5 June 2015

on the day BRIEFING

NHS SUCCESS REGIME, MONITOR'S RISK ASSESSMENT FRAMEWORK CONSULTATION AND SIMON STEVENS AND SECRETARY OF STATE SPEECHES

Following on from announcements made earlier in the week on agency spending and Very Senior Managers' pay, this briefing covers subsequent announcements also made this week:

- Establishment of a new NHS success regime
- Monitor's consultation on the Risk Assessment Framework
- Changes to the referral to treatment (RTT) waiting time targets
- Publication of *Five year forward view: Time to deliver*
- Speeches from Simon Stevens and Rt Hon Jeremy Hunt MP speeches

OVERVIEW

As highlighted above, this week has seen a whole host of national announcements coming out of both the Department of Health and the arms length bodies (Monitor, Trust Development Authority and NHS England). All focus on seeking to reverse the rapid decline in financial and performance problems. National recognition of the issues is welcome and important: for example focusing on the causes of very high spending on agency staff and understanding that we often need to look across the whole of a local health and social care system are both fundamental steps forward.

What we now have is a mosaic of measures and proposals that need to be pieced together so that we can assess their overall impact and understand what implementation will mean for NHS healthcare providers. There are a number of questions that NHS Providers will need to explore on your behalf including:

- How will proposals impact lines of accountability of individual providers to regulators and other statutory players in the system; and what will they mean for institutional autonomy?
- How workable are the proposals in terms of likely bureaucratic burden on regulators and providers?
- What is the statutory basis for the measures, and will the initial changes to a number of our existing frameworks lead to wholesale changes that would ultimately change the shape of the current system?
- What is the knock on effect on regimes, frameworks and organisations outside of the direct purview of this week's announcements?

Contact: Amber Davenport, Policy Advisor, amber.davenport@nhsproviders.org

NHS SUCCESS REGIME

On 3 June Monitor, TDA and NHS England published *The Success Regime: a whole systems intervention*, a guidance document for the new success regime for challenged local health economies. This regime is intended to create the conditions needed in these health economies to overcome the challenges they face, through aligned intervention and support. The regime signifies a shift from focussing solely on institutions to taking a system-wide approach to dealing with challenges.

Below is a short overview of the background to the regime and its key features, along with our view and next steps.

Background

The *Five year forward view* included a number of commitments from NHS England, Monitor, TDA, Care Quality Commission, Health Education England and Public Health England to provide aligned national NHS leadership in order to support the development of new care models and deliver the changes needed to continue to meet the expectations of patients and the public. This included a commitment from Monitor, TDA and NHS England to work together to create greater alignment between their respective assessment and intervention regimes for foundation trusts, NHS trusts and CCGs and the development of a whole-system, geographically based intervention regime.

Key features of the regime

The regime will be overseen jointly by NHS England, Monitor and the TDA, working closely with CQC. It will involve providers, commissioners and local authorities across whole health and care economies, addressing systemic issues rather than focussing solely on individual institutions. The expectation is that any intervention or transformation plans will contribute to the improvement and sustainability of the whole health system.

What is the regime seeking to achieve?

The regime aims to provide increased direction and support in three main areas:

1. Short term improvement against agreed quality, performance or financial metrics;
2. Medium and longer term transformation, including the application of new care models where applicable;
3. Developing leadership capacity and capability across the health system.

What will be involved in the regime?

The regime will work to a consistent nationally-defined approach which can be tailored to each set of local circumstances.

- Oversight for the regime will be led locally, by the regional directors from the three national bodies. A Programme Director will also be appointed to oversee action by the local health and care economy and manage the implementation of the regime locally on behalf of the three regional directors.
- The first stage of the regime is to undertake a single holistic diagnosis of the specific challenges facing the health and care economy. This will lead to the development of a set of interventions and support for the local health and care economy to deliver a transformation plan.
- Part of the process will be to consider whether it would appropriate for the area to adopt one of the new care models set out in the *Five year forward view,* in order to enable improvement.

How will this regime align with existing regulatory processes?

The guidance document sets out how this regime is distinct from existing initiatives such as special measures and the trust special administration process. The guidance states that existing intervention and change processes will

Contact: Amber Davenport, Policy Advisor, amber.davenport@nhsproviders.org

continue to be in place and will be aligned with the success regime as appropriate. However, during the regime the national bodies may also consider changing the relationship between oversight bodies and their respective organisations as well as considering an alternative approach to the way they oversee individual organisations. Examples provided include: increasing levels of escalation and setting a multi-year financial control total for a locality.

What areas will enter the success regime?

It has been announced that three health and care economies will initially enter the regime:

- North Cumbria
- Essex
- Northern, Eastern and Western Devon

Further localities may enter the regime in the future; however no specific 'entry criteria' has been confirmed. The guidance states that the three areas to enter to initially enter the regime were selected based on both quantitative (quality and financial performance) and qualitative information.

How will areas exit the success regime?

During the first stage of the regime, 'the diagnosis', clear exit criteria for that local health and care economy will be developed and agreed locally.

NHS Providers view

We support the overall intention of the regime, particularly the focus on the national bodies coming together and aligning their approaches to support whole local health economies, rather than solely focussing on institutions. We particularly welcome the recognition that the challenges faced in these areas rarely come from just one source and can often be systemic, deep-rooted and long-standing across geographical areas and therefore a holistic and supportive approach is necessary.

The guidance document sets out the proposed framework for the regime, including governance arrangements and expectations around what would be involved for each locality. However, it is clear that further detail is needed in some areas to ensure that the regime is implemented effectively. For example, we have reservations about what *"changing the relationship between oversight bodies and their respective local organisations"* will mean in practice and ensuring that the role of the Programme Director, appointed to *"oversee action by the local health and care economy"* does not undermine local autonomy and accountability. Autonomous provider boards are best placed to deliver meaningful development and are ultimately responsible for delivering change.

In addition, while the role of Monitor, the TDA and NHS England in this regime is clear, we feel that the importance of CQC and local commissioners in particular in the regime is currently understated. For the NHS leadership to develop a truly aligned approach and avoid any conflicts of interest, it is essential that CQC takes the local context into account and develops its regulatory approach in line with this regime. The need to improve commissioning to address some of the challenges faced across local health economies must also be addressed in more detail as part of the regime.

Along with clear exit criteria, it is essential that the national bodies also establish some clear entry criteria. Overall, we remain conscious of the need to reduce the existing burden of regulation and will work with our members and the

Contact: Amber Davenport, Policy Advisor, amber.davenport@nhsproviders.org

national bodies to ensure that this new regime enables providers to drive improvement as opposed to adding another bureaucratic process.

Next steps

We will continue to engage with Monitor, TDA and NHS England as they develop more detail for the regime, to influence on our members behalf and raise concerns as and when necessary. In addition, the three national bodies have committed to working with us, the NHS Confederation and NHS Clinical Commissioners to deliver a design workshop ahead of full implementation of the regime to ensure that the sector helps shape its implementation.

If you have any comments or concerns about the new success regime or any other work in this area please contact Amber Davenport, policy advisor (amber.davenport@nhsproviders.org 020 7304 6913).

To read our press statement on the new success regime please follow this link.

MONITOR'S RISK ASSESSMENT FRAMEWORK CONSULTATION

Yesterday Monitor published a consultation on proposed changes to its Risk Assessment Framework (RAF). Monitor is proposing these changes to strengthen its regulatory regime to deal with the current financial challenges facing the foundation trust sector, a move prompted by the DH announcements earlier this week on value for money and the urgent need to move towards financial balance.

The proposed changes will make it easier for Monitor to take regulatory action, such as launch an investigation, earlier if a foundation trust is in deficit, failing to deliver its financial plan and/or not providing value for money. Monitor is proposing to enable this by:

- Re-introducing two previously used measures: on tracking foundation trust deficits and another on the accuracy of planning
- Combining a trust's rating on these new measures with its existing continuity of services ratings (COSRR) to produce a new four-level financial sustainability and performance risk rating, with appropriate regulatory responses to each rating level
- Making two further changes to ensure trusts make sure they deliver value for money by adding a measure within a trust's governance rating and making a change to the accounting officer memorandum.

NHS Providers view

We responded to Monitor's annual consultation on changes to it's RAF in February 2015. In this response we reiterated our position for the regulators to adopt a more proportionate risk-based regulatory approach balanced with appropriate support for providers in significant financial difficulty.

We have concerns that the changes outlined in Monitor's current consultation will result in an increase in the number of interventions and/or investigations at providers which are historically well-led and are currently facing financial difficulties due to systemic issues that are usually beyond their control. These changes combined with the

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announcements on capping agency spends and controls on very senior manager pay risks placing more pressure on providers and signals a move to a more interventionist approach of the national bodies.

Next steps

We will be engaging with Monitor directly on the above issues and raising our member's concerns, as well submitting a formal consultation response (the consultation deadline is 1 July 2015). To inform our response we will shortly be circulating an email to members inviting feedback on the potential impact of the changes. However, if you and/or your board have any initial comments or concerns that you would like to discuss please contact Amber Davenport, regulatory policy advisor, (amber.davenport@nhsproviders.org, 020 7304 6913).

REFERRAL TO TREATMENT WAITING TARGETS

Yesterday all NHS providers and CCGs received a letter from Simon Stevens about changes to the referral to treatment (RTT) waiting time targets and the expansion of an ambulance service pilot. These changes follow a review undertaken by Sir Bruce Keogh, to ensure that all waiting time measures make sense for patients and are operationally well-designed.

18 week referral to treatment waiting time targets

Sir Bruce found that the 18 week RTT standard was being measured in three conflicting ways – through admitted, non-admitted and incomplete standards, and that using these three measures results in perverse incentives. The admitted and non-admitted standards essentially penalise providers for treating patients who have waited more than 18 weeks, whereas the incomplete standard, introduced in 2012, incentivises hospitals to treat patients who have been waiting the longest.

Simon Stevens has accepted Sir Bruce's proposal to abolish the admitted and non-admitted measures as soon as practically possible, using only the incomplete standard as a measure.

Expansion of South West ambulance pilot

Sir Bruce also proposed, and Simon Stevens has accepted the proposal, to extend the ambulance pilot currently being conducted in the South West, which is dealing with challenges around incorrectly triaging emergency calls. In an effort to meet the NHS Constitution standard of responding to urgent (Red 1 and Red 2) calls within eight minutes, many non-urgent calls are being incorrectly categorised as Red 2, resulting in ambulances being unavailable to answer more urgent, life-threatening calls. The pilot involves the ambulance service taking an additional 120 seconds to assess each call's urgency prior to assigning it a category and responding.

Sir Bruce Keogh will work with the ambulance service to set out the details of the proposed changes and geographies in summer 2015 and will make recommendations on national standards, based on these pilots, in autumn 2016.

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NHS Providers view

We welcome Sir Bruce Keogh's proposals to abolish the admitted and non-admitted measures of the 18 week RTT waiting time target. While this change will take some time to implement in full, it will enable providers to manage their waiting times more effectively, remove perverse incentives and improve patient experience.

FIVE YEAR FORWARD VIEW: TIME TO DELIVER

The arms length bodies (NHS England, Monitor, TDA, Public Health England, CQC and Health Education England) with private input from NHS Providers, have published an overview of the progress made with the *Five year forward view* to date, and the steps that need to be taken if the ambition of FYFV is to be delivered. We believe it is a helpful document which is well worth a read. You may find it find it useful to distribute more widely in your organisation to provide strategic context.

The report can be accessed here.

SIMON STEVENS SPEECH, 3 JUNE 2015

Simon Stevens' speech was framed around progressing the *Five year forward view* through: (1) a financially sustainable basis this year; (2) a redesign of urgent and emergency care provision; (3) focus on prevention; and (4) new ways of working locally and nationally. Here are the key points from the speech.

Funding: He warned that the health service should not expect a further increase in funding in the current financial year on top of the extra £2 billion already announced by the Treasury. There is a need to get the next annual commissioning round on the level of funded activity and capacity planning right – that didn't happen this year.

Agency staffing: This is single largest cause of provider deficits; it is understandable but unsustainable. The NHS needs to make use of its collective purchasing power to create more flexible permanent jobs. Temporary staffing is first of many areas where muscular action will be taken to reduce costs.

Service developments: There is a need to ensure new standards – such as emergency care, cancer, and mental health targets – are delivered. There is also need to be realistic about the new asks made of the NHS. Sir Bruce Keogh has been asked to review how 'referral to treatment' (RTT) targets are working. Jane Cummings is to look at new nursing guidelines for urgent and emergency care and vanguards.

Success regime: This will involve coordinated support for parts of the country that have had long-standing service and financial problems, and where individual hospitals have in some cases for many years struggled to tackle them on their own. First three areas are Cumbria, Essex and North, East and West (NEW) Devon. If traditional approaches were going to work, they would have done so by now. The success regime will bring full range of freedoms to bear, not just for individual organisations – potential for multiyear financial control – to ensure care models evolve.

Efficiency: Action needs to be taken at three levels: nationally, organisationally and collectively. Individual NHS organisations have too often worked alone, and there is too little use of collective financial muscle. There is too much clinical variation. There is underinvestment in general practice. Collaborative working with frontline leaders,

Contact: Amber Davenport, Policy Advisor, amber.davenport@nhsproviders.org

patient groups, ALBs and the Government will feed into the spending review and converge with the next financial planning round, so that by the autumn we will have the building blocks for efficiency between 2016 and 2020. This isn't just about money, but about the kind of health and care system we want; it needs to be sustainable and backed by efficiency.

Urgent care: Stevens called for more convenient urgent care services, in a bid to make the health service more responsive to the changing needs of an aging population, and better able to cope with rising demands. Substantial redesign is required. This includes seeking urgent care "vanguards", testing new approaches that aim to overhaul and join up GP out of hours services, the NHS 111 helpline, and improve the links between ambulance services, care homes and A&E departments.

Prevention: Now is the time to step up efforts to improve prevention, make services more efficient and change the way care is delivered, so that more care is done outside of hospital. We are failing the younger generation on obesity.

Transformation: The big challenge for NHS leaders is to focus on practical change that enables them to both manage the pressures of today and get ready for tomorrow at the same time. Transformation is a means to sustainability; they are not two separate tasks. The NHS needs to take collective action now to address immediate pressures without putting the future on hold.

Q&A: Stevens responded to need to boost GP numbers, highlighting the rate of increase in hospital consultants being three times greater than that of GPs, and affirming that this is something we need to get right with an "all of the above" approach. He also stated that a "huge" announcement was due from NHS England on the role of pharmacists.

To read our press statement on Simon Stevens' speech please follow this link.

RT HON JEREMY HUNT MP SPEECH, 4 JUNE 2015

Rt Hon Jeremy Hunt MP gave his speech at the NHS Confederation Conference on 4 June 2015. Below is an overview of the key points.

Improvements in quality of care: Over the last parliament, significant increases in number of cancer tests and operations carried out, fastest A&E turnaround in the world, greater safety and control over MRSA, with remarkable performance under winter pressures. We will build on Norman Lamb's legacy to ensure mental health is centre stage.

Values based leadership: NHS depends on this; government can help but NHS leaders are crucial. Now is the time for action. Need to think about culture from the start.

Challenges faced: The system is under massive pressure from national deficit, ageing population and rising expectations. But the NHS has a plan – the Five year forward view – and government backing for it. Government is putting £2bn towards NHS now, and at least £8bn a year by 2020. Time for discussion about whether that is the right amount has passed. Now need to focus on making the £22bn efficiencies that the NHS has also committed to.

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Costs and safety: The mantra of Virginia Mason in Seattle is that the path to lower costs is the same as the path to safer care, and they have found their costs are 20-60% lower than similar hospitals. This has also been found in the NHS and in other industries, such as the airline industry. After Mid Staffs, the rest of the NHS did not argue that was an isolated case – it accepted there were wider areas of poor care, and this has transformed the approach to safety and quality in the NHS.

Government support for local leaders: efficiencies will take a lot of effort, and they can't be delivered by the government. However, government can provide help, and sought to support cost control in recent announcements on agency staff, and very senior managers and management consultant costs.

Procurement: Hunt confirmed that Lord Carter will publish his report shortly. The NHS is not good at buying products – there is significant price variation (currently 35 per cent, not efficient 2 per cent) and an inefficient number of product lines (currently 500,000 not efficient 7-9,000), with nurses also spending significant time on admin rather than patient care. Lord Carter in September will provide a figure for the savings that could be made, and by December that figure will have been agreed with the NHS. From January 2016 those savings will need to be delivered.

Sharing best practice: The NHS is not good at spreading its good practice through the system. Hospital chains can help this, and in September first four NHS chains will be announced by NHS England and Monitor.

Performance data: Sir Bruce Keogh has set out the inconsistencies in performance data publication, with some released weekly, monthly or quarterly. These will now be produced monthly, on the same day.

Out of hospital: Hunt confirmed that the government will publish its childhood obesity strategy this year.

Commissioning: The government will look to bring transparency and accountability to CCGs in the same way as for providers. The King's Fund is developing the metrics for holding CCGs to account for the delivery of healthcare – because, while others are involved, CCGs hold the chequebook. Metrics will be outcomes and patient focused and five key groups have been provisionally identified: older people, those with long term conditions, those with mental health conditions, mothers and children, and the generally health. Alongside those, resilience and transformation will also be monitored.

Driving change: There is a need to move beyond targets, and look to transparency, peer review and learning as the way to improve. That will be transformational. Nye Bevan talked about "universalising the best"; the NHS has universalised access, but has been less good at universalising quality.

Q&A: Responding to a question from the floor, Hunt reiterated the need to work at pace towards full integration of health and social care.

To read our press statement on Rt Hon Jeremy Hunt MP's speech please follow this link.

For further information on any of these issues please contact Amber Davenport (amber.davenport@nhsproviders.org).