South West Governors’ Exchange Network (SWGEN)
The Auditorium, Somerset College, Wellington Road, Taunton
Thursday 19th November 2015, 10.00 – 3.00pm

Programme

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<th>Time</th>
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<th>Speaker/Comments</th>
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<tr>
<td>10.00am</td>
<td>1. Welcome</td>
<td>Dr Nick Marsden, Salisbury NHS Foundation Trust and Prof Clair Chilvers, Gloucestershire Hospitals NHS Foundation Trust</td>
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<tr>
<td>10.05am</td>
<td>2. Political and Strategic Challenges facing the NHS in the future</td>
<td>Saffron Cordery, Director of Policy and Strategy, NHS Providers</td>
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<td><em>Presentation and discussion</em></td>
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<td>12.00pm</td>
<td>3. Lunch</td>
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<td>1.30pm</td>
<td>4. Future Provider Regulation</td>
<td>Kate Holden, Deputy Regional Director, South Monitor</td>
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<td><em>Presentation and discussion</em></td>
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<td>2.30pm</td>
<td>5. Wrap up Q&amp;A and future Agenda Topics</td>
<td>Dr Nick Marsden, Salisbury NHS Foundation Trust and Prof Clair Chilvers, Gloucestershire Hospitals NHS Foundation Trust</td>
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<td><em>Discussion</em></td>
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<td>3.00pm</td>
<td>6. Close</td>
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All documents can be found on:  
[http://www.salisbury.nhs.uk/Foundation/Pages/SWGEN.aspx](http://www.salisbury.nhs.uk/Foundation/Pages/SWGEN.aspx)
Where are we?

- Waiting for the money
- Flux in the central bodies
- Change on the ground
- Political interest
- Opportunity
What will we cover?

Money

Workforce

Regulation

Five Year Forward View

5 things that make me optimistic
What will we cover?

Money

Workforce

Regulation

Five Year Forward View

5 things that make me optimistic
Overview of the money

2015/16 (Short term)
Contain the £2bn deficit

2016/17 and 2017/18 (Mid term)
Tackle structural deficit, from a £2bn hole

2020/21 (Long term)
Nearly double productivity growth
Grim outlook for 2015/16 finances

£2bn estimated provider sector deficit for 2015/16 as a whole

£930m deficit at end of Q1 2015/16 alone

Already slippage and reforecasting at end of Q1. Worse expected at Q2 and Q3, without the usual Q4 recovery.

Variance between Q1 15/16 planned and actual surplus/deficit
(n = 81)

Largest decrease £4.1m
12 with no change
Largest increase £2.8m

Source: NHS Providers survey Aug 2015
With two-thirds of the sector projecting deficits

- Staffing & activity cost pressures
- Zero sum game commissioning behaviours e.g. on CQUIN
- Significant unallocated M12 CIPs
- Some clinicians asking ‘Why not spend and add a few more £m onto the deficit position, if we and everyone else is in deficit anyway?’

“It’s like being a dairy farmer - our costs are simply not covered.”
(Nuffield Trust leaders panel)

Source: Kings Fund QMR July 2015
MH sector now only sector reporting surplus

Financial position at Q1 2015/16

<table>
<thead>
<tr>
<th>Trust type</th>
<th>Number of providers</th>
<th>Number of providers in deficit</th>
<th>Net position</th>
<th>Proportion of providers in deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>138</td>
<td>132</td>
<td>-£912m</td>
<td>96%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>10</td>
<td>8</td>
<td>-£7.4m</td>
<td>80%</td>
</tr>
<tr>
<td>Community</td>
<td>19</td>
<td>9</td>
<td>-£2.0</td>
<td>47%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>57</td>
<td>31</td>
<td>2.1m</td>
<td>54%</td>
</tr>
<tr>
<td>Specialist</td>
<td>17</td>
<td>10</td>
<td>-£11m</td>
<td>59%</td>
</tr>
<tr>
<td><strong>All</strong></td>
<td><strong>241</strong></td>
<td><strong>190</strong></td>
<td><strong>-£930m</strong></td>
<td><strong>79%</strong></td>
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MH trust type

<table>
<thead>
<tr>
<th>MH trust type</th>
<th>Number of providers</th>
<th>Number of providers in deficit</th>
<th>Net position</th>
<th>Proportion of providers in deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS trust</td>
<td>14</td>
<td>6</td>
<td>-£4.9</td>
<td>43%</td>
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<tr>
<td>Foundation trust</td>
<td>43</td>
<td>25</td>
<td>7</td>
<td>58%</td>
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Source: Monitor and Trust Development Authority Board papers (2015)
HMT worried about institutional grip

What is the calibration of ‘good’ when everyone is in deficit, and it becomes about ‘not being the biggest failure’ – do I just need to be in the middle of the peloton?

How do you motivate staff in this environment when it feels like you are 10-0 down at half time?
From specific challenged areas to systemic distress

THE CHARACTERISTICS OF A CHALLENGED HEALTH ECONOMY

• Structurally unsustainable healthcare services
• Solutions that will need a system-level response
• Difficult decisions that have been deferred for many years
• The scale and complexity of the challenge
• A history of reliance on external financial support
• Lack of consideration of the implications of the Better Care Fund & social care

Source: 11 Challenged Health Economies report, Monitor NED survey Mar 2015
Firefighting 2015/16 finances

- Management consultancy cap
- Agency staffing cap
- Capital to revenue swaps
- Very Senior Manager Pay
- RAF financial measures
- Monitor & TDA letters on 2015/16 financial plans
Where do you want to put financial risk in the system?

We now need to ensure that every CCG in the South West is using all appropriate contractual sanctions available to incentivise providers to focus on delivery of access standards.

....I expect any fines levied are neither waived nor “reinvested” into the same provider, except in highly exceptional and fully justified circumstances...

Where fines are levied the CCG is at liberty to spend this money with alternative providers to improve the delivery of the standard at a population level (for example in the Independent Sector in the case of RTT) or to use it to visibly improve your overall financial position in meeting Business Rules and delivering or improving on your Control Total.
2015/16 financial grip

If you lose control of your finances you lose control of your destiny

Simon Stevens, NHS England CEO
Overview of the money

2015/16 (Short term)
Contain the £2bn deficit

2016/17 and 2017/18 (Mid term)
Tackle structural deficit, from a £2bn hole

2020/21 (Long term)
Nearly double productivity growth
Potential impact of CSR on planning process

- 3 year spending review settlement for health & social care
- 3 year mandate from DH to NHS England
- 3 year allocations from NHS England to CCGs
- 3 year CCG and provider plans aligned – both system and institutional level
- 3 year contracts and elements of national tariff
What we expect: 2016/17 tariff and planning

**Tariff**
- Delayed publication in early 2016
- Efficiency factor as low as possible to rebalance financial risk
- Retain punitive marginal rates for specialised and emergency care
- Moves towards multi-year tariffs

**Planning**
- Better Care Fund to stay for at least 2016/17
- Common set of high level strategic objectives for local health system (CCG footprint)
- Detailed operational plan for each organisation for 2016/17
- Multi-year strategic roadmap across the local health care system (Autumn 2016)
What we expect: 2016/17 tariff and planning

Delayed publication of 2016/17 tariff with less consultation than last year or year before

A late, very stretching, tariff efficiency factor reflecting the need for steep savings in 2016/17 and beyond

A request for rapid 2016/17 and multi year plans for both your institution and your local health and social care system
Overview of the money

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2020/21 (Long term)
Nearly double productivity growth
2020: What is the strategy for the £8bn?

When will it come?
• Front-load, back-load, linear?

Who is it for?
• DH or NHS England? The ‘NHS’ is protected, not the DH budget

What is it for?
• Keep show on road / gap filling or transformation or both?

How should it flow?
• Push through payment system, hypothecate, conditionality?
Social care funding

- Already seeing impact of public health cuts on services such as smoking cessation
- Lack of deficit budget setting driving behaviours
- Pulling levers that NHS does not have e.g. stopping services
- Some real deeply-held anger at lack of equitable ring-fencing

Source: LGA CSR 2015 submission
What is the strategy for the £22bn?

- Income generation
- Reducing system overheads
- Reducing pay & prices
- Reducing activity
- Increase productivity

- Prescription charges, hotel costs, Healthcare UK
- Central budgets (e.g. nursery milk), admin
- 1% pay restraint, drug prices, procurement prices
- New models of care, better commissioning, prevention, clinical thresholds
- Carter review (£5bn by 2019/20), agency, workforce productivity, Estates, back office, Technology, GIRFT
New care models increase value…but reduce costs?


2% efficiency → 2% → 2% → 3% → 3% → 3%

Additional 1% efficiency (c£4-5bn) expected from prevention, new care models and wider system improvements

Against a backdrop of
- £2bn starting deficit, rising rapidly
- Constraints imposed by recent quality/staffing political emphasis
- Poor track record on demand reduction and service transformation
- Disengagement of clinical staff
- Loss of management capability via CIPs

“We do have a plan and it is very innovative. But it won’t save the money that is required.”
(Nuffield Trust leaders panel)
Three conclusions to draw

The overall level of savings is very ambitious, very provider focussed and is dependent on pay restraint.

Too many of the savings are backloaded, giving the NHS a major problem for 2016/17 and 2017/18.

It’s taking a very long time to get to a NHS-wide plan engaging those who have to deliver savings.
What will we cover?

- Money
- **Workforce**
- Regulation
- Five Year Forward View
- 5 things that make me optimistic
What are finance directors most worried about?

Which aspects of your organisation’s performance are giving you most cause for concern at the moment? (NHS trust and CCG finance directors)

- Staff morale
- Delayed transfers of care
- A&E 4-hour wait target
- Emergency readmission threshold
- 18-week RTT
- Engagement in performance issues by clinicians
- Patients’ care experience
- Cancer treatment waiting time targets
- Health care–acquired infections

Per cent of all mentions

Source: Kings Fund QMR, July 2015
Should I stay or should I go?

What do we want?

Staff to be happy and do more i.e. work in new settings, work with new partners, work across 7 days, get involved in the business, cope with more demand, lead chains, turnaround trusts, take on commissioning

Reduce the pay bill and maintain quality

What are we doing about it?

• 1% pay award
• Junior doctors contract
• Consultant contract
• Reduce VSM pay
• Have 7DS standards in contracts and CQUIN in advance of costing and service development funding

• Pause safer staffing
• Agency controls
• Reduce supply through 35k emigration (730 nurses)
• Originally reducing supply through immigration (Tier 2 visas)
I have two emails next to each other in my inbox.

One is a letter from my national regulator about my finances, asking me to ensure “safe staffing guidance has been adopted in a proportionate and appropriate way”.

The other is a letter from my national commissioner reminding me that there “can be no compromise on the issue of staffing and its impact on patient safety”.

[LEFT]

“**It’s like the left hand doesn’t know what the far left hand is doing**”

[RIGHT]

Democrat Party social care reform in the West Wing
Some emerging coherence

Contracts
- Junior doctors
- Consultant contract
- 7DS, affordability, flexibility

Agency
- Still headed for 3.5bn+ spend
- Organisational caps, locum and agency caps, move to on-framework agreements considered medium-term solutions

Supply
- Safe staffing council new guidance
- Self-funded places
- Relax immigration controls
Providers not standing still

- Ask patients what extended hours they would value
- Use evidence to target services and particular periods to extend service
- Listen to concerns of patients over impact on staff
- Then start conversation with clinicians and support staff
- Get details right e.g. canteen
What will we cover?

Money

Workforce

Regulation

Five Year Forward View

5 things that make me optimistic
Regulatory map is a depressing picture

Monitor taking enforcement action against 24% of FTs for breaching their licences.

Source: HSJ, Aug 2015
Special measures:

15 trusts are in special measures

CQC inspection ratings:

71% of rated trusts are ‘requires improvement’ or inadequate

Monitor ratings:

6% rise in the number of FTs rated ‘1’ for Continuity of Services (Financial sustainability) and those rated ‘red’ for Governance in the last year

NTDA ratings:

75% of NHS trusts are receiving some form of intervention from the TDA

Source: NHS Providers, data correct as of 29th September 2015
Overall approach

- Absolute or relative performance?
- Balance short term and long term
- Explore the right unit of regulation
- Balance challenge and support
- Be clear on lines of accountability
Therefore, he said: “I would suspend the current pipeline; I’d say we’re going to work out a different policy... and in the meantime you’ve just got to focus on doing things better, but with the priorities set by your particular needs, rather than the more general needs of Monitor’s assessment process.”

He said: “One could easily adopt, and possibly slightly adapt, the [Care Quality Commission] regime. “Say there are four categories of performance, from outstanding through to inadequate and special measures, and you can say against those four categories of performance you get four degrees of autonomy. That’s essentially what we’re doing today, but I think it would make a lot of sense to formalise it.”

He added: “What this enables you to do in principle is to recognise that freedoms can be taken away as well as granted... I think it’d be helpful to just be very explicit about this.”
NHS Improvement (from Apr 2016)

The people

• Ed Smith Chair, Lord Darzi a NED, CEO Jim Mackey

The job

• Oversight of regulation, performance and development; maintain sector regulation (e.g. competition, pricing)
• Patient safety and Independent Patient Safety Investigation Service (IPSIS)
• More support through Provider Sustainability Directorate – ECIST, WAIST
• More regional presence aligned with NHS England
• All extra-legislative

What does it mean for you?

• Potential mix of Monitor rigour and TDA realism and experience
• More improvement support
• More integrated performance management at LHE level
• FTs & trusts in the same boat? More freedom for top NHS trusts? Less freedom for FTs?
The new team needs to decide whether they are an improvement agency, a market regulator or a provider regulator.

Stephen Dorrell MP
Care Quality Commission: five year strategy (2016-2021)

- Moving to a more risk based approach to registration
- Improving monitoring and insight from data
- A greater focus on co-regulation
- More responsive and tailored inspections
- Looking at the quality of care for populations and places
- Assessing a provider’s use of resources
And Jim Mackey

**History of delivery**
- PFI buy out
- Emergency care build
- North Cumbria
- Culture change
- Business units
- New care models – ACO
- New care models - Chain

**The continuing mission**
- Maximise number of good & outstanding CQC ratings
- Get sector into financial balance
What will we cover?

- Money
- Workforce
- Regulation
- Five Year Forward View
- 5 things that make me optimistic
**Update on 5YFV New Care Models**

| Multispecialty Community Providers | • Community psychiatric nurses and community therapists in primary care  
                                  | • Working on new training pathways with Royal Colleges, indemnity |
|-----------------------------------|---------------------------------------------------------------------|
| Integrated primary and acute care systems | • Developing capitated outcomes based contracts  
                                          | • Working with JVs to give GPs an exit strategy |
| Enhanced health in care homes      | • Offering older people better, joined up health, care and rehabilitation services |
| Acute care collaboratives          | • Chains, accountable clinical networks, specialty franchises, multi-provider hospital model |
| Urgent and emergency care          | • Developing whole system metrics  
                                          | • Starting to attract top talent to new roles |
“Acute care” collaboration

Multispecialty franchises

- Individual clinical services at local DGHs run onsite by specialists from regional centres of excellence (e.g. orthopaedics, ophthalmology, and neurology spinal)
- Includes collaboration of MH trusts

Accountable clinical networks

- Integrating care across DGHs and teaching hospitals for key services, including cancer and mental health. Links to model to be piloted by cancer vanguards which will work towards taking accountability for a population budget

Multihospital chains

- High performing NHS hospitals able to form NHS Foundation Groups to raise standards across a chain of hospitals
Being a vanguard

| Entering into an agreement, not winning the lottery e.g. ‘can I not just have the money?’ & filling in value proposition forms ad nauseum |
| Get to break the rules to some extent e.g. on information governance ‘the thing you have to ask yourself is (i) who would take you to court, and (ii) would they win?’ |
| But still less risk than we need e.g. how will we regulate your governance & financial risk as you start putting income through special purpose vehicles in a PAC? |

| Need to codify what makes you good |
| Need to share the learning at every detail e.g. working with primary care |
| Takes capacity and capability out of the day job |
And new care models are like marriages

- They look wonderful from the outside
- You get some advantages
- But they take a lot of work
- They cost a lot of money up front
- And they don’t magically solve a dysfunctional relationship
What will we cover?

- Money
- Workforce
- Regulation
- Five Year Forward View
- 5 things that make me optimistic
The glass is half full

- Increasing risk appetite
- Recognition that we are all in this together
- Commissioning & primary care
- Starting to think at the right scale and timeframe
- Systems leadership
Increasing risk appetite

- Bring out your dead on reporting, financial issues
- Challenging back to regulators on comply or explain
- New care models e.g. on information governance ‘the thing you have to ask yourself is (i) who would take you to court, and (ii) would they win?’
- National Physician Associate Expansion Programme managed by Hillingdon for 40 trusts
Starting to think at the right scale and timeframe

- Time frame
  - 10 year prime provider cancer contracts that have first 2 years spent on developing data
  - Longer term planning frameworks

- Unit of planning
  - LHE narratives, CQC quality in a place inspection in North Lincs, Tameside, Salford, success regime, devolution
  - Healthy new towns work integrating health, social care and wider society for population-based healthcare
Recognition that we are all in this together

Starting to think at the right scale and timeframe

Systems leadership

Increasing risk appetite

Commissioning & primary care

- Greater management of CCGs through beefed up indicators and assurance framework – potential removal of powers

- Voluntarily passing responsibilities to other bodies e.g. county-wide Collaborative Clinical Congress of CCGs, County Councils and NHS England; Northumbria SPV ACO

- Greater realism on planning assumptions

- From the Wild West to primary care federations (potential brain drain from CCGs)

- Direct employment of primary care, or operation of practices e.g. Northumbria Primary Care, Southern Health, Royal Chesterfield (1/2 Essex GPs retire in 15 years)
Recognition that we are all in this together

- Trying to model out zero sum game risk transfers (slowly)
- Everyone is moving onto the same platform (and it is burning) e.g. NHS England and the BCF ringfence
- Top-down relationships evolving
  - Ethos of Lord Carter work
  - No blame culture of IPSIS
Systems leadership

- HFMA Finance directors survey, roughly a third of Area Team, CCG, and Trust finance directors think their organisation is in charge. 10% think no one is in charge.

- It’s like working in a knotted ball of string…you have to be comfortable with chaos (Jan Vaughan, SCN)

- Building a locus of strategic planning e.g. Black Country Alliance, Wiltshire HWB, Cambridge & Peterborough Integration Board

- Core competency of new NHSLA training programme. Systems leadership is not ‘being in control of a system.’
There is always a risk that financial pressures will drive rational organisational behaviours that are irrational for the system.

But the cake is only so big, and the crisis is not purely local. So if we don’t collaborate in partnership, in the end, although we might triumph in the short term, we can’t in the long term.

*Professor Sir David Fish*  
*MD UCL Partners*
Q&A

THANK YOU

- Saffron Cordery
- Director of Policy and Strategy | NHS Providers
- One Birdcage Walk | London | SW1H 9JJ
- DDI: 020 7304 6808
- Saffron.cordery@nhsproviders.org
Update on 5YFV taskforces

**Mental health**
- Focusing on access, prevention, choice, attitudes, funding, integration of services
- Final report due October 2015

**Cancer**
- Published 5 year strategy for England (2015-20),
- Focus on early diagnosis, improved treatment & networks

**Maternity**
- Expanded role for independent midwives; networking; learning culture
- Expected to report by the end of the year.
What I will cover

- NHS Improvement
- Five year forward view
- Holding Boards to account: how?
- Questions
NHS Improvement

Five year forward view

Holding Boards to account: how?

Questions
Ed is Chair of Monitor and the NHS TDA

He is also Chair-Designate of NHS Improvement until its formation in April 2016, when he will become Chair
Jim became joint chief executive of Monitor and NHS TDA on 2 November

He is also Chief Executive-Designate of NHS Improvement until its formation in April 2016, when he will become Chief Executive
What will make up NHS Improvement?

- Monitor
- NHS TDA
- Patient Safety (from NHSE)
- Advancing Change (from NHS Improving Quality)
- Intensive Support Teams (from NHS IMAS)

Programme team with Integration Director: John Wilderspin

April 2016
NHS Improvement will seek to support providers to improve the quality and efficiency of services:

- Enable as many providers as possible to achieve “Good” or “Outstanding” CQC ratings;
- support improvements to patient safety by NHS providers; and
- increase scope for the identification and promulgation of good/best practice.

- Support the development of more effective and better supported Boards and leaders;
- support improvements in provider productivity; and
- support providers to deliver sustainable performance standards, maintain financial control and demonstrate high standards of governance, while engaging effectively with staff and stakeholders.
NHS Improvement will seek to support providers to improve the quality and efficiency of services:

- Through high levels of collaboration with system partners, oversee:
  - the payment system;
  - the rules governing how procurement, choice and competition operate; and
  - take a health economy wide approach to ensuring sustainable health care services.

- Support the changes to the structure and form of providers which will enable quality and productivity improvement, embracing and enabling the 5YFV new models of care.
Until then…

• NHS Improvement will not exist until April 2016

• Until then, all organisations will continue to work closely together

• Monitor’s immediate priorities are:
  o Annual plans need to be more robust and realistic
  o Better controls on agency spend (initially nursing)
  o Safe staffing policy
NHS Improvement

Five year forward view

Holding Boards to account: how?

Questions
What does the future look like? FYFV

The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries.

Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected ‘episodes’ of care.

As a result there is now quite wide consensus on the direction we will be taking.
How does this happen? FYFV

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example, a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.
Monitor’s role

1. Make sure Foundation Trusts are well-led
   - Provider Appraisal

2. Make sure essential services are maintained
   - Provider Regulation

3. Make sure NHS payment system promotes quality and efficiency
   - Pricing

4. Make sure choice and competition operate in the best interests of patients
   - Co-operation and Competition

Legal duty to enable integrated care

Providing thought leadership and innovation on the broader challenges facing the health sector
The national picture: The financial challenge

Number of NHS providers reporting a deficit

NHS provider sector net surplus/deficit

- Foundation trusts
- NHS trusts
- Total

Monitor
Making the health sector work for patients
NHS providers operational performance over time - A&E
NHS providers operational performance over time - RTT

![RTT Incomplete - monthly performance chart](image)
NHS providers operational performance over time - Cancer

Cancer 62-day - monthly performance
(April 2012 - June 2015)
Increase in regulatory action and interventions

% of foundation trust sector subject to formal enforcement action

% of NHS trusts with oversight and escalation score of 1 to 3

Oversight and escalation scores:
1 – Special measures
2-3 – Intervention
4-5 – Standard Oversight
The Challenge

• The NHS needs to change and fast

Simultaneously:

• Continue to achieve significant improvements in quality of care

• Year-on-year productivity improvements

• Restructure itself to achieve long term sustainability
...so we are changing how we interact with FTs

**What Monitor has already done**

- Monitored performance more closely and stepped-in earlier
- Adopted a broader range of interventions, including:
  - appointing Turnaround Directors
  - using external support to diagnose problems and implement plans
  - Improvement Directors
  - ‘Buddy Trusts’
- Increased recruitment with NHS operational (62) & clinical (15) experience

**What Monitor is now doing**

- Maintaining principle of earned autonomy
- Scrutinising FT performance and plans more intensively
- Providing better support to the leaders of trusts
- Further upgrading our own capabilities through recruitment
- Acting where local controls are failing (consults, agency)
What do these changes mean to you

- You will hopefully notice some shifts in emphasis…
  - Genuine support for improvement (National and local)
  - People working alongside you
  - Supporting local systems in agreeing longer term solutions and delivering them
  - Balance between support and regulation – proportionate regulation and accountability
  - Working hand in glove with other national bodies, especially NHS England
  - Leadership support and development
The developing role of governors

Role of Board of Governors

The over-riding role of the council of governors is to hold the non-executive directors individually and collectively to account for the performance of the board of directors and to represent the interests of NHS foundation trust members and of the public.

This is expressly in the 2012 Act
The developing role of governors

Non-Executive Directors

- Must be member of the public/patients constituency (or if there is a medical/dental school, work for that medical/dental school)
- NEDs appoint/remove the chief executive
- Determine the terms and conditions of the executive directors
- Must form an audit committee
- The Chair is a NED and has a dual role: chairing the council of governors and the board of directors

So the role of Governors has a direct impact on the leadership of a trust.
The developing role of governors

Governors may require one or more of the directors to attend a governors’ meeting

- Approval of significant transactions
- Approval of mergers, acquisitions, separations and dissolutions
- Approval of non-NHS work (5% increase in yr)
- Approval of constitutional amendments
- Approval of a referral to the Governors’ Panel

Any of these may be triggered under consideration of the five year forward view.

So how to deliver the role?
The key role of public engagement

“Public engagement is the process of getting communities involved in decisions that affect them. Understanding the needs of a community can help providers to meet those needs, and ensure patients and service users get maximum benefit from their services.”

Responsibility to represent interests of the members and public to the trust; and also to communicate information from the trust

And this is a statutory responsibility of governors
Why is public engagement important?

"The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population."

"The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services."

NHS Constitution

- It is one of governors’ statutory duties
- It is increasingly being emphasised
  - NHS Constitution
  - Francis, Keogh, Berwick
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Governors give their time to undertake survey work to gain views on the way the trust operates.

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- High levels of engagement with excellent attendance at meetings and volunteering for sub committees.
- The breadth and wealth of experience and the knowledge base (both professional and personal) is unequalled in genuine perspective and advice to Boards.....

The Governors Focus Groups (Constitution, Quality and Strategy), enable detailed discussion and input throughout the year.
Governors will need to act as advocates for New Models of Care, using local intelligence to help share a vision of integration.

How have Trusts engaged with diverse audiences; such as young people and ethnically diverse communities?

Acting as a critical friend is important, but with an understanding that there is no magic bullet to address some of the financial issues.

Holding NEDS to account is key: any knowledge sharing would be helpful.

Are there any experienced Governors who would be willing to engage with our Governor body to help develop their approach and council?

We asked a selection of Chairs what they would like from today.
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And what if I need more support?

nhs.panel@nhs.net
NHS Improvement

Five year forward view: your role

Holding Boards to account: how?

Questions
Monitor
Making the health sector work for patients

SW Governors

Kate Holden
Deputy Regional Director

19 November 2015
What I will cover

- NHS Improvement
- Five year forward view
- Holding Boards to account: how?
- Questions
NHS Improvement

Five year forward view

Holding Boards to account: how?

Questions
• Ed is Chair of Monitor and the NHS TDA

• He is also Chair-Designate of NHS Improvement until its formation in April 2016, when he will become Chair
• Jim became joint chief executive of Monitor and NHS TDA on 2 November

• He is also Chief Executive-Designate of NHS Improvement until its formation in April 2016, when he will become Chief Executive
What will make up NHS Improvement?

- **Patient Safety** (from NHSE)
- **NHS TDA**
- **Advancing Change** (from NHS Improving Quality)
- **Intensive Support Teams (from NHS IMAS)**

April 2016

Programme team with Integration Director: John Wilderspin
NHS Improvement will seek to support providers to improve the quality and efficiency of services:

- Enable as many providers as possible to achieve “Good” or “Outstanding” CQC ratings;
- support improvements to patient safety by NHS providers; and
- increase scope for the identification and promulgation of good/best practice.

- Support the development of more effective and better supported Boards and leaders;
- support improvements in provider productivity; and
- support providers to deliver sustainable performance standards, maintain financial control and demonstrate high standards of governance, while engaging effectively with staff and stakeholders.
NHS Improvement will seek to support providers to improve the quality and efficiency of services:

- Through high levels of collaboration with system partners, oversee:
  - the payment system;
  - the rules governing how procurement, choice and competition operate; and
  - take a health economy wide approach to ensuring sustainable health care services.

- Support the changes to the structure and form of providers which will enable quality and productivity improvement, embracing and enabling the 5YFV new models of care.
Until then…

- NHS Improvement will not exist until April 2016
- Until then, all organisations will continue to work closely together
- Monitor’s immediate priorities are:
  - Annual plans need to be more robust and realistic
  - Better controls on agency spend (initially nursing)
  - Safe staffing policy
NHS Improvement

Five year forward view

Holding Boards to account: how?

Questions
What does the future look like? FYFV

The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries.

Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected ‘episodes’ of care.

As a result there is now quite wide consensus on the direction we will be taking.
How does this happen? FYFV

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.
Monitor’s role

1. Make sure Foundation Trusts are well-led
   - Provider Appraisal

2. Make sure essential services are maintained
   - Provider Regulation

3. Make sure NHS payment system promotes quality and efficiency
   - Pricing

4. Make sure choice and competition operate in the best interests of patients
   - Co-operation and Competition

Legal duty to enable integrated care

Providing thought leadership and innovation on the broader challenges facing the health sector
The national picture: The financial challenge

Number of NHS providers reporting a deficit

NHS provider sector net surplus/deficit

- Foundation trusts
- NHS trusts
- Total

Monitor
Making the health sector work for patients
NHS providers operational performance over time- A&E
NHS providers operational performance over time - RTT
NHS providers operational performance over time - Cancer

Cancer 62-day - monthly performance
(April 2012 - June 2015)
Increase in regulatory action and interventions

% of foundation trust sector subject to formal enforcement action

% of NHS trusts with oversight and escalation score of 1 to 3

Oversight and escalation scores:
1 – Special measures
2-3 – Intervention
4-5 – Standard Oversight
The Challenge

• The NHS needs to change and fast

Simultaneously:

• Continue to achieve significant improvements in quality of care

• Year-on-year productivity improvements

• Restructure itself to achieve long term sustainability
...so we are changing how we interact with FTs

**What Monitor has already done**

- Monitored performance more closely and stepped-in earlier
- Adopted a broader range of interventions, including:
  - appointing Turnaround Directors
  - using external support to diagnose problems and implement plans
  - Improvement Directors
  - ‘Buddy Trusts’
- Increased recruitment with NHS operational (62) & clinical (15) experience

**What Monitor is now doing**

- Maintaining principle of earned autonomy
- Scrutinising FT performance and plans more intensively
- Providing better support to the leaders of trusts
- Further upgrading our own capabilities through recruitment
- Acting where local controls are failing (consults, agency)
What do these changes mean to you

• You will hopefully notice some shifts in emphasis…
  – Genuine support for improvement (National and local)
  – People working alongside you
  – Supporting local systems in agreeing longer term solutions and delivering them
  – Balance between support and regulation – proportionate regulation and accountability
  – Working hand in glove with other national bodies, especially NHS England
  – Leadership support and development
The developing role of governors

Role of Board of Governors

The over-riding role of the council of governors is to hold the non-executive directors individually and collectively to account for the performance of the board of directors and to represent the interests of NHS foundation trust members and of the public.

This is expressly in the 2012 Act
The developing role of governors

Non-Executive Directors

- Must be member of the public/patients constituency (or if there is a medical/dental school, work for that medical/dental school)
- NEDs appoint/remove the chief executive
- Determine the terms and conditions of the executive directors
- Must form an audit committee
- The Chair is a NED and has a dual role: chairing the council of governors and the board of directors

So the role of Governors has a direct impact on the leadership of a trust.
The developing role of governors

Governors may require one or more of the directors to attend a governors’ meeting

- Approval of significant transactions
- Approval of mergers, acquisitions, separations and dissolutions
- Approval of non-NHS work (5% increase in yr)
- Approval of constitutional amendments
- Approval of a referral to the Governors’ Panel

Any of these may be triggered under consideration of the five year forward view

So how to deliver the role?
NHS Improvement

Five year forward view: your role

Holding Boards to account: how?

Questions
The key role of public engagement

“Public engagement is the process of getting communities involved in decisions that affect them. Understanding the needs of a community can help providers to meet those needs, and ensure patients and service users get maximum benefit from their services.”

And this is a statutory responsibility of governors

Responsibility to represent interests of the members and public to the trust; and also to communicate information from the trust
Why is public engagement important?

"The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population."

"The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services."

NHS Constitution

- It is one of governors’ statutory duties
- It is increasingly being emphasised
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