Monitor

Making the health sector work for patients

Monitor's strategy 2014-17

Helping to redesign healthcare provision in England

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Summary

A growing consensus has emerged that the way healthcare is delivered to the people of England needs to change. This represents a major opportunity for everyone who works in the sector to make improvements that will meet patients' changing needs and expectations better, provide them with consistent high quality and compassionate care, and make the money available to the NHS go as far as possible. Furthermore, there is considerable agreement within the sector as to what the broad thrust of this change should look like. Indeed, many of the proposed changes, such as better integration of care for people with multiple needs, are not new, and already there are examples across the sector of innovative and better practice.

However, if the NHS is to continue to thrive as a universal health service, free at the point of delivery – something which Monitor is committed to – and if the opportunity to provide better care for more people is to be seized, then the pace of change must be much faster than we have achieved in the recent past. Commissioners and providers on the front line must be allowed and encouraged to develop the new models of care provision that are needed at a local level, whilst at the same time everyone involved in the sector must do significantly more to improve the quality and efficiency of care delivery today.

Under the Health and Social Care Act 2012 ('the 2012 Act') Monitor was established as the 'sector regulator' for health services in England to help in this transformation. We were given a new primary duty "to protect and promote the interests of people who use healthcare services" and a wide range of new responsibilities: making sure public providers are well led; making sure essential services are maintained; making sure the NHS payment system promotes quality and efficiency; and making sure procurement, choice and competition operate in the best interests of patients.

In simple terms, our job is to work with the other system leaders and those who work on the front line to make the health sector work better for patients. This is our mission. Our strategy describes what we plan to do to achieve this mission, focussing on the critical priorities for the next three years against each of our core responsibilities. It has four cross-cutting themes:

1. **Paying more attention to provider capability.** The capabilities of provider organisations and their leaders will be more important than ever if they are to sustain the provision of high quality services in the face of a highly challenging and fast-changing environment. Therefore, we will pay more attention to the issue of provider capability, including providing support, alongside partner organisations as appropriate, to NHS foundation trusts – not just underperformers – to enhance their institutional and individual capabilities. We will focus in particular on the capabilities that drive long-term performance: strategic and business planning; organisational development; operational

performance improvement; and individual leadership. We will also place more weight on the assessment of these capabilities at trusts seeking to demonstrate that they have achieved the foundation trust standard, although we will not do so in a way that raises the 'bar' that NHS trusts must clear to qualify as a foundation trust.

2. **Balancing freedom to change and risk of failure.** Change and innovation require that local decision-makers are granted the freedom to get on and do their jobs. However, at a time when there is increasing attention being paid to the quality of care and when resources are scarce we must actively play our part in reducing the risk that failings go uncorrected for any significant period. Therefore, we are changing our approach to monitoring providers in order to minimise the burden we impose whilst also seeking to spot emerging problems as early as possible and to step in swiftly when we do. We will also keep under review our toolkit of interventions so as to make sure they are as effective as possible given the resources available to us.

3. **Making sure rules operate in the best interests of patients.** Monitor has responsibility for two sets of rules which are central to how the health sector operates: those governing the payment system and those governing procurement, patient choice and competition. In both areas we will work with partners to make sure these rules are aligned with the way the rest of the system operates and to ensure they are all designed and operated to incentivise behaviours that are in the best interests of patients. We will also work hard to make sure there is a good understanding of how to use the rules so that they are not an obstacle to doing the right thing for patients.

4. **Joining up nationally and locally.** The new architecture of the NHS means that responsibilities are divided amongst many bodies. At Monitor we will reach out to and seek to work closely with our partner organisations, nationally and locally. This means, in particular, NHS England, the NHS Trust Development Authority, the Care Quality Commission, the Competition and Markets Authority, and the Department of Health. Not only must we work together collaboratively but we must have a common vision for what we're trying to achieve and a shared approach to how we will get there. In particular, we will seek to work with partners to take a health economy-wide approach to promoting change and fixing problems.

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Background

The health sector in England today faces a major opportunity and a major challenge. It has the opportunity to reshape the way care is delivered so that it better meets the needs and expectations of a changing population, provides better quality and more compassionate care, and also delivers that care more efficiently, so the money available for patients goes further. However, it also faces the challenge of doing this at a time when finances are squeezed and the quality of today's care has become a pressing concern in the wake of unacceptable failings at a few trusts: as the NHS Constitution says, patients have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of the healthcare they commission or provide. There are also growing pressures to improve access to care – especially GP services – and to provide the same quality of care 24/7.

The pressure to deliver better quality care for less money – in other words to improve productivity – is mounting for a number of familiar reasons: we are living longer, many of us with long-term conditions, such as diabetes, asthma and arthritis; 1 in 4 of us will have a mental health problem at some stage in our lives; and more of us are pursuing unhealthy lifestyles. These factors, along with increasingly expensive treatments, all contribute to health sector cost pressures rising around 4% a year faster than general inflation. NHS revenues are unlikely to keep pace with this for the foreseeable future. The result is a growing gap between costs and revenues. If current trends continue, people across the sector broadly agree that this gap will reach about £30 billion a year by 2020/21, or just under 30% of current NHS annual spending.

Neither the opportunity nor the challenge is new, nor indeed unique to England. Most health systems in the developed world face the same fundamental challenge: to improve care at a time when the growth in costs is outpacing the potential to grow funding. Nor has the sector been standing still. Every year providers and commissioners have been improving efficiency and changing the way care is delivered. Nevertheless, the scale and pace of change needed in the NHS today is probably greater than ever before.

Monitor, as we said in the 'Call to Action'[1] published by NHS England, is committed to preserving the values that underpin a universal health service, free at the point of use. However, as the 'Call to Action' goes on to say, this will mean fundamental changes to how we deliver and use health and care services, not least by providing access to care that is much better integrated around the people who need it.

There is broad agreement about the general direction of change required. For example, it will mean breaking down traditional divisions between types of care provider – primary and secondary, physical and mental, health and social. It will mean doing less in hospitals, more outside. It will mean significant changes to

[1] See: www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

primary care, including achieving greater scale. It will mean concentrating specialised services and developing new, sometimes radically different, models of general hospital care. And many patients will need to interact with the NHS in different ways.

How these general themes translate into concrete changes on the ground – in terms of who works where, doing what, and what the organisations they work for look like – must largely be determined area by area, reflecting local circumstances and needs. But what they add up to is nothing short of a complete redesign of how care is delivered in England. And this must happen at the same time as the system addresses its urgent quality and financial priorities.

Monitor's new role as sector regulator

Under the Health and Social Care Act 2012 ('the 2012 Act') Monitor was established as the 'sector regulator' for health services in England and given a new primary duty: "to protect and promote the interests of people who use healthcare services by promoting provision of healthcare services which is economic, efficient and effective, and maintains or improves the quality of the services". In other words, our job is to make the health sector work better for patients. This is our mission.

With this new mission has come a broader set of responsibilities. Our strategy, set out in this document, describes what we plan to do to achieve this mission, focussing on the critical priorities for the next three years against each of our new responsibilities. However, our mission is also underpinned by a redefined set of values and a renewed commitment to playing our part in ensuring that everyone receives good quality, compassionate care from the NHS.

Our responsibilities

Before April 2013 Monitor's main task was to authorise and regulate NHS foundation trusts, currently 60% of all public providers of NHS services. However, under the 2012 Act we were given a wide range of additional responsibilities. Our core responsibilities can now be summarised under four main headings:

1. **Making sure public providers are well led.** From its inception, Monitor has been tasked with making sure public providers of NHS care are well led, delivering quality care on a sustainable basis. We do this in two ways, first by setting a required standard that all NHS providers must meet (our foundation trust authorisation standard or 'bar') and by working, most recently with the NHS Trust Development Authority (NHS TDA), to ensure that, in due course, all NHS providers meet this standard. Second, we seek to control the risk that foundation trusts, once authorised, fall back below the required standard. If they do, we take remedial action. We also work with others to support the on-going development of foundation trust capabilities so that they are able to deal better with the challenges they face.

2. **Making sure essential services are maintained.** If a provider of essential NHS services, whether an NHS foundation trust or an independent sector provider, gets into such serious difficulty that it is unlikely to be able to continue providing its essential services for much longer, Monitor is responsible for making sure those services are maintained and protected for local patients. The services may continue to be provided by the failing provider, while it restructures, or by alternative providers.

3. **Making sure the NHS payment system promotes quality and efficiency.** One of Monitor's new duties is to work with NHS England to design and operate the payment system for all NHS services. NHS England specifies how services should be grouped for payment purposes (known as currencies), and Monitor sets the rules for how the level of any payment should be determined.

4. **Making sure procurement, choice and competition operate in the best interests of patients.** The purpose of promoting good procurement and, where appropriate, enabling patients and commissioners to choose between competing service providers is to support improvements in the quality of care and the efficiency with which it is provided. Monitor's role is to help commissioners and providers make sure patients do not lose out through poor commissioning, restrictions on their rights to make choices or inappropriate anti-competitive behaviour by commissioners or providers.

Our values

Our mission describes in simple terms what we are trying to achieve. Our strategy describes what we plan to do to achieve our mission. Our values, however, are more fundamental. They describe the sort of organisation we want to be in the long term. They serve to remind us and others of what we see as of central importance to Monitor.

In the light of Monitor's much expanded responsibilities and the significant changes to the architecture of the health system in England, we have taken the opportunity to update our values:

Patients first

Our primary duty – and therefore our mission – focuses on patients. This is a significant and welcome emphasis for Monitor. Making a difference for patients will govern all that we do. It means we will be guided by what the evidence shows works for patients, not by ideology. We will not enforce rules for their own sake but because we believe they will lead to better outcomes for patients. Similarly, when we need to balance the use of different levers – for example, improving sector efficiency through the national tariff and securing the viability of individual foundation trusts, or

maintaining patient choice and consolidating services for improved quality – our guiding principle will be to do what is in the best interests of the people who use the services.

Work with partners

The new architecture of the NHS means that responsibilities are divided amongst many bodies. This is not necessarily a bad thing. Making explicit, even public, the inevitable trade-offs between different responsibilities can lead to better decisions. Exposing for all to see how well different parts of the system are working together should make us all work together better. To be an effective organisation Monitor must reach out to and work closely with our many partner organisations, in particular NHS England, NHS TDA, the Care Quality Commission (CQC), the Competition and Markets Authority (CMA) and the Department of Health. Not only must we work together collaboratively, we must also have a common vision for what we're trying to achieve and a shared approach for how we will get there. Consistent with this, everyone in Monitor should have a network of collaborators from partner bodies and other stakeholders.

Support the front line

Monitor does not deliver care. It is our job to support those who do – the nurses, doctors, carers, managers and many more who work inside and beyond the NHS. This means recognising and respecting the challenges they face every day and their commitment to do the best for their patients. It means helping them do the right thing rather than waiting for them to do the wrong thing. It means giving them as much freedom as possible to do what they are good at: to innovate and make changes at a local level that are in the best interests of the people they serve.

One team

Even within Monitor there are many different levers we can pull to play our part in helping to ensure that patients and service users get the best possible care, delivered as efficiently as possible. So we too must work together, establishing a culture of collaboration and support that values helping a colleague achieve their objectives and develop as much as taking personal accountability for achieving our own goals. This will help us focus on what is best for patients as we look for the right balance between the different levers.

Professional

At Monitor we are proud of our reputation for being professional in the way we do things. We don't want this to change. We will bring evidence, analytical rigour and objectivity to bear on all our decisions. We will be open and transparent about how we make decisions. We will focus on what works, being pragmatic in pursuit of the patients' interests. We will always try to make sure people understand what we

intend to do, and then do it. We will try to do all of this whilst consuming as little of the NHS's resources as possible.

Our commitment to quality care

Monitor has always been more than a financial or economic regulator. In our historic role as NHS foundation trust regulator we made sure trusts were well led so that they could deliver quality care for patients. This dimension of our work was amplified by the wider powers we acquired in April 2013, and given further impetus by the emphasis on quality across the NHS initiated by the Francis Inquiry. We now work closely with CQC to adopt a seamless approach to quality regulation with the aim of preventing problems arising in the first place, detecting quickly problems that do arise, and taking prompt action to remedy them when they do (see box).

Monitor's quality priorities

Preventing serious quality problems arising

- We build the capability of trust boards and senior leaders to oversee quality
- We set clear standards of quality governance
- We do not authorise foundation status for trusts with poor quality care or inadequate quality governance

Detecting problems quickly

- We contribute to spotting quality problems through our 'Risk Assessment Framework'
- We work with partners to share intelligence that may be an early warning of problems, through regular communications at national level and local risk summits

Taking action promptly

- We use our enforcement powers to make sure quality problems are, once identified, fixed, placing trusts in special measures in the most serious cases
- We are explicit about the actions required to resolve quality problems and the timescales required to fix them
- We provide support and oversight to bring about change

Monitor's strategy for 2014-17

The changes that will lead to more and better care for patients need to take place on the front line. So our strategy for the next three years is about helping the whole sector redesign itself. Working with our national partners we are aligning the rules and incentives that inform decisions taken by clinicians, managers and commissioners. Our aim is to create a stable and coherent framework of incentives that supports these decision-makers in designing and implementing new patterns of care.

The strategy, set out below, describes our main priorities for achieving our mission. Its scope is broad, reflecting the sector-wide responsibilities we were given under the 2012 Act. We have organised it around our four core responsibilities and two supporting elements:

- promoting change through high quality analysis and debate, and encouraging innovation
- making sure Monitor is a high performing organisation.

1. Making sure public providers are well led

Our approach to making sure provider organisations are well led has focused up to now on the role of the board and the organisation's governance arrangements, and especially more recently, quality governance. We have also paid significant attention to current and near-term planned performance as a good indicator of the strength of the board and its governance processes.

Looking forward, and recognising the scale of the challenges facing providers, we plan to pay more attention to the capability of provider organisations and their leaders to sustain performance in a rapidly changing world. In particular we believe we need to focus on the capabilities that drive long term performance: strategic and business planning; organisational development; operational performance improvement; and individual leadership.

Working towards all NHS providers achieving the foundation trust standard

Given the challenges faced by the sector it is becoming increasingly clear that the organisational structure and form of many providers will have to evolve. This might well include some providers not surviving in standalone form, perhaps becoming part of larger organisations, such as provider chains or organisations with a wider remit to deliver integrated care. However, whatever the precise structure or form of public sector providers, we believe that we should continue to work with other bodies, especially NHS TDA and CQC, to ensure all providers achieve the quality,

operational and financial standards required to become a foundation trust. To do this we will in particular:

i. **Emphasise the assessment of a provider's ability to sustain the provision of high quality services.** As outlined above, this means placing more weight on the assessment of an applicant's institutional and individual capabilities. So far, we have mostly assessed these capabilities by looking at an applicant's board and quality governance, and by testing how well they are able to respond to a potential deteriorating environment. However, given the real uncertainties faced by provider organisations and the need for many to transform how they deliver care, we will seek in future to assess more directly whether they have the capabilities they need to make the necessary changes. This should also enable us to be more flexible in assessing trusts with new and possibly untried business models, or trusts which have only a very limited track record in their current configuration. Nevertheless, we are conscious that we must do this in a way that does not constitute a raising of the foundation trust 'bar'. Rather, it needs to be a careful and measured change of emphasis in how we assess whether a trust meets the bar.

ii. **Do all that we can to help NHS TDA ensure that the remaining NHS trusts meet the foundation trust authorisation standard.** Monitor must make an independent assessment of applicants for foundation trust status. However, we believe we can find ways to help NHS TDA support aspiring trusts to achieve the required standard without compromising our independence. At a minimum, we must make sure that both NHS TDA and applicant trusts fully understand the criteria against which we assess applicants, and that we share the lessons from previous applications.

iii. **Remove any duplication or inconsistencies from Monitor, NHS TDA and CQC processes.** We know that in the past some applicant trusts have gone through assessment processes similar to Monitor's before they start going through ours. We will work closely with NHS TDA to remove as far as possible any duplication or inconsistencies in our two processes, including when an NHS and foundation trust seek to merge. Similarly, as CQC takes on responsibility for assessing whether providers are well led, we will work with them to make sure that there is no duplication or inconsistency in the way we regulate providers and in particular that we both take a single, consistent approach to assessing their quality governance, building on Monitor's previous work in this area.

Regulating providers

As in the past, our main goal will be to control the risk that authorised NHS foundation trusts fall below the required performance and governance standards. However, when foundation trusts do get into difficulty and seem unable to resolve

their problems for themselves we will intervene to find a solution to their performance problems and oversee the implementation of the solution.

In the future, as we do this work, we will need to focus on two issues in particular. First, we must constantly recalibrate our approach to risk. On the one hand, we must keep in mind the need for change in the sector and the resulting requirement for us to give providers the freedom to take appropriate risks. On the other, at a time when there is increasing attention being paid to the quality of care and when resources are scarce, we need to reduce any risk that failings go uncorrected for long.

Second, when we do step in to help a struggling provider address any problems we must work not just on the symptoms but also the underlying causes so that solutions can be long lasting. This includes addressing internal matters, such as poor governance, weak leadership or the wrong culture, but also a trust's external environment, such as the performance of the local health economy that it sits in, and any structural disadvantages from which it may be suffering.

For 2014-17, we will focus in particular on:

i. **Minimising the impact on patients of poorly performing providers of NHS services by identifying problems early and acting quickly.** We are changing our approach to monitoring providers in order to minimise the burden we impose whilst trying to identify potential problems early on, so as to minimise the risk that a provider eventually fails. This includes making greater use of soft and leading indicators of provider performance. For example, under the new 'Risk Assessment Framework'[2] we monitor staff satisfaction, staff absence and retention rates, in addition to a provider's financial plans and performance against targets, as indicators of current or potential governance problems. We will also continue to enhance our analysis of foundation trusts' annual plans to identify potential risks, and improve our understanding of the dynamics of individual health economies so that we get better at both identifying potential risks and helping to develop solutions for failing trusts.

   In addition, when foundation trusts undertake a significant transaction that we regard as particularly risky, such as a merger or acquisition, we will carefully compare their performance following the transaction with their planned performance so that we can spot early on if a trust is not managing its risks well. If a trust proposes to make a very risky transaction and we judge that it has not identified adequate means of mitigating the risk, we may use our powers to halt the transaction until the risks can be managed better.

   When an NHS foundation trust does get into difficulty and seems unable to resolve its problems for itself we will take action swiftly and set clear deadlines

[2] See: www.monitor.gov.uk/raf

for developing and implementing a recovery plan. We will examine our 'kit' of intervention tools with a view to making better use of those which are most effective and offer the greatest impact in relation to the resources required. We will also look to develop new tools that are even more effective as we have, for example, for trusts that have serious quality failings and are judged unable to remedy them under their current leadership. We now place these trusts in 'special measures', providing the additional support necessary to remedy the failings in patient care and hospital governance, subjecting them to particularly close scrutiny and appointing a senior improvement director to support and monitor the trust's turnaround.

ii. **Making it easier for providers to innovate by helping to lower barriers to change.** As in our assessment process, in regulating existing foundation trusts we need to be flexible in considering new business models and balanced in our approach to risk management. This will include accepting that foundation trusts must be able to take measured risks as they shift to new business models. If we do not allow them to take controlled risks then we could obstruct the innovation and change that the sector needs, leading to much greater long-run risks for the sector as a whole. However, this in turn means we must all accept that, from time to time, some provider organisations in some localities may fail. When providers do fail, we must ensure local patients continue to have access to all the services they need, an eventuality covered by the second element of our strategy: making sure essential NHS services are maintained.

   We will also support change and innovation by facilitating debate about what changes to the 'provider landscape' will meet changing patient needs. We will continue to undertake, with other organisations and experts, research and analysis that will support local commissioners, providers and patients in the development of new models of service and care. We will also seek to play our part, alongside clinicians, commissioners, patient groups and providers, in securing public support for change that will benefit patients (see the fifth element of our strategy: promoting change through high quality analysis and debate, and by encouraging innovation).

iii. **Helping to strengthen the capabilities of individuals and institutions.** In line with paying greater attention to the capabilities today's environment requires when we assess applicant trusts, we also want to work with other organisations, such as the Foundation Trust Network, to help all NHS foundation trusts strengthen and develop their capabilities, not just trusts that are falling below the required standard. So we will continue to sponsor training courses for board members and develop tools and identify good practices in areas such as strategic planning, service line management, operational performance improvement and the role of foundation trust governors. We

expect this to become a more important area of our work in the coming years as the whole sector's need to improve its performance becomes more urgent.

Attending our courses or using these tools or techniques will be voluntary for foundation trusts, although we do want to make available good quality support for those that want to make use of it. Furthermore, we are keen to see all foundation trusts adopt best practices wherever appropriate, so we will consider how we might use regulatory 'nudges' to encourage them to do this. One example is the suggestion in the 'Risk Assessment Framework' that foundation trust boards should carry out a review of their board governance every three years. Providers who choose not to undertake a review will be expected to explain to their local communities and other stakeholders why not.

Finally, in recognition that recruiting high quality chief executives, chairs, medical directors and finance directors is getting increasingly difficult, especially in some parts of the country, Monitor will work with the NHS Leadership Academy and other appropriate organisations to do all that we can to improve the availability of senior leaders to lead the transformational change that is needed at providers.

2. Making sure essential NHS services are maintained

If a provider of essential NHS services, whether a foundation trust or an independent sector provider, gets into such serious difficulty that it is unlikely to be able to continue providing its services for much longer, Monitor is responsible for making sure the services are maintained and protected for local patients. The services may continue to be provided by the failing provider while it restructures, or by alternative providers. For 2014-17, our priorities in this area are:

i. **Reducing the risk that providers fail by helping to develop robust local service strategies.** Providers in the most serious difficulties often have underlying structural problems, for example some of their services may be too small to be provided at high quality on a sustainable basis. Ideally, in such cases providers themselves would have identified that they have structural problems and worked with commissioners to find a strategic solution before the consequences are fully felt. This is why, in part, we want to encourage and support trusts in developing their long-term strategic planning capabilities. However, we also recognise that high quality provider strategies need to be based on robust service strategies for the whole of the local health economy. Commissioners should take the lead in developing such strategies and so we will work with NHS England to support commissioners as appropriate in developing strategies for each local health economy, concentrating in particular on health economies and providers that have underlying structural problems and are already struggling.

ii. **Taking a health-economy-wide approach to resolving problems when a provider does fail.** Because a failing provider often reflects broader problems in its local health economy, securing the long-term sustainable provision of essential services often requires the reconfiguration of services or restructuring of organisations beyond the failing provider itself. Therefore, we will continue to work with national and local stakeholders in tackling provider failure from the perspective of the whole health economy wherever that is feasible.

iii. **Concentrating on maintaining services, not institutions, where provider failure cannot be avoided.** As described above, securing the long-term provision of essential services when a provider fails may require the reconfiguration of service provision in the local health economy and restructuring the local provider landscape. The objective of such changes should be securing the best possible services for local patients rather than the survival of any individual provider in its current organisational form. Focusing on the needs of patients in this way will also provide room for successful providers to expand, and new and better providers to come in to offer services to patients. In support of this approach, we will work with NHS TDA, NHS England and provider organisations to develop new ways in which service provision can be maintained under circumstances where standalone providers are failing. This includes looking at a range of existing and new approaches such as merger or acquisition, clinical partnerships, joint ventures, provider chains and the use of management contracts or franchise arrangements to realise economies of scale, to improve the spread of best practice and to maximise the utilisation of our most talented leaders.

3. Making sure the NHS payment system promotes quality and efficiency

One of Monitor's new duties is to work with NHS England to design and operate the payment system for all NHS services. NHS England specifies how services should be grouped for payment purposes (known as currencies), and Monitor sets the rules for how the level of any payment should be determined. We believe that the design of the payment system can support both commissioners and providers in making the changes to patterns of care that the NHS needs. Currencies and prices, whether national or local, inform decision-making, including what services a commissioner can afford to buy and what services a provider can sustainably provide. For example, paying for patient outcomes can challenge providers to decide how best to achieve those outcomes, alone or with partners.

Taking all price signals together, the payment system should promote behaviours that support an efficient allocation of scarce resources for the maximum benefit of patients. Ideally, prices determined in accordance with the national tariff would be set to reflect the costs of an efficient system of high quality care delivery. This would mean the value of care purchased (that is, the quality and amount of care) could be

maximised for a given commissioning budget, and that informed choices could be made in setting that budget. However, in practice many providers are currently well below maximum efficiency and so prices must be moved at a measured pace towards this optimum in order to avoid putting too many providers under excessive financial pressure.

As a first step in taking on this new duty, we commissioned research in 2012[3] to find out how the payment system was working at present. This work identified a number of ways the system could be improved and both it and our subsequent research now inform our strategy in this area. This has three priorities for 2014-17:

i. **Taking a long term 'clean sheet redesign' approach to the payment system.** The current NHS payment system was not designed to meet the challenges facing the NHS today. So, in designing the next evolution of the system we are returning to first principles, tailoring it to the specific dynamics and economics of providing each type of patient care. This includes considering where a national price is the right payment approach and where it is not. Although, of course, we will not discard any element of the current system that is working well, our aim over time will be to move to a system that is better at promoting the behaviours and decisions by commissioners and providers that will lead to better outcomes for patients. As we do this we will seek to follow best practice by designing a system that:

    - provides effective, predictable and well understood payment signals
    - responds to changing priorities
    - develops in a measured way so that the pace of change is carefully balanced against the risks of destabilising providers or commissioners
    - truly reflects the efficient costs for the system of delivering good quality care
    - treats all providers and commissioners fairly
    - places incentives and risks with those bodies that are best able to deal with them.

ii. **Taking a pragmatic approach to short term priorities.** A full redesign of the payments system will take many years, going beyond 2017. However, we recognise that there are a number of pressing priorities that must be addressed in the next few years. These include agreeing the best way forward to ensure mental health care needs are considered on a par with physical health care needs, providing tools to support local health economies in paying

[3] See: www.monitor.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-15

for a significant movement of care out of hospitals, and improving incentives for controlling activity growth. We will work with NHS England to address these priorities as effectively as possible whilst we also work on the longer term evolution of the system. This will involve, in particular, encouraging commissioners to make effective use of the flexibilities available in the current national tariff. We will undertake widespread stakeholder consultation as we do this.

iii. **Pursuing a step change in the quality and use of data on cost, activity and outcomes that underpin the payment system.** A critical element underpinning a high quality payment system is good quality data from providers across the care system about what it costs to deliver their services, the associated activity levels, and the resulting outcomes for patients. Our work last year indicated that this data needs to improve significantly. It showed a particular need to collect more accurate cost, activity and outcome data at the level of individual patients, and especially outside acute providers. We will, therefore, require more accurate and consistent patient-level data from providers in the future, building on our voluntary patient-level cost collection exercise in 2013/14 for the acute sector. Higher quality data will not only help us design a more effective payment system, but it should also directly help providers manage their operations more effectively and help commissioners make better procurement decisions, as well as helping us assess the effects of our decisions. Indeed, we believe this direct impact of better data on decision-making could bring greater and faster benefits for patients than its impact through the payment system. So, we will also strongly encourage the sector to make significantly better use of the data as it becomes available, for example by using it to benchmark performance, quality and value.

4. Making sure procurement, choice and competition operate in the best interests of patients

Many people value choice as it gives them a degree of control over their care and enables them to make trade-offs between things that matter to them, such as where their care is provided and how long they will have to wait for their treatment. Sometimes this control is achieved through choice of provider, other times through choice of clinician or treatment. Such choice is more effective when there are a number of different providers or services available, whether delivered by NHS organisations or the independent sector.

When patients are able to choose which provider they prefer to use, or when commissioners can choose between alternative providers when awarding a contract, providers are incentivised to make sure they are delivering high quality services that are tailored to the needs of patients. For this sort of competition to drive quality

improvement patients need to be able to exercise their rights to choice, and also have access to good information to help them make those choices.

Similarly, commissioners need to make good decisions on behalf of patients, including recognising when and how competition can help to deliver better outcomes. However, choice and competition are only two of the levers available to commissioners to help drive up the quality and efficiency of care provision. They will not always be the best levers. Other tools include, for example, redesigning or better managing existing contracts. Such tools may be used alongside or instead of choice and competition. In some circumstances choice or competition will simply not be appropriate, for example when there is only one capable provider of a service. First and foremost, it is up to commissioners to determine if choice and competition could improve services for patients.

If the health sector is working properly for patients, providers will respond positively to incentives to improve their services resulting from patient and commissioner choices. This may legitimately include co-operating with other providers. However, providers must not act anti-competitively, colluding in a way that is not in the interests of patients. Similarly, incentives to improve may be reduced if providers that are alternatives for patients or commissioners decide to merge. It is therefore important that a merger happens only where the benefits to patients outweigh the costs associated with any loss of competitive pressure to improve services for patients.

Monitor's role in all of this – consistent with our objective to make sure the health sector is working properly for patients – is to ensure that procurement, choice and competition operate in the best interests of patients. This means helping commissioners and providers make sure patients do not lose out through poor commissioning, restrictions on their rights to make choices or inappropriate anti-competitive behaviour by commissioners or providers. To do this we have been granted a range of powers, including concurrent powers with CMA under the Competition Act 1998 and the Enterprise Act 2002, and powers to regulate commissioners under the 2012 Act and the associated Procurement, Patient Choice and Competition Regulations.

Our work in this area rests on the actual experiences of patients: are they and will they in future be able to access the best possible care that could be available to them? Much of our early thinking was summarised in our 'Fair Playing Field Review'[4] where we set out changes that should be made so that patients can access the provider best able to meet their needs, irrespective of the type or ownership of the provider. Building on this, and work undertaken by the Co-operation and Competition

[4] See: www.monitor.gov.uk/sites/default/files/publications/The%20Fair%20Playing%20Field%20Review%20FINAL.pdf

Panel before Monitor took on its new responsibilities, we have two priorities in particular for the next few years:

i. **Educating and informing patients, commissioners, providers and the wider health system about how the rules on procurement, choice and competition affect them and why they benefit patients.** There is currently concern as to how the rules on procurement, choice and competition affect the sector. Some commissioners and providers are anxious that the rules will obstruct them in their efforts to improve patient care, for example by preventing the necessary reconfiguration or integration of services. This should never be the case. The rules should not prevent changes that are clearly in the overall interests of patients. We will, therefore, work hard to help the sector understand how the rules can help them deliver better patient care and better value for money. Specifically, we will significantly increase the resources available to answer informal queries from the sector, develop more worked examples to show how patient benefits should be assessed, and proactively reach out to the sector, particularly the new commissioning groups. We will also focus on helping ensure that mergers between provider organisations proceed swiftly and at minimum cost where it is clear that they will result in net benefits for patients.

ii. **Focusing our action where we will have the greatest benefit for patients.** Our philosophy throughout our work in this area is to focus on helping people do the right thing for patients, not punishing them for doing the wrong thing. However, this does not preclude the need for us to investigate potential breaches of the rules and sometimes take enforcement action to make sure any harm to patients arising from a breach – or a potential future breach – is corrected. Similarly, we will from time-to-time undertake market analyses to determine whether the interests of patients are well served by the existing arrangements and behaviours of providers and/or commissioners. We will concentrate this work in those areas where improvements are likely to have the greatest benefit for patients. We will continuously assess where this is likely to be, including undertaking or sponsoring research to understand better where and how choice and competition can drive beneficial change for patients. In the short term we will have a particular focus on how to ensure that the regimes for the reconfiguration of services and for mergers operate in the best interests of patients.

5. Promoting change through high quality analysis and debate, and by encouraging innovation

The change required to improve patient care needs to happen in front line organisations. Monitor can only fulfil its mission if, in conjunction with our partners, we can influence what people in those front line organisations do. Some of this influence will derive from our formal powers, described above. However, as the

sector regulator we also have an opportunity to promote change by undertaking high quality analysis and using it to stimulate debate on critical issues, and by encouraging innovation. Three areas of particular importance are:

i. **Supporting the identification of the new service/care models that will meet changing patient needs.** As set out above, it is broadly accepted that if the NHS is to meet the twin challenges of achieving significant improvements in quality whilst also achieving a step change in productivity it will have to identify new and in some cases radically different models of care, often delivering new types of services. We believe that much of this redesigning of care delivery needs to take place at the local level, with commissioners and providers working together to identify which models will best meet the needs of their communities. However, it is also clear that there are many common issues facing local commissioners and providers. It is our intention, therefore, to work with other partners to undertake or promote research and analysis that will shed useful light on these critical matters, for example as in our work with the Integrated Care and Support Collaborative or with NHS England under the 'Call to Action'.

   An example of such an issue – faced in particular by smaller and medium-sized hospital trusts – is the need to understand better the drivers of performance, particularly the extent of economies of scale and scope. The belief that increased scale is necessary for long-term survival is driving many providers to consider merger or acquisition. However, such consolidation is often unpopular with patients if it leads to a reduction in access and/or choice. As described above, any reduction in competitive pressure on providers to improve their services is also of concern. Furthermore, the benefits realised by mergers are often smaller than anticipated, creating a risk to such consolidation. Monitor is therefore undertaking work to understand more systematically how to think about the trade-offs between quality, access and choice in situations where providers are considering merging to address the challenges they face.

   Most of the work Monitor will do on the provider landscape and provider economics is likely to be done collaboratively with partner organisations, particularly NHS TDA and NHS England. Not only will it help us support the sector as it seeks to redesign itself, but it will also underpin many of our other core regulatory functions, including:

   - our reviews of applicant and existing NHS foundation trust plans and strategies, where it is important to have a sound understanding of provider economics and likely changes to the provider landscape
   - our work with struggling foundation trusts to improve their performance, where again it is important to understand provider economics

- our work to restructure failing and failed organisations, where as well as understanding their economics it is important to make sure any reconfiguration of services that we sponsor goes with the grain of the overall changes required to the provider landscape.

ii. **Encouraging the adoption of innovative approaches.** Not only must new models of care and service delivery be identified, but they must also be adopted on the ground, and at a faster pace than in the past. This will require significant innovation, learning from what is happening in other health and care systems and learning from each other. Although much of this innovation needs to take place at the local level, we believe Monitor and other national bodies have an important role to play in facilitating such change, including removing barriers to change and being flexible in our approach to regulation. In addition to actions mentioned elsewhere in this strategy, this will include actively supporting 'proof of concept' initiatives – such as our work with the Integrated Care Pioneers – and working to understand what does and doesn't work to encourage local innovation.

iii. **Working with clinicians, commissioners, patient groups and providers to secure public support for the required changes.** Whatever the outcome of our own and others' work on provider economics and the provider landscape, it is clear that significant changes to the patterns of service delivery will be needed over the coming years. Such changes will need to start with an understanding of the local population and their needs. For example considering those groups of patients who would benefit from much more proactive care co-ordination in managing their long-term conditions, and other groups who would benefit from choice of service or timely access to expert advice or treatment even though their needs are unpredictable. However, although grounded in patients' needs, such changes can often be controversial with the public. It is our aim to help address public concern by, first, helping the sector identify new models of care that address underlying clinical and financial challenges but minimise the impact on patient access or choice and, second, by ensuring that any change is based on firm evidence that it represents the best available results for patients in terms of quality, access, choice and affordability. In doing this it will be essential that we work closely with local and national partners.

6. Making sure Monitor is a high performing organisation

In order to deliver our strategy we must ourselves strive to be a high performing and effective organisation. We must do this against the backdrop of the very significant expansion in scope of our responsibilities and the corresponding growth in our

organisation. We believe there are three essential elements to achieving high performance:

i. **Shaping our culture so patients are at the heart of what we do.** The values set out at the beginning of this document need to be driven ever deeper into our organisation. This means leadership at all levels must engage those who work with them, above all to make sure we put patients first in all that we do.

ii. **Ensuring Monitor is a highly effective organisation.** This means continuously improving our organisational and operational effectiveness, and agility. Areas for particular focus over the period of this strategy will be achieving transformations in both our information systems, to support our legacy and new responsibilities, and in the breadth and effectiveness of our engagement with our many new stakeholders. We will continually review the effectiveness of our regulatory actions to understand what works and what doesn't. We will also be developing and consulting on concrete measures of our own performance, in line with this strategy, against which others can judge how well we are delivering the strategy and fulfilling our mission.

iii. **Recruiting, developing and retaining outstanding people.** Without high performing people we cannot be a high performing organisation. At its most fundamental this means recruiting people with the right mix of capabilities and technical skills. In particular, we need more people with front line clinical and operational experience. We also need to achieve a step change in our approach to personal development, both to enhance our attractiveness to potential recruits and to maximise the potential of our existing staff.

Conclusion

The way healthcare is delivered to patients in England needs to change fundamentally and the pace of change must be very much greater than we have achieved in the recent past.

Commissioners and providers on the front line must drive this change. The national organisations that oversee and regulate the sector must support them by working together with a shared purpose to provide effective system leadership.

Monitor itself – like the other system leaders – must strike a careful balance between direction and support. We must facilitate innovation but manage risk. We must let people at the front line get on and decide what is best for their communities and make sure the incentives we create encourage the best decisions. Above all, we must judge our success by the difference we make for the people who use the NHS.

Monitor

Making the health sector work for patients

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