds of innovations in payment systems has far exceeded change on the ground despite repeated exhortations from various sources on the need to align payment systems with changing policy objectives. The need to move from exhortation to action is now urgent.

In our view, there needs to be active testing of capitated budgets under which MCPs and PACS take on responsibility for services delivered to defined populations. These budgets would pool resources currently allocated through separate funding streams including social care. As discussed earlier, multilateral risk-sharing arrangements would be put in place so that budgets could be managed effectively.

Pooled budgets also have a part to play in supporting health and social care integration, extending the joint commissioning arrangements established in a number of areas and promoted by the Better Care Fund. One of the risks to be managed here is that transfers of NHS funds into pooled budgets may result in deeper cuts in social care funding than would otherwise have occurred as local authorities seek to cope with further reductions in grant support from central government. Putting in place shared governance through health and wellbeing boards or other forms of partnership working may help mitigate these risks.

Urgent and emergency care networks would similarly be funded through a budget under which providers would decide how best to deliver this care in the right place at the right time. A budget taken on by an alliance of providers linked to the delivery of defined outcomes (and therefore different from old-style block contracts) has much more potential to deliver timely and co-ordinated care of the right quality

than the current tariff-based system. The providers in the alliance would determine how the budget would be shared between them and the balance to be struck between paying for activity and rewarding quality of care. In so doing, they would need to take account of the balance between fixed and variable costs in different providers and other relevant considerations.

New incentives could also play a part in empowering patients and service users to be key agents in making a reality of new models of care. Building on the experience of direct payments in social care and personal health budgets, integrated personal commissioning will enable people to make their own choices about the care they need and where to get it. Integrated personal commissioning is a practical example of an innovation that could be seen as a 'disruptive innovation' in moving towards the ambitions set out in the Forward View.

The pressures facing acute hospitals as a result of successive changes to Payment by Results, including reduced payments for emergency admissions above the level recorded in 2008, and more recently the decision to extend a similar principle to the funding of specialised services, underline the importance of putting in place new ways of paying for care. This has been recognised in the plans published by NHS England and Monitor to reform payment systems (**Monitor and NHS England 2014a**, **2014b**). Both bodies should ensure this work is given priority by strengthening their own capabilities in this area.

Recommendation

NHS England and Monitor should accelerate the development of new payment systems such as capitated budgets, pooled budgets and integrated personal commissioning. They should strengthen their own capabilities for doing this work.

How the NHS is regulated

Assessing the quality of local systems of care

Many of the models of care outlined in the Forward View require care to be much more integrated than it is now. One of the challenges in migrating towards these new models is to ensure that the behaviour of the regulators facilitates their development. Nowhere is this more important than in relation to the Care Quality Commission (CQC) and its role in inspecting the quality of health and social care.

The CQC currently discharges its responsibilities through chief inspectors of hospitals, general practice and social care and the teams that support them. While there is a logic to this way of organising inspections, particularly in the context of well-publicised failures in performance in hospitals and care homes, it reinforces current organisational and service silos. The CQC may therefore unintentionally inhibit the emergence of integrated models of care by requiring organisations to focus on their own performance almost regardless of the impact on other providers in their area.

A particular weakness of the CQC's current approach is that it pays relatively little attention to the experience of people whose complex needs lead them to seek help from different providers. These people are often older and frailer patients and service users with a number of needs that require treatment both in hospitals and other settings. Each contact with a health or social care professional may be of a high standard but the experience of patients may suffer through lack of effective co-ordination or poor communication.

For these reasons, the CQC needs to move quickly to fulfil its commitment to assess how well care is integrated, building on recent work on the care of people with dementia (Care Quality Commission 2014). This requires the development of a methodology for inspecting the performance of local systems of care with a particular focus on the experience of patients and service users who seek help from different providers of care. Other measures such as emergency admissions and

readmissions are also important but need to be viewed in the context of service users' experience as they are uniquely well placed to assess how well care is co-ordinated.

A good starting point would be to survey patients and service users in order to understand their experience and whether or not their care was well co-ordinated, for example in relation to timely admission to and discharge from hospital, sharing of information between health and social care professionals, readmissions, and outcomes of care. These issues are particularly important to the growing numbers of older people using health and social care services. To avoid the risk of over-inspection and intrusive regulation, a balance would need to be struck between the CQC's current approach and a focus on local systems of care.

Recommendation

The CQC should move quickly to assess how well care is integrated in local systems of care for groups such as older people. It should survey patients and service users to understand their experiences of whether care was well co-ordinated.

A whole-system intervention regime

The number of organisations in financial difficulties has risen sharply over the past year. Much of this increase has been driven by the exceptionally challenging environment that has combined rising demand for NHS services and little real-terms growth in spending. However, within this group are also several organisations whose difficulties run much deeper and who, even in relatively good times, struggled to maintain financial balance and/or deliver high-quality services.

There is good evidence that many cases of persistent underperformance arise from weaknesses in leadership (**Murray *et al* 2014**). The NHS can intervene, and often has, to change the leadership of struggling organisations. Indeed, it has sometimes done so too often and too quickly, leaving too little time for new leaders to turn the organisation round. It also now has a sophisticated early warning system operated by Monitor and the NHS Trust Development Authority (NHS TDA) (on finance) and the CQC (on quality), to identify organisations that appear at risk and to intervene early.

All of these tools and powers, and others such as the trust special administrator (TSA) regime, are primarily directed at the organisation in distress. This is all well and good where the solution lies within the power of this single, challenged organisation. However, in an increasing number of cases difficulties in one organisation arise from more fundamental misalignment across a whole health economy. This may include weaknesses in social care and local government services, which may face even greater challenges than NHS services.

Already, NHS England, NHS TDA and Monitor have come together to provide additional support to 11 challenged health economies as part of the 2014 planning process and these bodies have summarised the learning from this work (**Monitor *et al* 2014**). Also, the existing contingency planning team approach used before any decision to invoke the TSA does look across a health economy. More recently, Simon Stevens (2014) has set out plans for a 'success regime' rather than a 'failure regime' that will help challenged areas rather than individual challenged organisations. The effectiveness of these forms of support, including the use of management consultants, needs to be evaluated.

Any new regime will need to help areas develop a recovery plan that both diagnoses the underlying problem and then goes on to propose a solution. With the models of care set out by the Forward View there will soon be a menu of potential options to help local areas design this new configuration of services, although it is important that any plan must still have real local ownership and local leadership in order to succeed. This plan then needs a new approach to whole health economy governance to ensure that each stakeholder delivers on its commitments, including partners in local government and the third sector.

One of the lessons from experience to date is that recovery plans in challenged health economies call for both reconfiguration of services and integration of care (Hazell 2014). This means that alongside existing performance metrics for each organisation, there is a need for new, whole health economy metrics that capture the progress towards more integrated services and new models of care. To ensure consistency these will need to become a coherent part of the regulatory system managed by all the national bodies acting in concert. Regulators must avoid intervening in individual organisations in ways that conflict with health economy solutions, particularly given the bewildering complexity of regulation noted in the Berwick report (**National Advisory Group on the Safety of Patients in England 2013**).

Recommendation

NHS England, Monitor and the NHS TDA should extend the use of interventions in whole health economies. They should avoid intervening in individual organisations in ways that conflict with this.

Procurement and tendering

One of the legacies of the Health and Social Care Act 2012 is a statutory framework building on other legislation designed to ensure that anti-competitive practices are tackled and new care providers are able to enter the market. This includes rules on procurement and tendering under which commissioners in certain circumstances are required to test the market when they let contracts. How these rules operate in the context of the Forward View needs to be reviewed to ensure they do not inhibit the development of new care models like MCPs and PACS.

As the sector regulator, Monitor has sought to clarify when commissioners need to use tendering; its detailed guidance runs to more than 70 pages (**Monitor 2013**). Monitor has also issued guidance on integrated care and competition, making clear that the two are not mutually exclusive (**Monitor 2015**). Notwithstanding these efforts, there remains uncertainty among both commissioners and providers on how competition rules operate in practice, and a concern that they create barriers to the development of new care models.

To date, for some organisations, 'ask forgiveness, not permission' has been cover enough to take forward local initiatives. Others have been willing to invest their own time and get legal advice for developments such as prime contractor arrangements or federations in primary care. However, for many in the NHS the potential risks around 'asking forgiveness' and the undoubted costs in time and money of due diligence around every novel initiative will be a disincentive to experimentation and implementation.

The Forward View looks to a set of early adopters to explore and develop the new models of care and provide learning for the rest of the NHS. National bodies should clarify as a matter of urgency how they expect early adopters to do this while not falling foul of rules on procurement and tendering. In some cases, national bodies

should consider giving commissioners and providers a waiver to depart from rules that are barriers (real or perceived) to the development of new care models. For this to happen, there needs to be greater clarity about the scope for waivers in relation to EU rules and how these are changing.

There is also a case for making central legal advice available to local areas as they develop and implement their plans. The alternative – extensive written technical guidance – may not be sufficient. This could extend to providing support around options for payment systems (as discussed above). These will also be areas where gaining local experience is difficult and where there is scope to learn from other parts of the country. Without this active support, the NHS risks making both slower progress and incurring more cost than necessary at a local level.

Recommendation

NHS England and Monitor should review current rules on procurement and tendering to remove any barriers to the development of new care models, and provide access to legal advice. Where appropriate they should provide a waiver to enable commissioners to depart from these rules.

How improvements in care are delivered by local leaders

Leadership and improvement expertise

In previous work we have argued that reform of the NHS should rely less on external pressures and stimuli like targets and inspection and more on support for leaders and staff to bring about improvement from within (**Ham 2014**). Two main forms of support are needed: first, in developing leaders at all levels of the NHS; second, in providing the 1.4 million staff who work in the NHS with the skills needed to improve care for patients.

The review of the work of the NHS Leadership Academy and NHS Improving Quality set up by NHS England provides an opportunity to consider how national expertise in these two areas can be effectively aligned behind the Forward View. The experience of the NHS Modernisation Agency between 2001 and 2005 demonstrates the risks of taking improvement expertise out of NHS organisations and placing it in a national body, which in effect becomes an agent of government rather than a source of advice and expertise for the NHS itself. Although the Modernisation Agency carried out some good work, it was soon superseded as greater emphasis was placed on improvement programmes being led from within the NHS both at the regional level and in NHS providers themselves.

Our analysis of high-performing health care organisations and systems in the NHS and elsewhere underlines the importance of this observation and shows that there is no substitute for every NHS organisation taking its own responsibility for the development of its leaders and for providing staff with skills in quality improvement. Larger organisations like Salford Royal NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust have developed their own capabilities to do this. Others have collaborated to get the expertise they need through agencies like Advancing Quality Alliance (AQuA) in the north-west of England.

Some of the most effective forms of national support are provided by organisations like the Emergency Care Intensive Support Team (ECIST). Its frontline practitioners visit challenged providers to offer advice on how improvements in urgent and emergency care can be achieved. The team is small and agile and appears to be effective in large part because of the expertise and credibility of the people who work in it and their experience in delivering the services they are asked to review. Any plans to strengthen national support on quality improvement should build on this example and resist the temptation to recreate a large national improvement body like the Modernisation Agency.

Support for areas of the country to fast-track the development of new care models could come from many different sources; there is now a much more extensive and diverse market offering support than was the case when the Modernisation Agency was set up. Funds currently locked up in agencies like NHS Improving Quality could be released to enable NHS organisations and systems to buy in the expertise they need instead of them having to select from a limited menu. One approach would be for local and regional sources of expertise within the NHS, including academic health science networks, to form a virtual improvement and support system to promote learning and sharing of scarce expertise.

Much the same applies to leadership development. Responsibility for talent management, succession planning and leadership development rests with every NHS organisation working either individually or in collaboration with other organisations. Vacancies in senior leadership positions across the NHS are an indication of the failure of recent approaches to leadership development at a national level, including the Top Leaders Programme which was intended to increase the supply of qualified people for these roles (**Janjua 2014**).

Most of the resources of the NHS Leadership Academy would be better deployed by NHS organisations themselves with national support focused only on those activities that cannot be better undertaken at a local or regional level, such as the graduate management training scheme. NHS organisations should be required to account publicly for their leadership development including the resources they commit to it. In many cases, they may choose to work with other NHS organisations to bring together the expertise needed to fulfil their responsibilities, for example through regional leadership academies.

National bodies should develop an explicit strategy for quality improvement and leadership development in collaboration with NHS leaders. This would draw on Lord Darzi's work for the previous government (**Department of Health 2008**) as well as proposals for a national quality programme for the NHS in England advanced by the Nuffield Trust (**Leatherman and Sutherland 2008**). Such a strategy could benefit from the experience in the NHS in Scotland where work on quality and patient safety is well established (**Healthcare Improvement Scotland 2015**). Plans to revitalise the role of the National Quality Board in England provide an opportunity to revisit these ideas and ensure they encompass leadership development as well as quality improvement.

These changes could contribute to the NHS becoming a learning organisation, as advocated in the Berwick report on patient safety (**National Advisory Group on the Safety of Patients in England 2013**). As the report noted, the current over-emphasis on regulation is unlikely to deliver the sustainable improvements in the quality of care and safety that are needed. What is required is to strengthen leadership and to change cultures to work towards the aim of the NHS becoming a zero-harm organisation. The resources used to support leadership development and quality improvement need to be aligned behind the Forward View.

Recommendation

National bodies should develop a strategy for quality improvement and leadership development for the NHS in England to enable it to become a learning organisation. This should be based on the presumption that the main responsibility lies with NHS organisations, with national support for improvement being provided through small teams of credible experts.

System leadership

Many of the new models of care outlined in the Forward View require different ways of working in which organisations collaborate to achieve closer integration of care. Collaboration may involve GPs working with specialists and other clinicians in MCPs, hospitals and primary care providers coming together in PACS, and a range of organisations and services establishing urgent and emergency care networks.

New kinds of leadership will be needed to make a reality of new models of care. Specifically, leaders of different organisations will need to work together to provide leadership across local systems of care, however these are defined. The challenge this presents is that most NHS leaders are first and foremost organisational leaders rather than system leaders, and they will have to learn new skills to operate effectively in the NHS of the future.

They also operate in a context in which regulators and other national bodies have demands and expectations that may work against collaboration and integration. This is especially the case when changes in the interests of the whole health economy impact adversely on the performance of individual organisations. As noted earlier, it is essential that regulators work in concert to avoid this happening through a single and coherent system of regulation and intervention.

The new skills required by leaders include how to exert influence in the absence of hierarchical controls and positional authority. Related to this, system leadership is often designed to enable collaboration between agencies to deliver integrated care, and may run counter to attempts to stimulate greater competition. Handling the tension between collaboration and competition is therefore critical.

Our research into emergent models of system leadership in the NHS has identified several lessons (**Fillingham and Weir 2014**). These include adapting and applying the principles of complexity science and understanding the importance of learning by doing. System leadership is more likely to develop where there is a shared focus on a particular community and when effort is put into the development of many system leaders at multiple levels of the system concerned.

Many areas are already seeking to fill the gap in system leadership by establishing partnership boards and leaders' groups that bring together commissioners and providers. The composition and role of these boards varies but their existence signifies the complexity of governance and accountability at a local level following the changes brought about by the Health and Social Care Act 2012. Health and wellbeing boards are used in some areas to promote partnership working, but the absence of key stakeholders such as NHS providers in some areas means that the right leaders are not always around the table.

Mechanisms are needed for handling conflict, and time is required to build the will, skills and relationships needed to make integrated care systems a success. Although the NHS has relatively little experience of system leadership, there are lessons from local government where these principles are often well understood, as well as from the third and the private sectors. The NHS therefore needs to be open to learning from other sectors, for example in leadership development programmes and work shadowing arrangements (Senge *et al* 2014).

These ideas are being discussed and implemented in a context in which most top leaders in the NHS employ a pace-setting style that reflects the dominant approach to leadership in the past decade or more. Pace-setting is unlikely to be conducive to effective system leadership and these leaders will need to use a wider repertoire of styles including coaching and facilitation. They may also find value in agreeing an explicit compact with fellow system leaders, setting out values and behaviours to be aspired to.

System leadership is one example of the collective leadership we have argued the NHS needs. Leadership of this kind must be both shared and distributed and based on a willingness to negotiate and accommodate rather than command and control. Developing system leadership 'in place' between the guiding coalitions that will deliver the new models of care in the Forward View should be the priority, ensuring that all relevant stakeholders are included.

Recommendation

National bodies and NHS organisations should prioritise the development of system leadership both for the NHS as a whole and in local health economies. This should include learning from other sectors and moving beyond the pace-setting styles that have been dominant in the recent past.

Provider leadership

The new care models outlined in the Forward View will present major challenges for providers as greater emphasis is given to integrated care and providers come together in alliances and networks to deliver this care. As discussed above, innovations in commissioning and contracting are likely to lead to the development

of supply chains, for example when prime contracts are used. NHS leaders and their peers in other sectors will need to develop new ways of working in these supply chains to be able to respond to the demands of commissioners and to work collaboratively.

Similar challenges exist in the development of MCPs and PACS. In many cases, MCPs will be built on the foundations of emergent federations and networks of general practices, where the tensions involved in preserving sufficient autonomy for practices within a collective endeavour are already being worked through. These challenges will increase as MCPs reach beyond practices to encompass other staff working in the community, and some hospital-based specialists. Leaders of MCPs (many of whom are likely to be GPs) will need exceptional skills in managing diverse professional groups to realise the potential of this new model of care.

The same applies to PACS where the longstanding separation between primary and secondary care needs to be bridged. Hospital leaders cannot assume that a style of leadership that has served them well in one context will work in a very different context. Many GPs will have concerns about the potential loss of autonomy and will need reassurance that they will benefit from working in a new, more integrated system of care. Developing GP leaders to work with hospital leaders, as well as bringing all GPs and other staff into the fold of PACS, will take time and diplomacy to avoid any sense that one organisation is taking over others.

Alongside the Forward View, the Dalton review has outlined a range of organisational models for providers (**Dalton 2014**), and these also call for new forms of provider leadership. Like the Forward View, the Dalton review is permissive not prescriptive but with a clear expectation that providers will wish to collaborate through chains, joint ventures, buddying, integrated care organisations and other means where this brings benefits. In some cases, providers will choose to merge, as has already happened in the case of acute hospital services in north London and in Berkshire and Surrey.

While the NHS may be able to learn from other sectors in implementing these new provider models (**Crump and Edwards 2014**), the challenges in making them work in practice should not be underestimated. As we have noted, leaders whose careers have been built on progression to ever more senior roles in individual organisations will need to adapt quickly to the quite different environment of working across

organisations, often with their own distinctive cultures and values. It cannot be assumed that skills that work well in one environment will transfer easily to another.

National bodies should offer support to provider leaders, acting on the recommendations of the Dalton review and ensuring that sufficient time and freedom from burdensome regulation is allowed for new care models to get established. Particularly where challenged organisations come together with organisations performing well, there is likely to be a dip in performance before the benefits are realised. Regulators have often been slow to recognise this and to tailor their interventions to different circumstances.

They have also resorted too quickly to 'enforcement' actions and special measures in intervening in challenged providers rather than offering practical support to leaders to find a solution. The effect has been to add to the pressures on organisations already in considerable difficulty, often resulting in leaders being replaced. In a context in which the NHS faces growing problems in recruiting to executive-level board roles, the loss of experienced leaders will only accentuate these problems.

Recommendation

New care models and the organisational models outlined in the Dalton review require new styles of provider leadership. These must be supported by national bodies to avoid the wrong kind of regulation and to avoid leaders being deterred from applying for executive-level board roles.

How might a transformation fund contribute?

To help facilitate change, The King's Fund has argued for a transformation fund to provide financial support through transition (Appleby *et al* 2014), and the scale and ambition of the new models of care set out in the Forward View reinforce this need. This case is increasingly accepted, with the Autumn Statement providing a first £200 million for transformation next year. However, funding and running a transformation fund is not straightforward.

To begin with, funding for transformation should not be confused with emergency support for troubled health economies. Rather, its principal purpose should be to pump-prime the development of new care models by covering their running costs ahead of existing models being decommissioned.

Any transformation fund also needs to be flexible enough to handle the complexity of change in the NHS. This includes recognising that in many health economies different organisations may gain and lose; some organisations of the future may not yet exist.

Many changes will also require co-ordinated action across multiple organisations and stakeholders, with success dependent on joint ownership of a delivery plan. This is likely to require a new whole health economy approach to the governance of delivering change as well as more resources. Developing such an approach means developing a cadre of system leaders able to work across organisational and professional boundaries, as discussed above.

Mental health achieved a fundamental redesign of services, switching from a system based on hospital care to one focused on community services (**Gilburt *et al* 2014**) in a process that benefited from funding to cover double running costs. Working with The Health Foundation, The King's Fund is investigating this and other examples to recommend how to establish and run a transformation fund. Some of the funding may come from within the NHS itself if existing unused assets can be unlocked and resources released back into transformation.

A transformation fund is likely to be particularly beneficial in areas of care where improvements in current ways of working offer most potential to relieve pressure on both the NHS and social care, and deliver better outcomes for service users and patients. A good example is care of older people, who account for a high proportion of need and demand and where there is evidence of inappropriate use of services, often because of the lack of alternatives. Analysis by The King's Fund has described what good integrated health and social care for older people looks like (**Oliver *et al* 2014**), and the systematic adoption of known best practice would go a long way towards fulfilling the ambitions of the Forward View.

This is likely to include investing in the provision of services in the community to provide realistic alternatives to hospitals for older people who can be supported appropriately in this way. A transformation fund should be used to enhance both health and social care services in view of the role of social care in admission avoidance and supported early discharge from hospital. It should also be used to fund innovations in care that support greater integration, including information and communication technologies, as has been seen in areas that have made use of telecare and telehealth to enhance care in people's homes and in nursing homes (as is already happening in Airedale – see Naylor *et al*, forthcoming).

Recommendation

NHS England should work with other national bodies to put in place a transformation fund to support NHS leaders and their partners to implement new care models. This should learn from experience in mental health and ensure that resources are used for transformation, not to keep existing services solvent.

Where next?

The ideas outlined in this paper describe some, but by no means all, of the changes needed to support implementation of the Forward View. We have focused deliberately on the implementation challenges of the Forward View because of the historic neglect of these challenges in the development of health policy, and the urgency associated with resolving them. In so doing, it is important to emphasise that policy changes and support from national bodies are necessary but not sufficient conditions in making a reality of new models of care. Even more important is leadership within the NHS, without which even the most supportive and aligned policy context will make little difference.

To make this point is to acknowledge that implementation of the Forward View should involve a process of discovery and not design. By this we mean that national bodies should keep faith in their expressed wish to support 'diverse solutions and local leadership' and should resist the temptation (or indeed pressure) to prescribe what should be done and how. The NHS has suffered over many years from the mistaken belief that change should be driven from the top down, with the unfortunate consequence in some places of learned helplessness in which leaders of NHS organisations wait to be told what to do rather than taking the initiative themselves.

To avoid this happening, the care models set out in the Forward View should be seen as a starting point for debate rather than the end of the story. For example, in some areas there may be interest in going beyond MCPs and PACS to establish integrated care for whole populations. This possibility is recognised in the Forward View in the context of the development of accountable care organisations in other countries; if implemented thoughtfully it has the potential to make a bigger impact than the other models that have been proposed. National bodies should actively support options of this kind as part of a concerted effort to put integrated care at the heart of the policy agenda, as The King's Fund has argued for some time (**Ham and Curry 2010**).

Planning guidance issued in December 2014 defined three types of areas to take forward the Forward View: vanguard sites to fast-track the new care models with support; a new regime of intervention for challenged systems; and support for other areas to develop a shared vision and create the conditions 'for rapid early adoption' (NHS England 2014). For all areas the guidance indicated that national bodies would have developed a better understanding of how far critical conditions for transformation are present in each part of the NHS by April 2015.

As this happens, it will be critically important to evaluate experience in different areas in real time and invest time and resources in sharing the emerging learning. In the case of innovations in commissioning and contracting we have proposed that a community of practice should be established and a similar approach is likely to bring benefits in the other work streams discussed in this paper. If the NHS aspires to be a learning organisation, then now is the time to use both evaluation and sharing of experience to accelerate progress in the direction set by the Forward View.

The difficulties of acting on the ideas set out in this paper should not be underestimated. Each of the policy changes we have discussed presents its own challenges, and working on them all and at the same time is daunting to say the least. It is also the case that transformational changes of the kind set out in the Forward View are almost invariably emergent in nature, requiring adaptability and flexibility as they are implemented. National leadership of the highest order is therefore needed to align policies with the plan and to avoid the Forward View gathering dust on the shelf.

This is particularly the case in the context of an NHS in which operational pressures around finance and performance are increasing. The focus of leaders within the NHS on dealing with financial deficits, A&E pressures and performance against waiting time targets is understandable but is crowding out the time and space needed to attend to the opportunities offered by the Forward View. The risk is that these opportunities will be missed because, in the time-honoured phrase, the urgent takes precedence over the important.

National bodies have a responsibility to avoid this happening by making it clear that delivery of the Forward View is as important as operational performance and by supporting leaders in the NHS in the ways we have described in this paper. Leaders within the NHS also have a responsibility to release key staff, including clinicians, to work on the development of new care models and to provide them with the support and skills they need to convert plans into practice. Too often the NHS has failed to create the implementation and improvement capabilities required to take forward new strategies. This risk must be recognised and managed without resorting to expensive external support from management consultants and others.

The importance of focusing on the execution and implementation of the Forward View is underscored by experience in the United States of establishing integrated delivery networks in the 1990s, referred to earlier. As Burns and Pauly (2012) observe in their assessment, 'Much of the evidence shows that strategic change needs to be carefully implemented. Unfortunately, implementation and execution are poorly understood processes. Providers may need to put greater effort into change management going forward' (p 2414). National bodies in England should heed this insight by acting on our recommendations.

Recommendation

Implementation of the Forward View should involve a process of discovery and not design. There should be a commitment to real-time evaluation and learning throughout the process.

Summary of recommendations

- **National bodies should support NHS commissioners to implement new forms of commissioning and contracting. This should include establishing a community of practice to share learning and expertise, and offering expert legal and other advice.**

- **NHS commissioners should work with interested and capable general practices operating at sufficient scale to establish MCPs taking control of a capitated budget to deliver integrated out-of-hospital services. National bodies should provide access to learning from relevant experience of other health care systems.**

- **Different options for PACS should be explored, recognising the cultural differences between GPs and hospital clinicians and concerns that community services and GPs could become the poor relations. These options should include PACS being established as virtual organisations as well as single organisations.**

- **NHS England and Monitor should accelerate the development of new payment systems such as capitated budgets, pooled budgets and integrated personal commissioning. They should strengthen their own capabilities for doing this work.**

- **The CQC should move quickly to assess how well care is integrated in local systems of care for groups such as older people. It should survey patients and service users to understand their experiences of whether care was well co-ordinated.**

- **NHS England, Monitor and the NHS TDA should extend the use of interventions in whole health economies. They should avoid intervening in individual organisations in ways that conflict with this.**

- **NHS England and Monitor should review current rules on procurement and tendering to remove any barriers to the development of new care models, and provide access to legal advice. Where appropriate they should provide a waiver to enable commissioners to depart from these rules.**

- **National bodies should develop a strategy for quality improvement and leadership development for the NHS in England to enable it to become a learning organisation. This should be based on the presumption that the main responsibility lies with NHS organisations with national support for improvement being provided through small teams of credible experts.**

- **National bodies and NHS organisations should prioritise the development of system leadership both for the NHS as a whole and in local health economies. This should include learning from other sectors and moving beyond the pace-setting styles that have been dominant in the recent past.**

- **New care models and the organisational models outlined in the Dalton review require new styles of provider leadership. These must be supported by national bodies to avoid the wrong kind of regulation and to avoid leaders being deterred from applying for executive-level board roles.**

- **NHS England should work with other national bodies to put in place a transformation fund to support NHS leaders and their partners to implement new care models. This should learn from experience in mental health and ensure that resources are used for transformation, not to keep existing services solvent.**

- **Implementation of the Forward View should involve a process of discovery and not design. There should be a commitment to real-time evaluation and learning throughout the process.**

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