



**IMPLEMENTING THE *FORWARD VIEW*:  
Supporting providers to deliver**

## Implementing the *Forward View*

### Supporting providers to deliver

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**Prepared by:** NHS Improvement in collaboration with a range of provider leaders, NHS Providers, NHS Confederation, NHS Clinical Commissioners, NHS Partners and the Local Government Association.

**This document is for:** Boards, senior leaders and clinicians, and interested staff in NHS trusts and NHS foundation trusts as well as their commissioners.

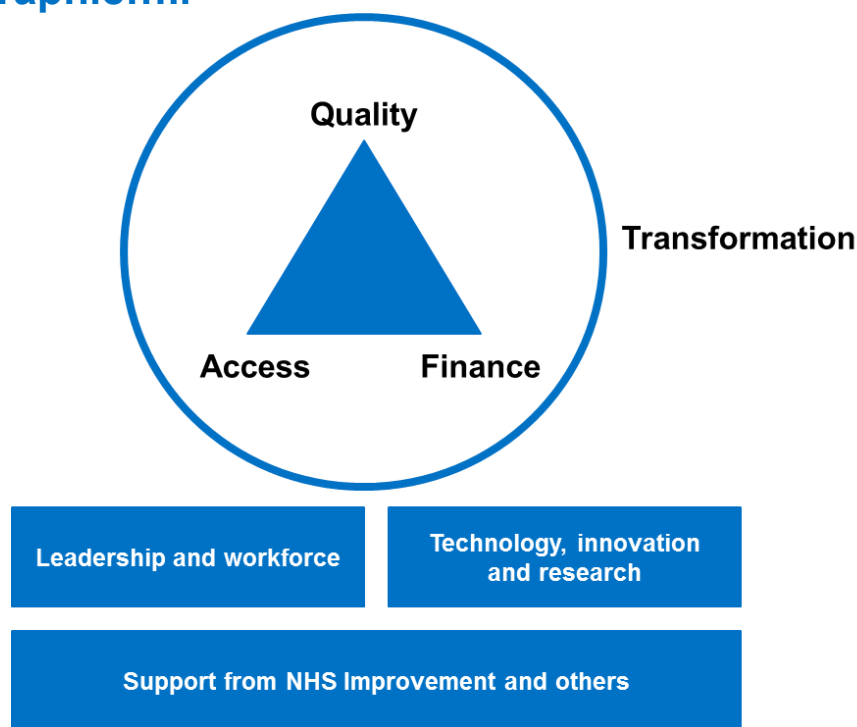
This document is designed for NHS provider organisations. It is part of a series of roadmaps that draw on messages from the [NHS Planning Guidance](#) and set out the key priorities for specific audiences that are responsible for delivering high quality health and care this year and beyond. Each roadmap draws on a shared vision for the health and care sector as set out in the [Five Year Forward View](#) (5YFV) – about the challenges ahead and the choices we face about the kind of health and care service we want and need in 2020. This is not just about stabilising services for today, but about driving the necessary scale of transformation required to meet the needs of future patients in a sustainable way and to help close the three gaps identified in the 5YFV: health and wellbeing; care and quality; and finance and efficiency.

The solutions to today's problems lie in a radical upgrade of prevention and new models of service delivery. This means working differently, and collaboratively, on identifying solutions and sharing problems, at both national and local levels and with wider stakeholders, such as local government, individuals and community partners. This will be increasingly important as we move further towards place-based planning, commissioning and delivery of preventative, person-centred and co-ordinated care in which individuals are increasingly empowered to take responsibility for their own care where relevant, thereby reducing pressure on existing services. Success will require us all to think beyond our statutory and organisational borders to meet the needs of the people we serve. Further strengthening of collective system leadership at both national and local levels is essential to ensure that we succeed.

## The provider task to 2020 is...

Delivering outstanding *quality of patient care*, NHS Constitution *access standards* and *financial balance*, eliminating unwarranted variation across all these areas, while also making the *transformation* that is needed to ensure long-term sustainability. This requires providers to increase their capability by improving *leadership and engaging staff* fully to maximise their contribution, as well as improving *technology, innovation and research*. We will not achieve this by individual organisations working in isolation – it is best delivered by working collaboratively in partnership across local health and care economies and with other providers. NHS Improvement has been established to provide the *support* providers will need to deliver this ambitious and stretching task.

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## Foreword

The NHS aspires to high quality care for all. I know from my own professional experience that quality of care is what matters most. It is an agenda that unites patients and professionals alike. Fortunately, in healthcare, quality and efficiency are two sides of the same coin. High quality care means we get it right the first time; it means using the full talents of all professionals, and it means working with patients and carers as partners in their own care.

These are challenging times for the health service. While the NHS budget will rise each year, unless we reform the way we work, there will be a widening gap between the resources we have and the demands placed upon the service. There is an imperative to change the way we work to keep up with what is demanded of us.

This isn't unique to our country. Healthcare spending consumes a growing share of the wealth of all advanced nations. In many aspects, this is a reflection of our success: more people are living for longer, there are an expanding range of treatments and therapies, and people rightly expect higher and higher standards of care.

Yet there are many things that could be improved. There is still too much waste, too little process discipline, and unacceptable resistance to simple changes that would improve quality and efficiency. The way that the NHS works can, at times, be too complex, bureaucratic and frustrating for patients and professionals alike.

Healthcare is complex precisely because people are complex – each individual has unique needs and circumstances. But that inherent complexity has been added to and embellished by a system that has layered change upon change upon change. Improvement won't be achieved by adding yet more.

Now is the time to think afresh, to open up to new ways of working, and to take the patient perspective – how could we ever justify working apart when they rightly expect us to work together?

I know from my own practice that healthcare is delivered by a team. Today, that team extends well beyond the hospital walls – out into the community to colleagues in primary care and social care, mental health as much as physical health. We need to work together across the whole health and care system.

This document sets out the path ahead for providers of NHS services and the support they can expect from NHS Improvement. It emphasises the importance of maintaining and improving the quality of care for all while addressing financial challenges. And it sets out the challenges that must be faced and the changes that must be made ahead. I hope that NHS leaders will read it – and rise to meet the leadership challenge to turn their ambitions for the people they serve into reality.

**Professor the Lord Darzi of Denham OM KBE PC FRS**

Board Member, NHS Improvement

Director of Institute of Global Health Innovation, Imperial College London

## Overview

All providers of NHS services have been under increasing pressure in recent years – most acutely from slowing growth in the NHS budget, but also from rising expectations, an ageing population, and an expanding range of treatments and therapies. The impact of managing this demand increase during a period of limited funding growth was the key challenge identified in the Five Year Forward View (5YFV).

In response to the 5YFV, the government has pledged an additional £8.4 billion of real-term investment in the NHS by 2020. The profile of this investment is uneven. It is heavily weighted to the earlier years of the spending period for a reason: this is the time for the NHS to invest in making lasting improvements in the quality and efficiency of care so that standards can be sustained as funding growth slows again later in the period. This is an opportunity – and an obligation – that the NHS cannot afford to miss. Quality must be maintained or improved, performance against access standards recovered, financial performance stabilised, and the transformation of local health and care services begun.

### ***The provider task to 2020***

The provider task to 2020 is extremely stretching and ambitious.

Providers need to deliver high quality patient care, NHS constitutional access standards and financial balance, eliminating unwarranted variation across all these areas, while also making the transformation that is needed to ensure long-term sustainability and in doing so to reduce the three gaps described in the 5YFV: health and wellbeing, quality and finance. This requires providers to increase their capability by improving leadership and engaging staff fully to maximise their contribution, as well as improving technology, innovation and research.

NHS Improvement has been established to provide the support providers will need to deliver.

### ***The purpose of this document***

This document sets out the task and clear expectations of what needs to be delivered. It brings together all the key requirements into one document, for the first time, while providing links to the detail. It also shows how NHS Improvement and our arm's length body colleagues will support you.

### ***Who this document is aimed at and how you should use it***

The document is aimed at NHS provider boards and senior leadership teams, but it will be of interest to a wider audience. We would like you to share it widely and actively in your organisation so that your team can understand what is being asked of the organisation they work for and how they can contribute to delivery. The document

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can be used to stimulate a wider debate with your team about the strategic context in which they and your organisation operate, and we will be developing a simple set of materials based on the document's content to help with that task.

The scale of the ambition and stretch in this task needs to be matched by the scale of realism about how much can be delivered how quickly. Clearly, it will be impossible for every provider to deliver every single requirement, but this document sets out clear expectations of what must be delivered. In some areas of activity, the task will require urgent action, whereas in others it will be a process of evolution. It is, rightly, for provider boards to set organisational and local system priorities within this framework, and then develop clear plans to deliver those priorities.

In addition, delivery of these improvements requires a new partnership with patients, carers and their families. This goes beyond simply providing better information: it requires the promotion of active patient involvement and empowerment, and enabling patients to take ownership of their health and wellbeing. There is clear evidence that patient engagement in treatment decisions leads to more cost-effective utilisation and better health outcomes. Providers will need to work with their members and governors, commissioners, local third-sector bodies and local HealthWatch to consider how best to create this new partnership.

The success we have had in cutting NHS waiting lists, transforming infection control and moving mental health services into the community over the last 20 years suggests that if we head towards an ambitious vision with purpose and energy, we can surprise even ourselves by how much we can achieve.

We look forward to supporting you on the delivery of the provider task to 2020 set out in this document.

**Ed Smith**  
Chairman  
NHS Improvement

**Jim Mackey**  
Chief Executive  
NHS Improvement

## **1 Delivering value: a combined focus on quality, access and finance**

The challenge for providers is to deliver high levels of performance while at the same time transforming services for long-term sustainability. As all healthcare leaders know, day-to-day performance requires a combination of delivery of the right quality of care and appropriate patient access to services within the resources available – the well-known triangle of quality, access and finance.

First and foremost, providers need to focus on the quality of patient care they can deliver within the resources available to them. Quality and efficiency are two sides of the same coin, and provider boards must take equal responsibility for both, achieving the best results for patients and taxpayers alike.

Current unwarranted variations in quality need to be urgently addressed. Particular improvements are needed in cancer, mental health, maternity, dementia services and urgent and emergency care. More providers need to achieve ‘good’ and ‘outstanding’ ratings from the Care Quality Commission (CQC); and high quality seven-day services for urgent care need to be delivered consistently across the system. There must be a further focus on safety, with providers supporting system-wide patient-safety priorities, and demonstrating a culture of continuous learning and improvement.

The NHS Constitution defines a set of access standards which patients can expect. Consistent delivery of these standards is central to the provider task, and providers need both to recover current under delivery against targets and then deliver sustained performance against them over the long term.

At the same time, the NHS needs to return rapidly to financial balance and rise to the efficiency challenge as part of its efforts to maximise value for patients. Lord Carter’s reviews identify the considerable efficiency opportunities for acute hospitals in fields such as workforce, procurement and estates. This work will now move on to consider the scope and nature of efficiency savings that mental health, community, specialist and ambulance providers can make. Recent changes to address the excessive costs of temporary staffing will enable further savings to be made, while improving continuity of care.

The next three chapters of this document set out the task for providers and what is needed in each of these three areas – quality, access and finance.



## Delivering value: quality

The 5YFV described the care and quality gap: unless we reshape care and drive down variations in quality of care, patients' changing needs will go unmet and unacceptable variations in outcomes will persist.

To close this gap, providers will need to:

- achieve more 'good' and 'outstanding' ratings following CQC inspections, with no providers in special measures
- tackle variations including delivering specific improvements to services such as mental health and cancer
- further improve patient safety
- deliver seven-day services in line with agreed clinical standards.

This chapter summarises these elements, with links for further details.

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### *PROVIDERS IMPROVING THE QUALITY OF PATIENT CARE*

*Providers have demonstrated over the last decade how, with the right focus and support, massive improvements can be made in the quality of patient care.*

- In the three years to 2014/15 cases of Methicillin-resistant Staphylococcus aureus (MRSA) fell by 22%.<sup>1</sup>
- In the five years up to 2015 mixed-sex accommodation breaches in providers decreased by 97%.<sup>2</sup>
- The fourth annual report on a strategy for cancer highlights that cancer survival estimates have continued to increase, and mortality rates have continued to fall.<sup>3</sup> Cancer survival rates in England for breast, lung, prostate, colorectal and ovarian cancer all continue to improve.<sup>4</sup>
- Over the last 30 years there has been an upward trend in life expectancy at older ages in England. Life expectancy for those aged 65 has increased at an average rate of 1.2% per year for men and 0.7% per year for women.
- In November 2015, the percentage of patients admitted, aged 75 and over, who were initially identified for potential dementia or given a case finding was 90.4%, compared to 83.5% in 2013/14.<sup>5</sup>

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<sup>1</sup> [www.gov.uk/government/statistics/mrsa-bacteraemia-annual-data](http://www.gov.uk/government/statistics/mrsa-bacteraemia-annual-data)

<sup>2</sup> [/www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/msa-data/](http://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/msa-data/)

<sup>3</sup> [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/388160/fourth\\_annual\\_report.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/388160/fourth_annual_report.pdf)

<sup>4</sup> [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/449365/Annual\\_report\\_29july-WEB-final.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449365/Annual_report_29july-WEB-final.pdf)

<sup>5</sup> [www.england.nhs.uk/statistics/statistical-work-areas/dementia/](http://www.england.nhs.uk/statistics/statistical-work-areas/dementia/)



## 1.1 CQC ratings

Achieving much greater consistency in the quality of care remains our most fundamental challenge. While the initial round of new CQC inspections is not yet complete, only a small minority of trusts have so far achieved 'Good' and 'Outstanding' ratings, and too many are in special measures. A key priority for the provider sector over the next four years will be for the majority of trusts to move from 'Requires improvement' towards 'Outstanding', and for there to be no trusts in special measures. The CQC framework is well known, and further details can be found [here](#). Provider boards will need a clear strategy for how to deliver the required improvements.

## 1.2 Eliminating unwarranted variation

A key challenge for providers is to ensure that the causes of unwarranted variations in clinical performance are understood and eliminated.

The [2016/17 planning guidance](#) sets out a small number of national clinical priorities where such improvements are needed, with local health systems expected to use the Sustainability and Transformation Planning process to develop local plans to address these priorities. These include, but are not limited to, the following:

- **Cancer care:** The [independent Cancer Taskforce strategy](#) has identified the action required over the next five years, increasing the focus on public health and prevention; earlier diagnosis; improving patient experience; transforming support for those surviving cancer; modernising cancer services; and transforming the commissioning and provision of cancer services.
- **Mental health:** The Mental Health Taskforce [interim report here](#) will shortly set out the scale of change required to ensure an equal response to mental and physical health. This will include how to address attitudes to mental health; improvements in prevention; access to and choice of support and treatment; further integration of care and support; and the mental health of NHS staff.
- **Maternity services:** The forthcoming independent national [Maternity Review](#) will consider what safe and efficient models of maternity services, including midwife-led units, will look like; what support is needed for pregnant women to make safe and appropriate choices of care for themselves and their babies; and what support is needed for NHS staff to provide responsive care.
- **Dementia care:** Dementia is a growing challenge for health and care systems internationally. Early diagnosis is critical, which is why the NHS must increase the proportion of people who are formally diagnosed from under a half to two-thirds or more.<sup>6</sup>

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<sup>6</sup> [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/262139/Dementia.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262139/Dementia.pdf)

- **Urgent and emergency care:** The [review of urgent and emergency care](#) set out how we need to provide better support for self-care; help people with urgent care needs get the right advice in the right place, first time; provide highly responsive urgent care services outside of hospital; ensure that those people with serious emergency care needs receive treatment in centres with the right facilities and expertise; and connect all urgent and emergency care services so the overall system becomes more than just the sum of its parts.

### 1.3 Improving patient safety

CQC's work to date demonstrates the particular challenges the sector faces on patient safety. This is why the NHS must strive to become the safest healthcare system in the world, devoted to continuous learning and improvement from top to bottom and end to end.

Since the publication of the [Francis Inquiry](#) and the [Berwick Report](#) in 2013, the NHS has embarked on an ambitious journey to deliver this vision. Providers should:

- engage effectively with the nationwide system of [patient safety collaboratives](#) which has been created in the 15 academic health science networks
- be active in the [Sign up to Safety](#) campaign
- apply the forthcoming methodology for reviewing avoidable mortality, which will be rolled out during 2016/17.

To support providers, the [National Reporting and Learning System](#) for reporting incidents will be enhanced when the successor safety incident management system is rolled out. In addition, a new [Healthcare Safety Investigation Branch](#) will be created in April 2016, to provide in-depth understanding of why care can go wrong and identify what should be done in response.

### 1.4 Seven-day services

Patients require non-elective hospital services 24 hours a day and seven days a week, and expect high quality, safe and responsive care at all times. Many providers have made significant progress towards achieving these objectives, but they now need to be delivered consistently across the sector as a whole by 2020. Providers should develop and deliver plans to make these [standards](#) a reality by 2020, beginning in 2016/17 with the full roll out of seven-day services for the four priority clinical standards in all specialties. We expect 50% of trusts to be meeting this standard by March 2018. NHS Improvement and NHS England will support trusts in earlier adoption where possible. This should be reflected in local Sustainability and Transformation Plans.

## **SUMMARY**

Our expectation is that by 2020 NHS patients will be cared for by providers that have an outstanding or good CQC rating and there will be no trusts in special measures. At the same time, all providers will have made the required improvements in the priority areas of cancer, mental health, maternity, dementia, and urgent and emergency care, and there will be significantly less unwarranted variation in the standards of patient care. Patient safety will have consistently improved and all providers will be delivering seven-day services in line with the priority clinical standards. This will be underpinned by a new partnership with patients and families, and a culture with much greater emphasis on learning and continuous improvement. These improvements in quality of patient care need to be accompanied by delivery of the right access to services, as the next section sets out.

## 2 Delivering value: access standards

The NHS Constitution sets out the importance of meeting a set of key access standards and new standards are being introduced for mental health, recognising the significance of improving these services.

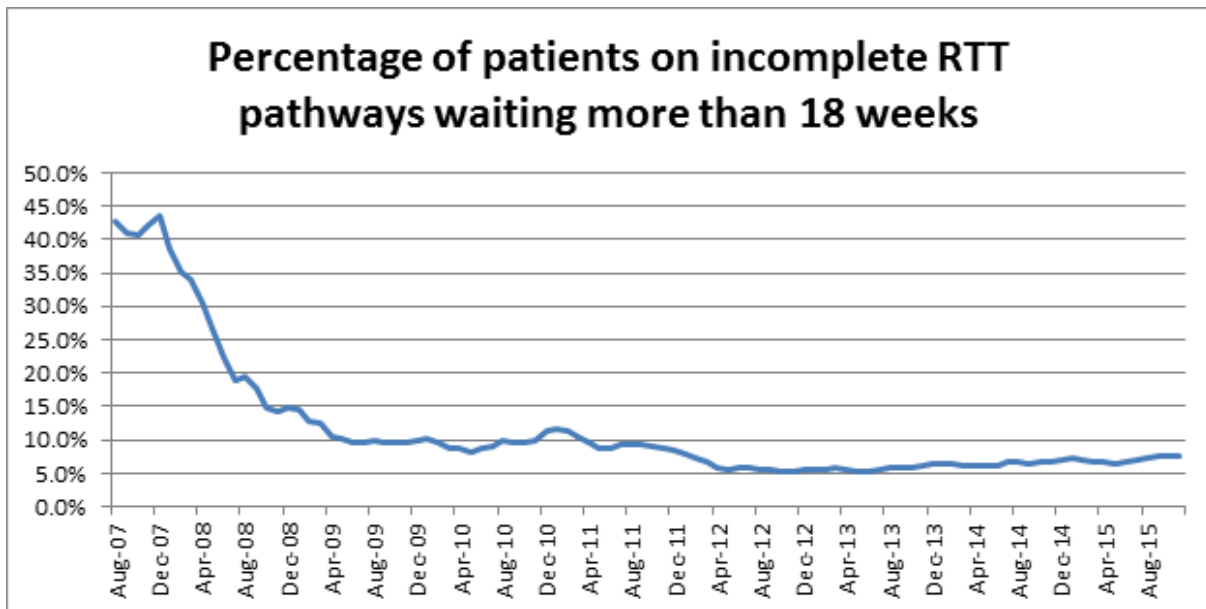
To meet their NHS Constitution obligations providers will need to recover and maintain performance against the standards for urgent and emergency care; referral to treatment times for elective care, diagnostics and cancer services; and the new standards for mental health services

This chapter summarises the requirements on providers in this area, and provides links for further details.

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### *PROVIDERS IMPROVING PATIENT ACCESS TO SERVICES*

Since 2000 providers have transformed speed of patient access to services. In the late 1990s<sup>7</sup> over a million patients were on the waiting list for inpatient admission, over 4% of whom had been waiting more than a year. As an example of one pathway, in 2007/08 up to 44% of patients on incomplete referral to treatment pathways had been waiting more than 18 weeks. This has improved to less than 8% since 2012/13.



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<sup>7</sup> <http://researchbriefings.files.parliament.uk/documents/RP99-60/RP99-60.pdf>

## 2.1 Delivering access standards

The [NHS Constitution standards](#) for urgent and emergency care, and elective and cancer care are well known. [New standards](#) for mental health services are being added. Consistent delivery of these standards across all providers is a guarantor of equity for patients no matter where they live, and it underpins patient and public confidence in the NHS. Delivery against the standards has deteriorated over the last two to three years and, although this will be a significant challenge, it must be a key priority for provider boards to recover these standards in 2016/17 and then maintain delivery beyond.

Providers will need to set out a clear recovery trajectory in their 2016/17 operational plan, and local health and care economy Sustainability and Transformation Plans will need to show how these trajectories will be sustained. These plans will need to consider a range of different improvement approaches, including:

- effective demand and capacity planning to ensure realistic plans are in place including use of the independent sector where additional capacity is required
- better use of data, including increased focus on data quality, use of real-time data and sharing of data across systems
- enhanced operational management both within individual providers and across local systems, including enhanced training and support, and better use of process and flow management techniques
- improved referral management and implementation of patient choice.

Further information on these approaches can be found in the work of the [Intensive Support Teams](#) and the Health Foundation's [report on patient flow](#), for example.

### **SUMMARY**

By 2020 we anticipate that patients will be receiving care in line with each of the agreed the NHS constitutional access standards and all NHS providers will have sustainable strategies to maintain this performance. Critically, improvements to both quality and access standards will be delivered in a way that is financially sustainable, as the next section sets out.

### 3 Delivering value: finances and efficiency

The 5YFV forecast the NHS's funding and efficiency gap as £30 billion by 2020/21. At the same time, the provider sector deficit in 2015/16 has clearly reached unsustainable levels and must be reversed, with the sector as a whole and as many individual providers as possible returning to financial balance in 2016/17.

Providers will need to return to financial balance as quickly as possible and close the long term funding and efficiency gap by:

- delivering the agreed 2016/17 control totals
- reducing their use of agency staffing
- delivering their share of the required efficiency savings and productivity gains by responding to the recommendations of the Carter Review
- maximising the use of existing estate and realising value from surplus estate.

This chapter summarises the requirements on providers in these areas, and provides links for further details.

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#### PROVIDERS IMPROVING EFFICIENCY AND PRODUCTIVITY

*Providers have already demonstrated that, with the right focus and support, significant productivity improvements and efficiency savings can be delivered.*

- *Providers were instrumental in the largely successful delivery of the £20 billion 'Nicholson Challenge' over the last Parliament.*
- *Monitor research to be published shortly shows that providers have improved staff productivity to decrease average length of stay, offsetting a rise in admissions. We estimate that without this productivity improvement there would have been a need for an extra 5,000 nurses at a cost of around £250m at today's agency rates.*
- *Providers have demonstrated that greater collaboration can be a significant driver of increased efficiency and productivity – for example, the NHS Southern Procurement Partnership, which standardised manufacturer and price data for generic products, has estimated savings of between 15% and 50% beyond current best NHS prices.<sup>8</sup>*

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<sup>8</sup> [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/499229/Operational\\_productivity\\_A.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf)

### 3.1 Delivering financial balance in 2016/17

In recent years, growing numbers of providers – particularly in the acute sector – have incurred significant deficits with the 2015/16 half-year provider deficit in excess of £1.6 billion and 75%<sup>9</sup> of providers in deficit. Our focus must now be on returning to financial balance, without compromising patient care. Providers need to achieve the best possible out-turn position in 2015/16 and develop a plan for 2016/17 based on agreed control totals.

The business rules – in particular the changes to tariff prices and the Sustainability and Transformation Fund, underpinned by the front-loaded Spending Review settlement – provide the financial framework to deliver this. As the control totals show, some stretch is needed and some changes, such as caps on agency spending, will be uncomfortable for some providers. However a rapid return to financial balance for the sector as a whole, and for as many providers as possible, is critical. NHS Improvement will be providing intensive support to those providers with the biggest financial deficits that often face large, long-standing, structural challenges that require a corresponding structural solution.

### 3.2 Temporary staff

One of the drivers of provider deficits in 2015/16 has been the rapid growth in the use of temporary staff. Working together as a sector we have already begun to take steps to address this inefficient use of scarce NHS resources. As the [recent guidance](#) sets out, providers will consistently need to:

- remain within a ceiling for the maximum spend on temporary staff as a percentage of total nursing staff for each hospital
- adhere to a maximum hourly rate for temporary staff (doctors, nurses and midwives, other clinical and non-clinical staff), so that by 1 April 2016, no temporary staff will be paid more than permanent employees
- only use agencies on approved frameworks.

These measures on temporary staff sit alongside other controls such as controls on use of consultancy and on forthcoming controls on very senior manager pay.

The temporary staff controls are a good example of an approach which will only work effectively if it is consistently adopted across the sector as a whole and where it is, therefore, legitimate for NHS Improvement to request all providers to adopt that approach, irrespective of their status or financial position.

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[www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/478860/Quarterly\\_report\\_on\\_the\\_performance\\_of\\_the\\_NHS\\_foundation\\_trusts\\_and\\_NHS\\_trusts\\_-\\_6\\_months\\_ended\\_30\\_September\\_2015\\_-\\_Overview\\_paper\\_2\\_.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478860/Quarterly_report_on_the_performance_of_the_NHS_foundation_trusts_and_NHS_trusts_-_6_months_ended_30_September_2015_-_Overview_paper_2_.pdf)



### 3.3 Efficiency, productivity and the Carter Review

Returning to financial surplus in 2016/17 can, however, only be part of the picture. Provider boards have to use the breathing space created by the front-loaded Spending Review settlement to ensure their organisations are financially sustainable over the longer term. There are two key elements here: long-term transformation, addressed in the next chapter, and efficiency savings/productivity improvements.

All providers have been delivering significant productivity improvements in recent years. However, delivering the £22 billion requirement set out in the 5YFV will require a new and different approach. Lord Carter's recent report shows that acute NHS trusts could save up to 10% of their expenditure through a range of productivity improvements and by eliminating unwarranted variation.

Lord Carter identifies opportunities for productivity improvement in clinical staffing, pharmacy and medicines, diagnostics and imaging, procurement, back-office functions and estates and facilities. There are wide variations in productivity and efficiency which the sector must address. Provider boards will therefore need to develop and then deliver clear plans to:

- increase workforce productivity through more efficient deployment of staff and a significant reduction in temporary staffing costs
- realise the significant savings available through better procurement practices, something which will require providers to work closely together
- generate savings through the more efficient organisation and operation of pharmacy, pathology and imaging services
- improve the management of estates and facilities to achieve the significant savings available in this area.

The requirements for provider boards, including milestones, are set out in the full [Unwarranted variation report](#).

### 3.4 Estates

NHS secondary and tertiary providers have some of the best hospital buildings in the world, but too much healthcare is still provided in inadequate buildings or the wrong settings. The NHS also needs to grasp the opportunity to deliver significant value from its surplus estate. Providers will therefore need to:

- co-locate primary and secondary care where possible
- run their estates more efficiently

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- transform the way in which we use surplus estate to fund these developments and to make a major contribution to the provision of additional housing for NHS staff and the wider population.

Providers will need to set out how they will achieve this and maximise value from their estate in their local Sustainability and Transformation Plans. More detailed guidance on this will be available in due course.

### **SUMMARY**

By 2020 we expect that all NHS providers will have balanced their books and released significant efficiency savings, maximising value for patients and improving the quality of care. Providers will be far less reliant on temporary staff, and the NHS estate will be better utilised in line with local Sustainability and Transformation Plans. Providers will be delivering the 'day job' of providing high quality care to patients more efficiently and, in many areas, there will have been a transformation in the way in which services are organised, as the next section sets out.

## 4 Transformation for sustainability

The challenge for providers is that delivering value for patients through improvements to quality, access and finance and eliminating unwarranted variation across these areas is not, by itself, enough. The 5YFV set out clearly why the NHS has to transform to become sustainable and providers have to play a key role alongside commissioners in leading the long term transformation of their local health and care economies.

Provider boards will need to:

- work with partners to create a new collaborative approach to delivering health and care across a local system
- move rapidly to creating new models of care in their local health and care economy
- assess the need for service reconfiguration with particular emphasis on the required speed for such reconfigurations as part of an overall path to long term sustainability
- ensure their organisation plays its part in getting serious about prevention, reducing health inequalities and improving life expectancy across the local system.

This chapter summarises the transformation task for providers and provides links for further details.

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### *PROVIDERS DELIVERING TRANSFORMATION*

*Over the last 20 years NHS providers have played a key role in delivering a range of service transformations of the type the service now needs:*

- ***At a national system level***, mental health providers, as a sector, have transformed the model of care for mental health services, closing inappropriate long-term bed-based services and developing a wide range of services to support people in their own communities. On prevention, the advances in smoking cessation over the last 10 years demonstrate the power of legislative change coupled with individual provider activity to support individual patients to change their lives.
- ***At a regional level***, services have been reconfigured, eliminating unnecessary duplication and improving quality of care; for example, by concentrating stroke care into eight hyper acute stroke units in London and developing regional trauma networks, concentrating complex trauma care into a smaller number of providers with the right skills and expertise.

- *At a local health and care economy level there are numerous examples of successful service reconfiguration such as: Northumbria Specialist Emergency Care Hospital enhancing specialist cover and transforming how the trust delivers emergency care to its local population, and the concentration of services in north and west London. Many areas are in the process of thinking about service reconfiguration at a local health economy level so the number of these examples will increase.*

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## 4.1 Working across local health and care systems

The current financial, regulatory and performance management processes for the NHS largely focus on individual institutional success. The transformation envisaged in the 5YFV requires a fundamental shift to focussing on the success of the whole local health and care system, recognising that individual institutional success will still have a role to play.

Providers will need to be at the forefront of driving this shift in focus. The [planning guidance](#) sets out the central importance of local health and care system Sustainability and Transformation Plans in this process. Providers will play a critical role in shaping these plans.

NHS Improvement and NHS England will support the required shift by increasingly engaging jointly with local health and care economies, encouraging joint planning and collaboration across boundaries, and supporting local systems to achieve long-term sustainability. They will also continue to give particular help to local health and care economies with long-standing or complex problems. The Success Regime, which is operating in North Cumbria, Devon and Essex, is one example of how we intend to work with the most challenged health systems.

Some health economies with well-established collaborative arrangements are seeking more radical changes through devolution. As we are seeing in Greater Manchester, it also brings providers and commissioners together to plan services more effectively across the public sector. Providers will want to keep abreast of any local plans for devolution and influence them accordingly.

## 4.2 The new care models programme

The 5YFV sets out how the way care is provided needs to change, with providers in future more connected:

- through integrated provision of primary, secondary and social care and physical and mental health
- through clinical networks bringing providers together in areas such as emergency care, cancer, stroke, mental health, maternity and neonatal

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- with providers coming together to work at scale, as part of a chain or group, to generate productivity savings through joint back-office functions, for example
- with commissioners to develop local health system-wide solutions through Sustainability and Transformation Plans
- with academic health science and other clinical networks, to develop and standardise best practice, and undertake research.

Success will involve working beyond organisational boundaries, or redefining them, to deliver high quality population and place-based care and best value for patients and local communities. Providers can no longer act in isolation – a range of partnerships will be needed to succeed.

Many providers are already at the forefront of creating new models of care that can act as blueprints for the NHS and wider health and care system. The [new care models programme](#) is testing five models which have the potential to greatly improve clinical outcomes, patient experience and efficiency by breaking down barriers between organisations and services, and taking a more population-centred approach:

- **integrated primary and acute care systems (PACS):** bringing together GPs, hospital, community, mental health and social care services in a single organisation or partnership
- **multispecialty community providers (MCPs):** providing specialist care services in the community, through partnerships of GPs and groups of acute, community, and social care services working together
- **urgent and emergency care (UEC):** redesigning urgent or emergency treatment through a clearer and more co-ordinated system that delivers urgent health or care as close to home as possible
- **acute care collaboration (ACC):** developing clinical networks where medical expertise is shared with clinicians working across different sites; or providers in different areas of the country joining up; or specialist care being provided by one NHS organisation but on different hospital sites. Some providers are partnering with independent sector organisations to accelerate change
- **enhanced health in care homes:** improving the quality of life, healthcare and planning for people in care homes in partnership with the health and care services, councils and the voluntary sector.

In addition, there are new care models in the 5YFV outside the NCM programme in which providers play a part, eg test beds and healthy new towns, and new care models outside, but related to, the 5YFV, eg integrated care pioneers that we would also wish to continue encouraging.

There are three key drivers for transformation and improvement that which frequently interact:

- First, there is a drive to join up acute, community and primary care services through different forms of vertical integration and joint approaches between commissioners and providers across local health economies.
- Second, there is a drive for the creation of chains, networks and joint ventures through different forms of horizontal integration.
- Third, there is a drive to systematically improve patient pathways using formal improvement methodology.

The most successful providers will be those that embrace and lead change across each of these different dimensions in pursuit of higher quality and productivity.

A key task for provider boards is therefore to identify how they will seek to rapidly move to new models of care and then, working in close collaboration with all relevant partners across their local health and care economy, deliver plans to do so. These will be one of the key centrepieces of each local health and care economy's Sustainability and Transformation Plan.

### **4.3 Service reconfiguration**

Closely linked to moving to new care models, and in some cases a likely part of any strategy to move to new care models, is the need for providers to consider service reconfigurations. Are there too many services of the same type in a broad geographic area to be sustainable?

Historically some reconfigurations have been difficult, requiring complex collaboration with other providers and commissioners and considerable time and effort to generate the required public and political support. Other ways of delivering changes to service models may have greater impact at a faster pace. However, the reality is that, in a number of local health and care economies, long-term sustainability will be dependent on reconfiguring services and there will be little choice but to pursue a reconfiguration.

In these situations, provider boards will want to be clear about what service reconfigurations are required. They will also want to use their local Sustainability and Transformation Plans as a means of generating the required alignment and support across their local health and care economy for such changes.

A key factor in this will be substantial and effective engagement with local communities and elected representatives to ensure a collective understanding of the benefits to be delivered through reconfiguration, and mitigation of understandable concerns raised.

## 4.4 Prevention

The 5YFV sets out a persuasive argument for the need to close the health and wellbeing gap. For too long, prevention, early intervention, improving life expectancy and tackling health inequalities have been regarded as issues for commissioners, local authorities and primary care rather than secondary care providers. The reality is that the health and wellbeing gap will only be closed by all partners in each local health and care economy working together in a different way that puts much greater emphasis on these priorities. Delivering this agenda is vital for the long-term sustainability of the NHS so it is important provider boards determine how they can harness their unparalleled resource, expertise and power in support of this priority.

Given how many staff NHS providers employ, a progressive and proactive staff health and wellbeing policy is an obvious place to start; as is working out how to use each provider's thousands of daily patient interactions to further the prevention and early intervention agenda.

Providers will want to incorporate these activities into each local system's Sustainability and Transformation Plan.

### SUMMARY

We anticipate that by 2020 individual providers will have connected with other organisations to transform services in ways that best meet the needs of their local population. Providers will be much more effectively working with partners and across their local health and care economies to plan and implement service changes, to resolve complex problems and support one another, and some will be working within a devolved framework. All local health and care systems will have clear plans to both move to new care models and reconfigure services where required, with providers having played a key part in the development of these plans. Providers will be playing a significantly enhanced role in closing the health and wellbeing gap.

The previous four chapters of this document have set out the scale of the task for providers – delivering outstanding quality of patient care, NHS Constitution access standards and financial balance, eliminating unwarranted variation across all these areas, while also making the transformation that is needed to ensure long-term sustainability.

However providers do not, at the moment, have sufficient capacity and capability to deliver this stretching and ambitious task. So, while we must be realistic about how much can be delivered how quickly, provider boards will also want to consider how they can increase their capability to deliver more of the task at a faster speed.

The next two chapters of the document therefore set out how NHS providers might enhance their capacity and capability by investing in workforce and leadership, and in improving technology, innovation and research.



## 5 Building capability: workforce and leadership

The dedicated staff who work in the NHS are its most important asset. A highly skilled, motivated and healthy workforce, deployed in the right place and at the right time, will continue to be the driving force in delivering high quality, innovative, patient-centred care. But if we are to transform, move to new care models and close the finance and efficiency gap, we have to enable those staff to deliver even greater value. Our workforce will need to change shape to meet changing patient needs and deliver new care models. There is also a real danger that the gap between increased demand and limited funding growth translates into an increasing burden on staff leading to a significant drop in engagement and morale, just at the point when we need them to engage enthusiastically in delivering the changes we need.

Provider boards will therefore need to give the right strategic priority to workforce and leadership issues to:

- recruit, retain and develop the right workforce to meet current needs
- be clear about how their workforce needs to change as we move to new care models and transform services
- support and enable staff to increase their productivity and deliver the changes required
- improve performance on equality and diversity issues
- significantly enhance leadership and management capacity and capability, including clinical leadership.

This chapter summarises the task in these areas and provides links for further details.

### 5.1 Recruit, retain and develop the right workforce

NHS providers employ around 750,000 of the NHS's total 1.2 million staff in over 300 different professions, from porters and paediatricians to receptionists and radiologists. Recruiting, developing and retaining these staff is key to providing effective patient care.

As employers, providers are responsible for ensuring they employ the right numbers of staff with the right skills, values and behaviours. This means identifying, funding and recruiting to vacancies, drawing on tools such as measuring the care hours per patient day across clinical teams and the requirements to bear down on agency spend to inform judgements. Given the drive to maximise the contribution of the entire workforce and implement new care models, providers will want to take a strategic, holistic and sophisticated view of staffing, rather than just focusing on

numbers. Outcome measures, not simple input metrics, should become the norm to better assess the staffing models in place.

It takes over three years to train a new nurse and up to 14 years to train a consultant doctor so, as employers, providers have a key role in retaining this precious resource. We know from the Carter Review that staff turnover varies hugely between trusts, leading to greater recruitment costs, poorer staff satisfaction and, consequently, poorer patient satisfaction.

The majority of our staff will be working in the NHS for over 40 years, so we have a responsibility to continually reskill them for the benefit of future patients. While 70% of the NHS budget is spent on employing the current workforce, Health Education England (HEE) is responsible for investing around 5% of the NHS budget on the future workforce. HEE draws on a wide range of national and international sources to shape their plans, but the [workforce plans produced by trusts and submitted to LETBs](#) (HEE's Local Education and Training Boards) are key. Providers therefore have a responsibility to ensure that the workforce plans they submit reflect the requirements which stem from local Sustainability and Transformation Plans and align with financial forecasts.

## 5.2 Future workforce

But the demands on our workforce are also changing: new care models mean new staffing models.

The 5YFV made clear that the vision for 2020 is of far more care being delivered closer to home, by multiprofessional teams with more generalist skills, able to operate between different care settings and with more specialist colleagues. This will require much more fluidity of roles and place, and a greater use of tools such as e-rostering and caring hours per patient day to ensure services are high quality, appropriately staffed and efficient. Multiprofessional working is already becoming the norm, and more generalist skills will be required to complement specialist skills.

Provider boards will therefore need a clear plan for how their workforce will change shape and how this changing shape will actually be delivered in practice.

## 5.3 Workforce health and productivity

There is growing evidence of a strong correlation between organisational performance and staff engagement. For example, [West and Dawson](#) found clear associations between high staff satisfaction/engagement scores and low staff absenteeism, low staff turnover, better patient satisfaction, lower mortality indicators and better safety measures. It is clearly in all providers' interest to foster a culture in which staff feel valued and engaged; where bullying and harassment are not tolerated; and where staff health and wellbeing are paramount. Providers have a leading role in improving the health and wellbeing of their staff, and in reducing the impact of ill health or disability for staff in work. This goes hand in hand with creating

the culture of learning and improvement that underpins the task outlined in the first five chapters of this document.

There is much more providers can do to support staff to become more productive. As outlined in Chapter 3, Lord Carter has suggested there are potential savings of around £2 billion from improving the workflow and productivity of the NHS workforce. There is significant variation across hospitals in the management of sickness and annual leave, and the use of e-rostering and management information to make decisions about workforce utilisation. There are also high rates of absenteeism, bullying and turnover in the NHS compared with other sectors, and significant, apparently unwarranted, variation between employers. Just a 1% reduction in sickness absence could save £400 million, excluding the costs associated with absence such as temporary cover.

Provider boards will want to have clear plans in these areas, as part of a wider workforce strategy.

## **5.4 Equality and diversity**

Provider boards need clear plans to tackle discrimination to improve patient care and ensure that NHS organisations have leadership which more closely resembles the communities they serve. There is also strong evidence that organisations where Boards have more diverse representation, eg across gender, ethnicity and other characteristics, tend to be more successful.

Recent [research](#) demonstrates the scale and persistence of discrimination at a time when evidence also demonstrates the link between the treatment of staff and patient experience and outcomes and, in particular, the links between patient experience and the treatment of black and minority ethnic staff.

A greater focus on equality and diversity and the needs of different employees (including the ageing workforce), for instance, altering shift patterns and rosters, will be an important contributor to the delivery of high quality healthcare.

## **5.5 Developing leadership and management**

The scale of the provider task requires a significant leap in leadership and management capacity and capability and determining how this will be achieved should be a key focus for provider boards.

The high turnover of provider chief executives and other board-level positions is a major concern and the supply of potential executives is insufficient to meet demand. More needs to be done to value and promote the role of leaders throughout organisations.

As in so many areas, this can only be achieved by national and local leaders successfully working together. Provider boards are responsible for ensuring they have the right leadership and management capacity and capability within their

organisation and, increasingly, within the wider local health and care system. To support this, in line with the recommendations of the [Smith Review](#), NHS Improvement is working with arm's length body colleagues, in particular Health Education England, and organisations like the Leadership Academy, NHS Providers and the King's Fund to:

- develop a national strategy for leadership development and improvement, including talent management from graduate to board level
- expand the pipeline of suitably qualified applicants for board-level roles for providers, and providing national level support programmes such as piloting new programmes for aspirant and newly appointed provider chief executives
- create an experienced cadre of interim executives to fill short-term vacancies on which provider boards can draw
- develop evidence-based tools and guidance to help provider boards address cultural issues, and design and deliver effective local leadership strategies
- facilitate professional networking events and encourage buddying, mentoring and coaching.

## **SUMMARY**

We expect that by 2020 provider boards will be devoting significantly more time and focus to strategic workforce solutions which underpin the delivery of high quality patient care. Far more care will be delivered closer to home, by multiprofessional teams with more generalist skills, able to operate between different care settings and with more specialist colleagues. Staffing levels will be appropriate to the needs of patients and care model, and providers will be using tools such as e-rostering and caring hours per patient day to ensure their services are both safe and efficient. Staff turnover and sickness absence will be much reduced, with a corresponding improvement in productivity and staff satisfaction. The supply of capable leaders will have significantly increased, as will have leadership and management capacity and capability more generally. There will be a much more supportive culture in which the role and importance of provider leadership and management is both recognised and valued. But this needs to be accompanied by greater investment in utilising new technology and data, as set out in the following section.

## 6 Building capability: technology, innovation and research

Advances in technology, innovation and research are transforming healthcare across the world at an unprecedented pace. The NHS has made good progress in some areas but we are a long way behind in others. We are, for example, a long way behind the US in using technology and data to risk stratify our populations, and target prevention and treatment according to the identified risk. We are a long way behind other advanced nations and the rest of the UK public sector in using technology to improve the efficiency of how we manage our organisations and enhance customer experience. There is significant public and political pressure for the NHS to close this gap at speed.

Provider boards will therefore need to:

- make significant progress in exploiting the benefits of technology and realise the ambition of the NHS being paperless by 2020
- clearly define their role in science, education and training, and research and innovation and ensure they speed up the adoption of research and innovation including through working with their local academic health science network.

This chapter summarises the task in these areas and provides links to further details.

### 6.1 Technology, data and a paperless NHS

Technology and data are critical enablers for improving standards and access, increasing personalisation of care, managing long-term conditions and preventing lifestyle diseases. Using technology and information effectively generates step-change efficiencies, and is key to successful research and innovation. Clinicians will need to maximise the potential of data to benchmark their practice, while providing patients with more information to inform their decisions and a better patient experience. In future we will be working with patients to help them take more responsibility for managing their own conditions and treatment. At the same time we need to use technology better to increase the productivity and efficiency of our organisations.

People have high expectations as technology has fundamentally changed other aspects of daily life; and the NHS should be no different. Providers need to exploit the benefits of technology and realise the ambition of being paperless by 2020.

Greater use of new technology and improved information can enable providers to streamline and re-engineer services, ensuring that care is more effective, safe and responsive. Providers should be able to interface seamlessly between different parts of the health and care system using new techniques and channels to communicate with patients, other providers and commissioners. Clinicians should be using systems that easily capture, share and analyse data to improve patient care. New investment

will support this transformation and the sharing of essential patient information to common standards across health and social care by 2020.

Harnessing the full potential of technology means providers will need to ensure:

- staff and assets are well managed based on real-time supply and demand information, improving flow and reducing pressure through the hospital
- automation of routine tasks, such as diagnostic requests, reducing waste and increasing safety of handoffs
- complete and up-to-date records accompanying patients around the health and care system wherever they are seen
- patients able to book services and order prescriptions online, reducing wasted time for patients and making better use of administration time
- when appropriate, appointments are available via video link, email or teleconference
- universal use of portable devices and apps in community care and maternity services, enabling mobile working and professionals spending more time with those they support
- patients are supported to use apps that allow monitoring and management of conditions.

The [digital roadmaps](#) being developed by local health economies provide a key opportunity to achieve a fully interoperable and paper-free health and care system for the benefit of patients and NHS staff.

Providers should engage in and lead these discussions, and ensure they are connected with broader strategic planning. NHS Improvement and NHS England plan to appoint a joint chief information and technology officer to support this local joint working.

## **6.2 Speeding up research and innovation**

Some of the greatest advancements in medicine have occurred in the UK: research and development are not only critical to the progression of treatment and care, but also make an important contribution to economic growth, and NHS providers have a key role to play in this area.

Providers will need to remain at the forefront of science, education and training, and research and innovation, and to realise the benefits of this rapidly.

We also need providers to collect and use health outcomes data and employ NHS clinical assets to support health research, with a view to improving care standards and practices. The roll out of the [Clinical Practice Research Datalink](#), and efforts to

embed high quality health research and clinical trials in routine clinical practice, are just two examples of initiatives to speed up the research process.

The use of innovative products and care pathways has been critical to transforming the care provided to patients; and a willingness to work at the leading edge of research and innovation is a hallmark of clinical excellence. Work is underway to ensure that new drugs and technologies are evaluated more speedily, and to ensure that greater numbers of new devices and equipment are evaluated by the National Institute for Health and Care Excellence. The [Accelerated Access Review](#), supported by the Wellcome Trust, is considering how innovations can be more rapidly translated into mainstream clinical practice. Academic health science centres and networks will play an increasing role in supporting the diffusion of innovations that enhance patient outcomes.

Provider boards should clearly define their role in science, education and training, and research and innovation and ensure they speed up the adoption of relevant research and innovation. This should include how they will work with their local academic health science network.

## **SUMMARY**

By 2020 providers should be fully exploiting the benefits of technology, to enable efficient patient-centred ways of working and improve interfaces between different parts of the health and care system. Clinicians and patients will benefit from improved information, less paper and rapid access to services facilitated by new technology. Advancement in the use of data and technology are also a critical enabler for research and innovation. Providers will support high quality, research and innovation which will be more rapidly translated into clinical practice to ensure patients and the population benefit from such leading-edge, cost-effective care. But delivery of this, and all the other elements of the provider task outlined in this document will only happen, if providers get the right support from NHS national leaders, particularly NHS Improvement. How this will happen is set out in the next chapter of the document.



## 7 Supporting providers to deliver: the role of NHS Improvement

NHS Improvement has been created to provide the system-level support that providers will need to deliver the ambitious and stretching task described in this document. This chapter describes what that support will be and how it will be provided, set out in sections on:

- NHS Improvement's role and purpose
- A new dialogue with providers
- developing the right relationships;
- a single definition of success;
- autonomy for good performers
- our approach to improvement.

### 7.1 System-level support – the role of NHS Improvement and partners

The creation of NHS Improvement is an opportunity to think afresh about how the national health system best support providers. Both NHS trusts and foundation trusts face similar opportunities and challenges, and NHS Improvement will provide consistent messages, support and oversight to all types of provider.

NHS Improvement's purpose is better health, transformed care delivery and sustainable finances: a purpose that we know NHS patients, carers, staff and organisations all share with us. NHS Improvement will realise this through leadership of the sector and by supporting providers and local health systems to improve. We will build on the best of what our constituent organisations already do, but with a change of emphasis: first and foremost, we will offer real support to providers and local health systems. We will, of course, hold boards to account, and sometimes it will still be necessary to intervene. But our emphasis is clear: our first and most important purpose is to support providers to deliver the task set out in this document.

We want to enable all providers to take control and provide the best possible care to their local communities. We will continue to afford considerable autonomy to providers that perform well. NHS Improvement will also support providers to become learning organisations so they can continually improve and drive up standards, delivering consistently safe, high quality care.

NHS Improvement is committed to working closely with CQC, NHS England and other partners, including professional regulators, at national, regional and local levels. We recognise that providers are frustrated by the fragmentation of national

system-level organisations and the inconsistencies and extra burdens this brings. We will collaborate with other arm's length body colleagues to streamline the data requests made of providers and reduce the burden of regulation across the board.

We have agreed to ensure a shared definition of quality and efficiency with CQC, and we will undertake the new use of resources assessment on CQC's behalf. We are also working with NHS England to ensure greater alignment between the financial levers for commissioners and providers.

In short, NHS Improvement will work closely alongside the sector and national partners to create the conditions for providers to flourish.

## **7.2 A new dialogue**

We are still in the process of developing NHS Improvement, just as many local health systems are in the early stages of setting their future strategy through the Sustainability and Transformation Planning process. We are creating a dialogue with providers about these challenges and how they can best be met. We intend to work with NHS Providers and other partners going forward to develop this new and critical dialogue with the sector.

In the short term, the scale of financial and operational challenges across the sector mean we will need to take a more involved and directive approach with more providers than we intend to in future. But as the sector comes back into balance, we will adopt a longer term oversight model with more and more providers. In this model, we support first, building deep and lasting relationships with providers and working alongside them to help them to improve, and only intervene when we have to. We cannot expect providers to expand their improvement capability overnight, especially those facing difficult challenges. So from the outset, we will be supporting the whole sector in sharing and improving the use of established improvement tools and techniques.

## **7.3 Developing the right relationships**

Developing the right relationships with providers and health systems will be crucial to our success. With this in mind, we aim to:

- put patients first: supporting providers and local health and care systems to improve the outcomes of patient care will drive everything we do
- respect and empower system leaders: We will respect the autonomy, expertise and experience of provider boards, and hold boards to account against a clear definition of success. We will intervene in a directive way only where necessary. We will give leaders space to innovate and take well-managed risks

- offer practical, evidence-based support, which recognises and shares good practice, enables providers to support each other and drives continuous improvement
- work towards eliminating any unnecessary data reporting requirements and lightening other regulatory burdens
- work with local health and care systems as much as with individual providers: Providers are already co-developing more 'system-wide' solutions, and we will continue to support this.

With our system partners at national level we aim to:

- create an environment for provider success and address sector-wide issues through national policy, pricing and other levers
- collaborate: we will instinctively and naturally collaborate with NHS England and CQC at national, regional and local levels
- speak with one voice to the service: NHS Improvement, NHS England and CQC will align approaches, ensuring that our collective messages and actions present a consistent set of priorities.

#### **7.4 A single definition of success**

We will align with CQC and NHS England to create a single and simple definition of success for providers. As we do this we are considering how we reflect five key issues touched on earlier in this document:

1. Quality: we will use CQC's quality assessment, and five key questions (safe, effective, caring, responsive, well-led), supplemented with real-time information. Success will represent a CQC rating of 'good' or better.
2. Finance/use of resources: NHS Improvement and CQC are co-developing a methodology for assessing providers' use of resources, which will reflect the recommendations of the Carter Review.
3. Operational performance: we will focus on delivery of a small number of core NHS standards and targets for acute, mental health, community and ambulance trusts. This may include A&E waiting times, referral to treatment times, cancer treatment times, ambulance response times, access to mental health services and progress on implementation of seven-day services.
4. Leadership: We will build on existing governance tools like the well-led framework to set out a single, shared system view on what good leadership looks like.

5. Strategic change: We will develop an assessment, jointly with other partners on the 5YFV Board, of how well trusts are delivering the strategic changes set out in the 5YFV, including new care models, based on areas' Sustainability and Transformation Plans, and where relevant devolution.

Having a single, shared view with our partners of what we are asking providers and the sector to achieve will allow us to focus as much of our resources as possible on providing support for improvement.

## **7.5 Autonomy for good performers**

Although some of the short-term challenges the sector faces require a closer grip from the centre, our broader ambition is to offer as much autonomy as possible to providers that perform well.

We will segment providers according to the extent to which they meet our single definition of success. Providers that closely meet our definition of success will have greater freedoms: fewer data and monitoring requirements; simpler and less burdensome processes for approving transactions, capital spending and transactions; and the opportunity to share best practice with others and to be recognised as a leader of improvement. These organisations and their leaders will be put forward as demonstrators of good practice, and will be encouraged to support and share their learning, skill and expertise with others.

Providers that do not meet the single definition of success will receive more intensive support in line with the scale of the challenges they face. Where providers are facing the biggest challenges – including foundation trusts in breach of licence, NHS trusts in similar circumstances and providers in special measures – this support will be more directive.

## **7.6 Our approach to improvement: supporting leaders and rapidly spreading good practice**

The [Health Foundation's \*Constructive Comfort\* report](#) makes clear that local health and care systems need a range of different forms of support; and that national bodies have often struggled to move beyond a 'prodding' approach to improvement. That report also emphasises the critical need to focus on supporting leadership capability-building. A critical challenge for NHS Improvement will be to improve the environment for NHS leaders, and to revitalise the systems of talent management and leadership development which the NHS so badly needs.

Much of the expertise needed to address the challenges set out in this document already exists in the system itself. One of our most important roles is to work collaboratively across the sector to support improvement, to broker support between providers and to help providers help themselves by sharing our analysis and insights

with the sector, where the sector needs to be more systematic about the sharing and adoption of best practice.

Improvement capability and capacity needs to be successfully embedded, valued and supported in all provider organisations. With the development of an expert improvement faculty, we will support providers and existing improvement agencies to develop leaders, and empower the workforce, to invest in improvement and develop improvement capabilities to meet the challenges set out earlier in this document.

Some of the current approaches to improvement which best exemplify the models we want to test and develop going forward include:

- the [Sign up to Safety campaign](#) which demonstrates the power of sector-led change and the speed at which good practice can spread when the energy of staff and leaders is unleashed
- the Emergency Care Improvement Programme which seeks to provide practical, hands-on support to providers and health systems in addressing a key improvement priority
- the Virginia Mason Institute's [work with five NHS trusts](#)<sup>10</sup> which focuses on long-term capability building, use of proven improvement techniques and deep-rooted cultural change to unlock improvement, even in very challenged providers;
- The [programmes](#) we have developed with NHS Providers and the NHS Leadership Academy to increase the pipeline of well-qualified provider chief executive candidates and support newly appointed chief executives.

As we have outlined throughout this document, addressing unwarranted variations in quality, access and efficiency between and within providers is a key challenge and will be at the core of NHS Improvement's activities. There is no 'silver bullet' solution: a combination of focused service improvement and a change to the culture and leadership environment will be needed. To support this, NHS Improvement will:

- support all trusts to develop the capability to improve and apply evidence-based improvement methodologies
- encourage providers to actively engage patients in the improvement of services
- scale up and spread the learning from providers more systematically
- support the coaching and mentoring of new leaders and create a cadre of interim executive leaders to stabilise the most challenged providers

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<sup>10</sup> <http://www.ntda.nhs.uk/blog/2015/07/16/nhs-tda-launches-ground-breaking-programme-with-top-us-hospital-to-transform-care-for-nhs-patients/>

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- continue to provide dedicated support and development for providers in, or at risk of being in, special measures, including senior leadership capacity and buddying with high-performing NHS providers, the independent sector nationally and internationally, and other sectors with relevant expertise
- support long-term capability-building through programmes such as the Virginia Mason initiative
- support providers in implementing the recommendations of the Carter Review. We will also be working with non-acute providers to apply similar methodologies and tools to these sectors. The review also recommends a single approach to defining success for providers on quality and productivity, which NHS Improvement and CQC are already working together to develop.

Underpinning this, NHS Improvement will embed the principle of continuous improvement in the way we work. We will monitor and evaluate the effectiveness of our support, and will seek to refine our methods based on evidence of what works to support improvement, including through feedback from providers.

### **SUMMARY**

The vision for 2020 is of an NHS Improvement that is effectively supporting providers that are, in turn, delivering the requirements set out in this document. Well-performing providers have considerable autonomy and NHS Improvement is only intervening where it has to. There is a high quality dialogue and partnership between NHS Improvement and the providers it supports. NHS Improvement is working much more effectively with its national system-level partners and, as a result, the regulatory burden, duplication and inconsistency currently experienced by providers has dramatically reduced. There is a single definition success used by all national system leaders and they have effectively supported the shift of focus towards the success of local health and care systems, not just individual organisations. NHS Improvement, working with providers and other partners, has developed an effective improvement offer that providers use, admire and rate highly.

The background of the image is a complex, abstract pattern of overlapping squares and diamonds in various shades of blue, ranging from light sky blue to deep navy blue. The pattern is dense and creates a sense of depth and movement.

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