Foundation Trust Network

The Health Foundation
Inspiring Improvement

Can the NHS maintain quality without additional resources?

Key themes from a workshop with NHS providers, 5 August 2014

Event report

September 2014

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The workshop was held to support the Health Foundation's work examining the implications of the NHS's 'financial gap' for quality of care. For more details, see *More than money: closing the NHS quality gap*: www.health.org.uk/morethanmoney

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Introduction

The Health Foundation and the Foundation Trust Network (FTN) co-hosted a workshop on 5 August 2014 to tackle the question of whether the NHS can maintain quality in the short to medium term without additional resources. The event brought together around 25 senior representatives of provider organisations, covering the acute, mental health, community and ambulance sectors. Attendees covered a range of senior roles, including Chairs, Chief Executives, Medical and Nursing Directors, Chief Operating Officers, Directors of Finance and Directors of Strategy. A full list of the organisations represented at the event can be found at Appendix A.

The workshop used two hypothetical scenarios to help guide a free thinking discussion: a challenged trust and a service user with multiple health and care needs. While these were 'scenarios', there was a broad view that many of the challenges we cited in the 'challenged trust scenario' rang true for many in the room, across all the sectors represented. Both scenarios can be found on page 7.

The workshop focused on three main questions.

- If no 'new money' were available, what choices would you need to make to balance the books and how would this impact on quality of care?
- If 'new money' became available, how would this best be spent, both in the short and medium term?
- What are the external facilitators or barriers which would help or hinder your ability to maintain quality while facing financial pressures?

The sessions were conducted through facilitated group discussions combined with plenary discussions and under the Chatham House rule.

Context for our discussion

The financial pressures facing the NHS in England are widely known and have been extensively discussed. The Nuffield Trust has calculated that there will be a shortfall in funding of around £28-34bn by 2021.[1] NHS England's own estimates place the gap at £30bn.[2]

NHS funding is projected to grow by an average of 0.4% in real terms in 2014/15 and 2015/16.[3] However, cost pressures on the NHS are projected to continue to grow at 4% a year. A growing and ageing population, rising chronic conditions and increasing input costs (principally pay) are all increasing pressure on the NHS.[1]

Recent policy developments, including the need to respond to the recommendations from the Francis and Keogh reviews, have added financial pressures to trust costs, estimated at £1.2bn in 2013/14 and 2014/15.[4] This is contributing to a rapid deterioration of NHS finances, largely falling on NHS providers.

The number of trusts recording a deficit rose by 50% in 2013/14, to 66 from 45 a year earlier.[5] Only 36% of foundation trusts and NHS trusts are confident that their trust will be able to meet their financial targets in 2014/15.[6] Wider health and care providers, for instance in primary care[7] and social care,[8] are also under increasing pressure, and the challenges experienced in any one sector frequently have a combined effect on heightening demand in pressure points across whole local health economies.

The Nuffield Trust calculations on the funding gap assume that quality will improve at historical rates and the range of service provision will remain the same as it was in 2010/11 when the projections were made. If the NHS fails to meet the £30bn shortfall the impact on quality (defined by Lord Darzi in the *Next Stage Review* as safety, effectiveness and experience) is unknown.[9] This workshop aimed to explore the possible relationship between the financial challenge and the possible impact on quality of care, from the perspective of a group of foundation trust and NHS trust leaders.

A recent FTN infographic illustrates the financial challenge facing NHS providers, presented on the following page.[6]

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1 Roberts A, Marshall L, Charlesworth A. *A decade of austerity? The funding pressures facing the NHS from 2010/11 to 2021/22*. The Nuffield Trust, 2012. www.nuffieldtrust.org.uk/sites/files/nuffield/121203_a_decade_of_austerity_full_report.pdf

2 NHS England. *The NHS belongs to the people. A call to action.* NHS England, 2013. www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

3 Public Expenditure Statistical Analyses 2014. Table 1.6.

4 Foundation Trust Network. FTN survey shows 1.2 billion being spent by NHS trusts on Francis and Keogh implementation

5 Lafond S, Arora S, Charlesworth A, McKeon A. *Into the red? The State of the NHS' finances. An analysis of NHS expenditure between 2010 and 2014* . The Nuffield Trust, 2014. www.nuffieldtrust.org.uk/sites/files/nuffield/publication/into_the_red.pdf

6 www.foundationtrustnetwork.org/influencing-and-policy/analysis/infographics/at-a-glance-nhs-provider-sector-finances/

7 Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R and Walsh N. *Securing the future of general practice, new models of primary care*. The Nuffield Trust, 2013. www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130718_securing_the_future_revised.pdf

8 Wittenberg R, Hu B, Comas-Herrera A, Fernandez J. *Care for Older People: Projected expenditure to 2022 on social care and continuing health care for England's older population*. The Nuffield Trust, 2012. www.nuffieldtrust.org.uk/sites/files/nuffield/publication/121203_care_for_older_people_1.pdf

9 Department of Health. *High Quality Care for All. The Next Stage Review.* Department of Health, 2008.

at a glance

NHS provider sector finances

Foundation Trust Network

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

£130bn
Required health expenditure by 2020/21

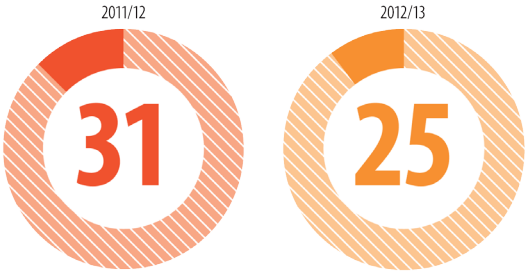
30bn
Funding gap

100bn
Expected NHS England budget

Source: NHS England, 2013; HM Treasury 2010 and 2013

What does this mean for provider finances?

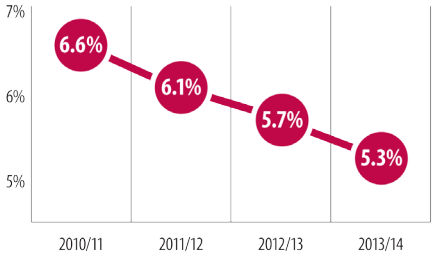
Number of providers in deficit



Source: NAO, 2012 and 2013; Monitor, 2014; TDA, 2014; HFMA 2014

Only one third of NHS providers are confident that their trust will be able meet their financial targets in 2014/15.

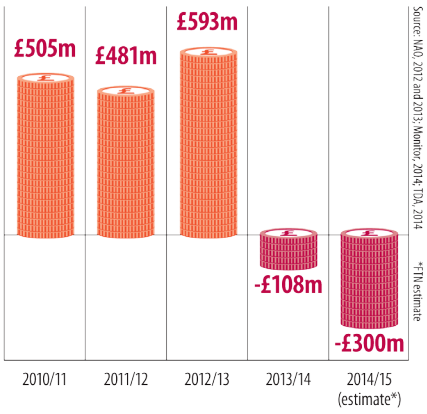
Financial performance (EBITDA for FT sector)



Source: Monitor, 2014; NAO, 2012 and 2013

> *"I'm putting in the trust's first deficit plan for over twenty years"*
>
> Finance director at an NHS trust

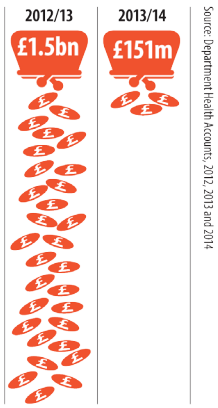
Net provider financial position (trusts and FTs)



Source: NAO, 2012 and 2013; Monitor, 2014; TDA, 2014

*FTN estimate

DH revenue underspend



Source: Department Health Accounts, 2012, 2013 and 2014

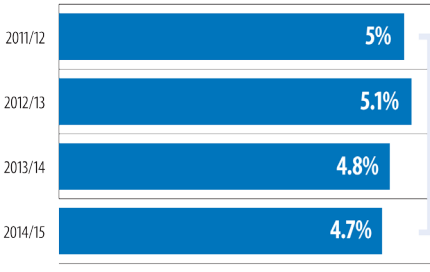
64% of providers are concerned about the financial and operational sustainability of their trust in the next 5 years.

Source: FTN, 2014

NHS providers are still managing to deliver high quality care, despite unprecedented levels of efficiency savings

Financial savings delivered

Source: The King's Fund, 2012–2014



£40m

To a medium sized trust (annual turnover of £200m), this is £40m of savings delivered in total over the past 4 years.

Staff numbers (FT sector)

Source: Monitor, 2014

+24,000
Foundation trusts hired an additional 24,000 members of staff in 2013/14.

This a 4.1% increase since last year. **4.1%**

£600m
24,000 nurses at band 5 represents an additional annual cost pressure of £600m across the sector in salaries alone.

Key messages from the workshop

- **Financial constraint can be a key driver of transformational change.** New models of care – preventative services, coordinated care and better use of technology are necessary to improve quality and efficiency.
- **There is a commitment from NHS providers to protect clinical quality and safety at all costs.** Participants wanted to prioritise clinical outcomes and safety, and found it difficult to accept options that might reduce quality even when fully assured that all efforts to improve productivity had been exhausted.
- **Difficult choices need to be made both politically and at local health economy levels.** Participants acknowledged that current activities to achieve efficiency savings will not go far or fast enough, in which case quality of care will be at risk in the immediate future. Some actions to 'make ends meet' could understandably be unpalatable for staff and the public, such as reductions in staffing or changes to staffing models, service level reconfigurations, or breaches in access targets. National and local political support for change is therefore essential, as well as openness and dialogue with the public and NHS staff.
- **To achieve faster change, collaborative leadership and effective management will be needed.** This reflects the interrelated nature of health and social care, and that no service exists in a vacuum. This is true within provider organisations, but particularly across the whole health economy where leaders will need to work together on system-wide solutions. At a local level, providers and commissioners should be actively driving pathway redesign and enabling change through innovative contracting and facilitating partnership working. Working collaboratively with other providers, commissioners and the public was a strong theme in discussions about achieving the transformation needed.
- **It is critical to ensure that national regulatory and policy frameworks enable and support local change.** This includes effective, proportionate and risk-based regulation, appropriate payment mechanisms, pump-priming investment. Providers may then wish to seek other forms of support locally to free management time ('headroom') to focus on more medium-term changes, to build management capability where needed, and to ensure effective, objective methods to evaluate progress.

Scenarios used to guide the discussion

Hypothetical scenario one: financially challenged trust

Holby NHS Foundation Trust has been a historically strong performer on finances and quality. However, by the end of this financial year 2014/15 it is projecting a £4m deficit on £280m turnover, based on flat revenue and an increase in expenditure.

In 2013 the trust had projected that nurse whole time equivalents would decrease in 2014/15 by 4%, but the latest forecast shows a 2% growth in staffing levels by the end of 2014/15 compared to the previous year, with high unit costs due to a reliance on bank and agency staff.

The trust has met its access targets in 2013/14 but is significantly behind national access standards and CQUIN metrics at the end of Q1 2014/15. An ambitious 5% cost improvement plan is being implemented, which is currently 20% behind plan for this point in the year. The continuity of services risk rating was reduced from three to two last quarter.

Little capital expenditure is planned for 2015/16, but the trust is considering a rebuild of its operating theatre suite and emergency department in 2015/16. This increased expenditure, coupled with pension revaluation costs that will not be recovered through tariffs and a 15% reduction in income from commissioner QIPPs, tariff efficiencies and the Better Care Fund, has led to the trust forecasting a £30m deficit in 2015/16. Cash flow is strong at present, but the trust forecasts that three years of deficit would challenge its status as a going concern.

Hypothetical scenario two: a service user living near the fictional trust

Dorothy is 80 and was recently widowed; she now lives alone and life is a struggle.

Her knees are playing up. She has seen her GP who was concerned about her and referred her to an orthopaedic consultant. Dorothy has an appointment next month to discuss her treatment and the possibility of an operation and she is worried about that.

Her diabetes hasn't been good for a year or two. She wants to know more about managing her condition so she has joined a local diabetes education programme. Her GP has recently told her that her smoker's cough is more serious and is something called 'COPD'.

All in all, she is feeling quite low; maybe she should talk to someone? Maybe she should even think about moving home – even the stairs are a struggle now.

Over the course of the next couple of months as Dorothy struggles with these new challenges she experiences a heart attack and is rushed to the nearest major acute hospital by ambulance and admitted for treatment. When she is discharged home she is invited to a cardiac rehabilitation programme at the local hospital for 4–6 weeks and starts a programme of physiotherapy.

Session one: If no 'new money' were available, what choices would you need to make in order to balance the books and how would this impact on quality of care?

Key points

- **There is a strong commitment from NHS providers to protect clinical quality and safety at all costs.** Participants were reluctant to consider any reductions in quality even when assured that the hypothetical organisation was operating at optimal levels of efficiency. They were clear that the quality of clinical care, in particular clinical outcomes and patient safety, must be protected.
- **However, quality is at risk during a time of constraint.** Quality-neutral measures are unlikely to enable the NHS to meet the full scale of the financial challenge. Difficult choices based on priorities will need to be made. Protecting clinical outcomes and patient safety were considered to be paramount, so it is most likely that experience of care and potentially access to services will be affected first, where this doesn't itself impact on outcomes or safety.
- **A whole system approach underpinned by partnership working is needed to address the financial challenge effectively.** Participants felt that it is essential to work with partners across primary and social care and with commissioners to ensure pathways are operating at optimum level with the right services provided in the right setting.
- **There was a preference to progress transformational change, alongside the recognition that firefighting to fix-short term problems inhibits the ability to do so.** Participants wanted to develop new models of care to ensure sustainable change, rather than doing more of the same, because this would provide better quality of care for patients in the long run. However, there was a feeling that there wasn't enough headroom- for local health leaders to do both and that short-term concerns would crowd out the time, staff resource and other investments needed to develop change for the medium term.

The groups considered three areas in relation to how they would improve the financial balance of the hypothetical trust: the process they would need to follow in making any decisions; the changes they would need to make; and the impact on quality of care. In this context, people were asked to consider the domains of quality in relation to the Darzi definition: clinical effectiveness, patient safety and patient experience.

In discussing how they would go about making decisions, participants came up with consistent themes regarding openness and transparency. There was a common view that it would be a mistake for the trust board to tackle the challenge of reducing the trust's deficit in isolation. Participants thought that openness with staff and the public would be needed from the outset. Being upfront about the challenges, involving staff, patients, service users and the public in the idea generation as well as the implementation, and working to a clear and consistent narrative were all cited as key factors in ensuring that the best choices were made and implemented as well as possible. However, participants acknowledged that these are thorny issues, so gaining a complete consensus around the specific approach to change locally may be very difficult to achieve.

There was also an overriding consensus that no service exists in a vacuum. This means that any changes and decisions in one area will inevitably have a knock-on effect elsewhere within the local health economy. Crucially, people felt that the main way to truly tackle the problem was by working in partnership across the whole local health economy to make sure pathways are working at their best to meet the needs of patients.

'This is Mini versus Rolls Royce. Can we provide the Mini version? It still gets you from A to B.'

CHAIR
AMBULANCE TRUST

In terms of changes providers would need to make, understandably examples of new models of care which invest in preventative measures to keep people healthy, improve community based provision, reduce reliance on emergency or crisis interventions, and make discharge processes swifter, were seen as better for the patient and service users – and for the sustainability of the system. Most of these models centred around the concept of supporting better integration between providers, for instance: better communications between primary, social care and secondary care; easier access to shared, electronic patient records; or making sure patients and service users, carers and professionals were aware of preventative services (eg falls support services or local voluntary support groups). However, there was agreement that transformations in care models would require strong leadership, an appropriate forum for the discussion to take place between stakeholders in the local health economy (seen as a gap in the current system) and ultimately investment in relationship building and collaborative planning to make this change.

Participants felt that in the current climate it was unlikely to be feasible to undertake such transformational change, while also tackling immediate financial pressures. Firefighting the immediate crises would automatically take precedence in order to protect patient safety day to day.

In considering the short-term changes the trust would need to make, there was a strong preference to take 'quality-positive' or 'quality-neutral' measures first. There was a reluctance to consider any measures that could directly harm quality. However, participants acknowledged that some areas of quality may be at risk if the focus of providers was skewed, for instance by central requirements to prioritise balancing budgets, or to meet new or burdensome regulatory demands.

Discussion of the options for change ranged across four broad areas: workforce, infrastructure, service change and indicators of quality.

Maximising the efficiency of the workforce was a consistent theme, although this potentially raises politically sensitive choices. Many participants looked to reduce the overall wage bill, given that this represents the largest share of expenditure for all trusts (ranging between 60% and 85% of budget). Some thought that reducing bank and agency spend was a natural source of efficiency savings, although a more sustainable approach would be to tackle the underlying recruitment and retention issues. Without this, the likelihood was that spend would be difficult to cut in the short term without an impact on quality and safe staffing ratios.

Common examples of **efficiency savings from infrastructure** focused around reductions in non-frontline staff such as back office support, improving the use of IT, or 'parking' long-term investments in estates. However, there was less detail discussed on the specific changes which could be achieved.

"I am sorry, I just can't sign up to that [active decision to let an element of care quality slip]... I would rather overspend than do that.'

DIRECTOR OF FINANCE, ACUTE TRUST

Service change, including reconfiguration, was another option where the dominant theme was the political sensitivity involved in taking such decisions. Examples were given from participants' own experiences of local plans for reconfiguration which had met resistance from councillors, MPs and the local public. There was a sense that new models of care were required which would focus on reforming pathways to better meet people's needs, but there was a risk that the acute hospital was still seen as the default option for most people unless they understood and felt engaged with the changes.

In discussions about the impact on care quality, **all participants had a strong commitment to protecting clinical outcomes and patient safety**. Participants acknowledged that it was unlikely that efficiency measures would go far enough in solving the financial challenge on their own. They agreed that some prioritisation would be needed when assessing which steps to take and their potential impact on quality of care. Access to particular services and patient experience were felt to be more likely to be at risk during a period of financial constraint. Individuals gave some examples of the areas of quality which they personally might consider 'nice to haves' during this time, such as personal TVs in hospital settings or choices related to hospital meals, while others focused on reducing the burden of national data collections (where the discussion ranged across waiting times to the friends and family test).

Access targets (eg those relating to A&E waits and referral to treatment times) were a source of particular debate. Some felt that these were so much in the regulatory and political spotlight that they would be prioritised by default, while others noted that the current emphasis could mean that equally valuable but less politically visible indicators suffered as a result. There was some suggestion of the possibility of short term 'planned breaches' being negotiated with commissioners in order to allow resources to focus on improvement elsewhere. However, some participants warned against heading down this route, not only due to the detrimental impact on patient experience but also as the unintended consequences of longer waiting times could include a deterioration in a patient's condition to the extent that clinical outcomes are also put at risk.

The group found it difficult to agree on which areas they would be content to see slip as participants had different views on the relative value and impact such choices could have on protecting clinical outcomes and patient safety, depending on the services they were most familiar with.

This dilemma typified a general debate throughout the session around the extent to which trust boards could realistically take 'active' decisions to allow, or significantly risk, reductions in quality versus the much more likely scenario of an indirect effect brought on by wider changes, unintended consequences, or focus being targeted elsewhere.

Finally, people considered how the changes they had discussed would impact on the patient described in the hypothetical scenario we used (see page 4). Here, participants felt that if models of care were transformed in a more sustainable way rather than by short-term fixes, this would be much better suited to patient and service user needs. However, in the absence of this change, there was general pessimism about the scope for meeting all of the care needs that 'Dorothy's' case described, with physiotherapy being the most commonly cited example of the treatment that may be cut back in this particular instance.

Session two: If 'new money' became available, how would this best be spent, both in the short and medium term?

Key points

- **There is a tension between the need to use 'new money' to pay for short-term fixes versus investing in medium-term changes that would be more sustainable.** Participants were drawn to the use of any available new funds to support transformational change, not to pay for more of the same. It was recognised that immediate pressures would need short-term relief, but there was a sense that potentially bigger gains could be achieved by investing in medium- to long-term solutions.
- **Providers do not work as islands; they want to work together, with commissioners and with other partners.** Crucially, providers did not opt to reverse any of the challenging productivity improvements they considered in the first scenario even when 'new money' became hypothetically available. The theme of partnership working was as prevalent throughout this discussion as it was during session one. Participants still saw working together as the best solution, rather than retreating back to old ways of institutional silos just because new funds were available.

In this session, participants were told that additional funds had become available, which would clear the deficit at the hypothetical trust and provide about another £30m of 'new money'. Where participants took the view that this was contingent on having already implemented the changes they had discussed in session one to close the deficit, rather than having been bailed out of the problem, it was interesting that many would not want to necessarily reverse the choices they had made during financial constraint. Some indicated a willingness to risk manage a short-term impact on some aspects of quality if it meant investing in what they saw as a more sustainable and better quality model of care in the medium- to longer-term. Many wanted to ensure this money was put to best use to develop services for the future, avoiding a repeat of the original problem. As in the discussion during session one, most participants saw the likely impact being on patient experience and potentially access times, as neither clinical outcome nor patient safety could be compromised.

'We need to invest to save.'

DIRECTOR, INTEGRATED TRUST

Like session one, **the dominant feeling was that any investment should reflect the needs of the local health economy as a whole**, rather than investing in provider services in isolation. Participants remarked that they didn't want to develop partnership working during times of constraint, only to revert to organisational silos again once the storm had passed. They wanted to ensure that the changes which intuitively felt like the best way forward for patients and service users, as well as for financially viable services, were actively taken forward while trust boards and partner organisations had the headroom to do so.

'The NHS has had the chance to transform care before. We really can't afford to waste the opportunity this time.'

DIRECTOR
INTEGRATED TRUST

Examples suggested as potential service models worth exploring included:

- 'GP in A&E schemes', and other methods of investing in primary and community-based care which would improve primary care treatment where appropriate and allow for the acute sector to be as lean as possible
- 'care coordinators in the community' to help people navigate the multiple providers involved in supporting people with chronic or multiple conditions
- 'single electronic patient records', which would allow people to access immediate and consistent information and to make decisions more quickly.

However, despite the fact that these models of care have been described and in some cases implemented in the NHS over some years, there is certainly room for much greater consistency in the adoption of all of these types of initiatives across local health economies nationally.

There were also a number of suggestions relating to the opportunity to **maximise the skills mix and capacity within the workforce,** for instance through provision of better training and development, composition of multidisciplinary teams or by investing in recruitment and retention to minimise excessive bank or agency staff costs later down the line. Participants also felt that there was a need to invest in the time to allow novel changes to bed in, and to manage risk during the interim period, for instance by funding some initial double-running of services.

Some participants expressed caution that the NHS has had opportunities to change before and that money could be perceived to have been wasted in some instances, particularly where grand infrastructure projects were attempted and did not deliver. There was an underlying sense that waste was not an option this time, as extra funds were likely to be a one-off. This led to a call for any **changes to models of care to be evidence based and their implementation monitored** to spot and tackle emerging issues as and when they occurred.

To make sure that providers and commissioners really focused on changes that had the strongest potential to work well, especially where concrete evidence was still emerging, there was a general question about improvement capacity and capability within the NHS. Some queried a tendency to look to external examples (for instance buying in advice or looking to other sectors outside health for inspiration) when there was already a lot of expertise internally, if only people had the time and confidence to share it and the openness to receive it. The recovery model within mental health services was a particular example of a mindset that wider services could look to for inspiration, especially to start to move away from a purely curative model of care to one focused on self-management, prevention and ongoing support.

A potential barrier to the NHS's ability to use any additional money as a transformation fund was the prospect of political imperatives resisting radical change in favour of propping up the status quo. Participants felt that this would miss a real opportunity to:

- avoid an impending financial crisis
- invest now in clinically and financially viable services for the benefit of patients
- avoid simply putting on hold the difficult choices the service faces.

Session three: What are the external facilitators or barriers which would help or hinder your ability to maintain quality while facing financial pressures?

Key points

- **Some national system rules were designed for a different era.** Some of the regulatory and financing rules affecting providers were perceived to reflect a different era and are not fit for purpose in a time of constraint. Participants called for changes to the payment and pricing system to better support integrated care.
- **Collaboration needs to be supported by system rules and infrastructure.** There was a sense that flexible contracting or payment mechanisms such as 'year of care' or pooled budgets could facilitate progress if used well. Effective sharing of information, in particular swift access to shared patient records, was repeatedly seen as a prerequisite for more effective cross-provider working.
- **New styles of collaborative, local leadership are needed to drive this change.** At a local level, commissioners and providers should be actively driving pathway redesign and enabling change through innovative contracting and facilitating partnership working. This will require working more collaboratively with partners for mutual benefit and to share risk. National bodies should allow local health partners the flexibility to make decisions which best suit the needs of their local health economies. Clarity over roles and responsibilities of different national bodies, including the regulators, would also minimise the duplication currently felt to exist within the system.

In this session, groups were asked to consider the external barriers they would like to see fewer of, as well as what they would like to see more of in the system in order to help them to meet the dual challenge of closing the financial gap while maintaining quality. Four broad categories emerged from the discussion: workforce, leadership, a forum for local discussion within the health economy, and payment systems.

First, workforce was a central theme of many discussions, with people citing a range of perceived barriers to innovation in the models of care and productivity. These issues ranged from training to pay and conditions. Individual examples included a concern that the adoption of new training curricula or practice was slower than needed, that the 'Agenda for Change' rules were designed for a time of plenty, allowing for significant overlap and variation in pay scales, and that there was a general over-reliance in the system on measuring workforce performance based on inputs, for instance numbers of nurses or GPs, rather than outcomes.

Second, on leadership, there was a distinction between the lenses through which different groups approached the discussion. Some focused on national bodies, system rules and political oversight whilst others saw the local health economy as more relevant to the key barriers and enablers to change. However, a consistent theme was for greater clarity about roles and responsibilities within the system.

'If we work together we can achieve this.'

CHIEF EXECUTIVE, ACUTE TRUST

At a national level, participants queried the justification for what was perceived to be multiple regulators operating within the same space. Participants welcomed the general move to have 'co-badged' communications between national bodies as it clarified that there was a joined-up approach in place on a particular issue, but questioned whether this potentially indicated a significant amount of role overlap. Some participants suggested a single regulator in place of multiple organisations, or a greater form of gatekeeping of the messages issued by the regulators. The political cycle was also seen as either an enabler or a barrier depending on where in that cycle you are at any time. Participants described potential 'windows for change' opening in the immediate aftermath of a general election in contrast to the feeling of a stalemate in the last period of a given government. Participants described a feeling that radical change is now off the table, either because people will want to wait and see what the outcome of the general election will be, or because they acknowledge than any difficult change will be contested by local or national politicians.

At a local level, participants discussed the challenges of working with multiple commissioners. There was a sense that size of commissioners' patch was important and that many CCGs cover too small a population to commission effectively for outcomes, however people were cautious about suggesting further structural changes. Participants wanted to know where the power base for change lay in their health economy, noting that in some areas providers were leading the way in pathway reform and reconfiguration rather than the commissioners.

The importance of clear and strong leadership was apparent regardless of the part people played in the system. The ability to tackle challenges transparently, make and stick to difficult decisions, consistency and clarity of message (including avoiding 'policy conflict') and working to support others around you were common factors of leadership cited in relation to those at all levels of the system, from politicians through to provider management.

Third, there was a general discussion about how well current payment systems support both high quality patient care and the need to transition to new care delivery models. The year-on-year deflation of national prices has led to short-term cost savings approaches in the NHS rather than the longer-term service redesign and innovation that will support system efficiency in the future. This is exacerbated by unpredictable injections of non-recurrent funding that do not provide a stable platform for planning or service delivery. New payment and contracting approaches are needed to better allocate risks and incentives in the system and to support more integrated care and cross-organisational collaboration. New funding approaches are needed that take a more credible view of deliverable efficiency and which allow commissioners and providers to develop and deliver transformational improvements for their local health economies.*

* The FTN is currently doing work in the area of payment and pricing development, working with NHS England and Monitor. For more information see: www.foundationtrustnetwork.org/influencing-and-policy/funding-and-sustainability/payment-systems

Fourth, there was a general call for more support for joint working between providers, as discussed in the earlier sessions. This broadly fell into two categories: infrastructure (such as joined-up IT systems or single electronic patient records to enable quicker communication and decision making along a pathway) and an appropriate forum for discussion between the main players in the system. On the latter, some participants instinctively thought that Health and Wellbeing Boards would be the most logical current forum for such discussions within a local health economy. However, providers in the room had mixed experiences and feelings with regard to the levels of provider engagement and the effectiveness of Health and Wellbeing Boards' current set-up, leading others to query whether they actually would be the most effective forum. Participants remarked that, in some areas, providers were not automatically included on the membership of Health and Wellbeing Boards and many had not yet been invited to engage appropriately.

Finally, participants were clear in this discussion that their comments reflected their initial reactions to the question, but were conscious that these immediately prompted the mind to focus on what was wrong within those areas outside their own control. The group was concerned that this could be perceived as laying the blame elsewhere for the challenges experienced in the system, when in reality everyone had a part to play in this and providers are critical to its success. There was caution about advocating structural reform given that the recent changes under the Health and Social Care Act 2012 are still bedding down, but rather to keep up the pressure on reform of some elements of the system rules in order to improve them and assure ourselves that they are working at their best.

Reflections on the implications of these messages for the system and for future work

There were some strong messages from this event, which will shape the work of the Health Foundation and the FTN over the coming months. These messages also have implications for the whole system to consider.

- **There is growing acknowledgement that current models of health care are not fit for the 21st century care patients and providers want and expect.** The combined challenges of rising demand, increasing chronic and multi-morbidity, rising costs of technology and increasing expectations are all well rehearsed, but the scale and immediacy of the financial challenge makes sustainable actions to address them even more important. Some providers and commissioners are already leading the way in taking change forward, but others feel constrained by the need to address the immediate issues at hand and are less able to plan ahead.
- **There is an expectation that the NHS can deliver high quality care today and focus on transforming care for tomorrow, while the financial belt is tightening.** The strong feeling among participants was that it is no longer credible to say that this expectation is realistic. The health system can only split its resources – including management time and focus – in a finite number of ways. A tension therefore exists between the short-term imperative and the longer-term requirement for transformation.
- **Currently, the scales are tipped towards focusing on the short term, which is reducing the headroom available for local leaders, including trusts, to develop more transformative ways of working.** Nationally, some of the current system rules, including provider regulation, are focused on the here and now. One-off sums of additional money are currently targeted towards specific immediate priorities, often those which are the most visible indicators of pressure in the system.
- **We need greater openness from national leaders that the status quo is unsustainable, with a full debate about how best to enable change at local levels.** To give the transition to a 'new NHS' the best chance of success, providers suggested that the main ingredients they need are the time and headroom to focus on transformative change, coupled with investment – potentially in the form of a 'transformation fund' – to establish new services and support from national polices. A repeated narrative of diverting resources and management focus on the maintenance of access targets was seen to be unconstructive. Providers need to be supported to work together, and with others including commissioners, to approach these issues in partnership. Their chances of success will be far greater if there is systematic sharing of learning, best practice and improvement methods, coupled with access to further support if required.

- **In reality, transforming models of care is about ensuring that services are operating around the needs of patients, service users and carers.** An open debate about the implications of these messages needs to start from this perspective. Those leading, working within and using the health service need to consider how the choices made in healthcare will impact on people who use health and care services and whether or not these are acceptable choices to make in light of the alternatives.
- **Targeting any additional funds towards transformation would help to focus on clinical and financial sustainability for the benefits of patients and the public.** However, this would need to be coupled with commitment to follow through from providers and commissioners. The quid pro quo of any headroom offered to providers is that people still need to be held to account for achieving changes to services for longer-term gain. Additional national performance management will not help as it will result in further firefighting at local levels. A more targeted, risk-based approach could be developed to ensure essential standards do not slip while new models of sustainable and appropriate 21st century care are introduced and embedded.
- **Short- and long-term choices will not be easy to make, and should be driven by what people using services really need.** We are conscious that these reflections are based on messages from providers and there is a risk that we perceive this as a position which suits the system but not the public it serves. There have been opportunities to make changes to the health system before, but often these have scratched at the surface or focused on structural changes rather than focusing squarely on the quality of care for patients. However, based on the evidence of this piece of research, the commitment is certainly there from providers to work in partnership locally, including with patients and the public, to adapt and improve pathways in their best interests. Some of the policy and regulatory rules may need to change to support this better.
- **In the run up to the general election, there is an opportunity for political leaders to acknowledge the scale of the challenge facing the NHS and to be clear about their priorities.** There should be an open and honest public debate on what the NHS can deliver over the short and long term. A period of constraint presents an opportunity to transform care to be fit for purpose, but this opportunity only exists if there is open, honest and frank discussion about the issues and acknowledgement of some of the difficult decisions. In addition, both the Health Foundation and the FTN will be taking forward further work to build on the messages we have heard here.

Future work – Health Foundation

The Health Foundation has work underway which supplements and builds on the messages we heard at this event.

1. This workshop was part of a wider piece of work looking at the 'quality gap' in light of the financial challenge. The report, *More than money: closing the NHS quality gap* report analyses the options available to reduce the financial gap, including drawing on lessons from international case studies of change under financial pressure. See www.health.org.uk/morethanmoney
2. In the run-up to the election, there will be a lot of talk about what needs to change, but less on how we should do this. Drawing on our quality improvement experience, we plan to publish a report setting out our views on how the system could best maximise the opportunities to take forward quality improvements at scale and pace.
3. In October, with the Nuffield Trust, we will publish the second QualityWatch Annual Statement. This report will draw on analysis of over 200 quality indicators and four in-depth reports, spanning a range of care settings, to provide an overview of how patterns of quality in care services are changing.

To stay informed about future Health Foundation work, sign up to our email newsletter at www.health.org.uk/enewsletter

Future work – Foundation Trust Network

FTN will be picking up the themes and evidence provided by our members in this workshop through the following routes.

1. FTN's manifesto, to be published ahead of the general election and designed to support and influence the thinking of the new government.
2. A specific publication planned for publication in the autumn, capturing member case studies reflecting the strategies and operating models that providers are adopting to ensure their sustainability and protect care in the current environment.

More specifically, the discussion will inform the following pieces of work:

- Our ongoing dialogue with government and the national bodies about the scale of the financial challenge facing NHS providers, and members' growing concern about the potential for this to impact on their ability to sustain quality of care.
- Dialogue with Monitor and NHS England about the need to develop more innovative payment mechanisms at pace for the acute, mental health, community and ambulance sectors. This will include a particular focus on the tariff deflator, which we believe to be unachievable in the current climate; the need to develop 'parity' of payment systems for mental health and community trusts at a pace; and particular rules such as the 30% marginal tariff for A&E which we believe should be abolished.
- Regular dialogue with Monitor, CQC and TDA to ensure the regulatory regime is streamlined across the regulators, proportionate, and risk based.
- Our wider engagement with a range of partners including NHS England, DH and other representative bodies with regard to enabling local health economies, protecting provider autonomy and enhancing relationships and integrated working between our members and other parts of the health and care system.

Appendix A: workshop attendees

	Organisation	Sector
1	Ashford and St Peter's Hospitals NHS Foundation Trust	Acute
2	Barnet, Enfield and Haringey Mental Health Trust	Mental Health
3	Basildon and Thurrock University Hospitals NHS Foundation Trust	Acute
4	Bedford Hospital NHS Trust	Acute
5	Birmingham Women's NHS Foundation Trust	Specialist
6	Coventry and Warwickshire Partnership Trust	Integrated
7	Dorset County Hospitals NHS Foundation Trust	Acute
8	East Midlands Ambulance Service NHS Trust	Ambulance
9	Greater Manchester Commissioning Support Unit	Commissioning
10	Kent and Medway NHS & Social Care Partnership	Integrated
11	Lincolnshire Community Health	Community
12	Medway NHS Foundation Trust	Acute
13	Norfolk and Suffolk NHS Foundation Trust	Integrated
14	North Essex Partnership University NHS Foundation Trust	Integrated
15	Northumbria Healthcare NHS Foundation Trust	Integrated
16	Salisbury NHS Foundation Trust	Acute
17	Sheffield Teaching Hospital NHS Foundation Trust	Acute
18	South Western Ambulance Service NHS Foundation Trust	Ambulance
19	Southend University Hospital NHS Foundation Trust	Acute
20	Sussex Partnership NHS Foundation Trust	Community
21	The Royal Orthopaedic Hospital NHS Foundation Trust	Specialist
22&23	Warrington and Halton Hospitals NHS Foundation Trust	Acute
24	West London Mental Health NHS Trust	Mental Health
25	Yorkshire Ambulance Service NHS Trust	Ambulance

The Health Foundation is an independent charity working to improve the quality of health care in the UK.

We are here to support people working in health care practice and policy to make lasting improvements to health services.

We carry out research and in-depth policy analysis, run improvement programmes to put ideas into practice in the NHS, support and develop leaders and share evidence to encourage wider change.

We want the UK to have a health care system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable.

The Health Foundation
90 Long Acre
London WC2E 9RA
T 020 7257 8000
E info@health.org.uk

Registered charity number: 286967
Registered company number: 1714937

For more information, visit:
www.health.org.uk

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The Foundation Trust Network (FTN) is the membership organisation for NHS public provider trusts, representing NHS acute hospitals, community, mental health and ambulance services. We currently have over 220 members – more than 90% of all NHS foundation trusts and aspirant trusts – who collectively account for £65 billion of annual expenditure and employ more than 920,000 staff.

As the single voice for NHS public providers, we help those NHS trusts deliver high quality care by promoting shared learning, providing support and development and, crucially, shaping the strategic system in which our members operate.

Foundation Trust Network
One Birdcage Walk
London SW1H 9JJ
T 020 7304 6977
E enquiries@foundationtrustnetwork.org

Registered charity number: 1140900
Registered in England number: 07525114

For more information, visit:
www.foundationtrustnetwork.org

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Chris Hopson, chief executive:
@ChrisCEOHopson