

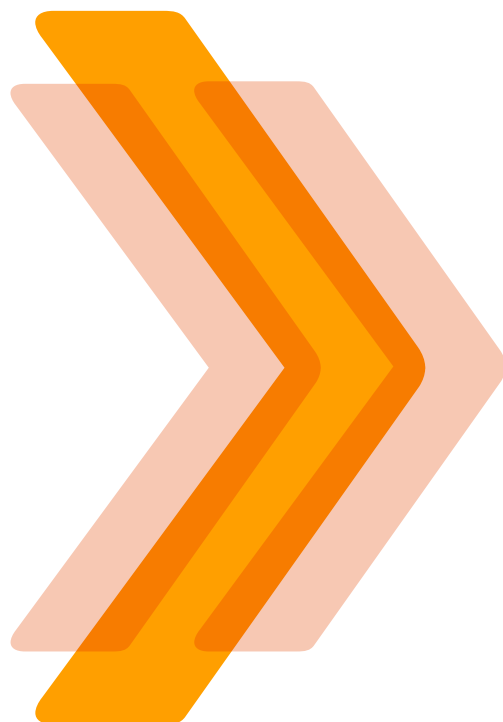
Implementing the NHS five year forward view: aligning policies with the plan

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Introduction

The *NHS five year forward view* (Forward View), published by NHS England and other national NHS bodies (2014), sets out a shared view on how services need to change and what models of care will be required in the future. Its key arguments are that much more attention should be given to prevention and public health; patients should have far greater control of their own care; and barriers in how care is provided should be broken down. This means putting in place new models of care in which care is much more integrated than at present.

The Forward View differs from many other plans for the NHS in arguing that England is too diverse for ‘one size fits all’ solutions. Instead of setting out a blueprint for the future, it outlines a number of care models that may be adapted in different areas to put in place services fit for the needs of local populations. The emphasis is on ‘diverse solutions and local leadership, in place of further structural distraction’ supported by ‘meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied’ (p 4).

Many of the ideas in the Forward View draw on work by The King’s Fund and others (see, for example, [Ham et al/2012](#)). Part of its purpose is to highlight the level of funding needed to implement new care models and what the NHS itself needs to do to fill the funding gap. This includes making substantial improvements in productivity, seen by some observers as unlikely to be achieved.

While the direction set by the Forward View has been broadly welcomed, it risks suffering the same fate as previous policy documents unless serious attention is given to the policy changes needed to support local leaders to make new care models a reality. The purpose of this paper is to outline some of the changes necessary to avoid reform being both slow and, in many cases, falling well short of the kind of future described by NHS England and its national partners.

It focuses on the following areas in which The King's Fund has particular expertise, particularly how:

- services are commissioned and paid for
- the NHS is regulated
- improvements in care are delivered by local leaders
- a transformation fund could contribute.

In writing the paper, our aim has been not only to describe why changes are required but also to make practical proposals on what should now be done to remove barriers to the development of new care models and how implementation of these models can be supported. Changes are also needed in other areas, such as workforce and information technology, but these are outside the scope of this paper. Implementing the changes we outline entails the fundamental redesign of policies on commissioning, regulation and payment systems, as well as the support provided to NHS organisations.

One of the challenges in acting on the ideas outlined here is the fragmentation of responsibility for the NHS at a national level. It is therefore all the more important that the guiding coalition – to borrow John Kotter's phrase – brought together by NHS England remains in place and works hand in hand with ministers and Department of Health officials in working through these ideas. The NHS desperately needs high-quality and consistent system leadership at the centre to avoid conflicting signals being given by different national bodies, and more positively to give confidence that there is a clear and shared direction for the NHS.

System leadership is equally important at a local level, where organisational changes following from the Health and Social Care Act 2012 have left a vacuum that commissioners and providers are seeking to fill through partnership arrangements of various forms. At a time of growing pressures within the NHS, the absence of a designated system leader places the onus on commissioners and providers to agree how this vacuum should be filled. Much then hinges on the quality of relationships between organisations and their leaders and their willingness to seek common cause to deal with the challenges facing the health and care system, as we discuss further below.

How services are commissioned and paid for

Innovations in commissioning and contracting

Our research has identified innovations in commissioning in a number of areas of England designed to support new care models, with a particular focus on the use of prime contracts and alliance contracts (Addicott 2014). These approaches are intended to facilitate new forms of integrated provision for specific groups such as older people or people with defined medical needs such as cancer and musculoskeletal conditions.

Innovations in commissioning are still in development and it is too early to draw firm conclusions. What is clear is that the process of developing prime contracts, alliance contracts and related approaches needs considerable investment of time and resources as well as work to develop effective relationships between commissioners and providers. Commissioners often need expert advice from lawyers and others in taking forward these innovations, and the preparatory work also consumes substantial funds.

In stylised terms, there are choices between a focus on specific diseases, care groups and whole populations. Although there is as yet no experience in England of seeking to commission care for whole populations, Alzira in Spain is a well-known European example and there are also examples in the United States. There are choices too as to whether to include social care within the scope of services to be commissioned.

Further choices are to be made about the type and content of contract that will best support the delivery of these services. This includes the outcomes to be used to hold providers to account under the terms of the contract and the incentives in place. Outcomes and incentives are often linked, as when commissioners make some of the funding conditional on providers delivering agreed standards.

Developing outcomes that matter to those people using the services is also likely to involve engagement with patients and the public.

Innovations in commissioning create opportunities for risk-sharing between commissioners and providers. This is particularly important in a cash-limited and increasingly cash-strapped NHS where gains in one part of the system may create problems in another part. Multilateral risk-sharing arrangements between commissioners and providers are needed to manage the consequences and this is a complex undertaking not least because commissioners often lack experience of developing such arrangements.

Prime and alliance contracts often transfer risk from commissioners to providers for a range of services. This means that the providers need to have developed the relationships that enable them to work together to provide care to the required standard. Often this will involve providers working as part of a supply chain in which resources are allocated in relation to their differing contributions. Lead providers in the supply chain in effect become commissioners, raising questions as to whether the current separation between providers and commissioners is sustainable.

Even when contracts are let, there can be difficulties in securing commitment from key stakeholders, as in the musculoskeletal contract in Bedfordshire (Welikala 2014). Structuring incentives within the supply chain presents as much of a challenge as in the contract negotiated between commissioners and providers. Providers will therefore need to agree how to resolve any conflicts that arise. This will require explicit legal agreements that bind providers together and specify their different roles.

Work on the technical aspects of commissioning and contracting needs to go hand in hand with the relational aspects. Our work shows that prime contracts and alliance contracts will only work in a context in which commissioners and providers work collaboratively and openly, based on a shared understanding of what they are seeking to achieve. Among other things, this means investing in the development of system leaders. This is discussed in more detail later in the paper.

To make these points is to illustrate the complexity of innovations in commissioning and contracting and also the challenges they present. Commissioners will need practical support and opportunities to learn from each other through a community of practice as they take forward this work. They also need to be able to access

information quickly and easily from other areas that are further advanced in implementing new forms of commissioning and contracting.

Recommendation

National bodies should support NHS commissioners to implement new forms of commissioning and contracting. This should include establishing a community of practice to share learning and expertise, and offering expert legal and other advice.

Multispecialty community providers

One of the models of care described in the Forward View is the multispecialty community provider (MCP). This involves the development of federations, networks and super partnerships to enable general practices to operate on the scale required to deliver a wider range of services. These services would include those provided by some specialists alongside other professionals such as nurses, therapists, pharmacists, social workers and psychologists.

In previous work, we have argued for the use of a population-based capitated contract linked to the delivery of agreed outcomes as the best way of commissioning MCPs ([Addicott and Ham 2014](#)). The budgets they take on would be determined by a combination of population size and need and the range of responsibilities included in it, including funding for general practice. The scope of budgets could be expanded as emerging MCPs demonstrate their ability to work in this way.

MCPs would use their budgets to take ‘make or buy’ decisions. This would mean delivering services directly where possible or commissioning services from other providers. There would be a blurring of the distinction between commissioners and providers to enable GPs, in partnership with other clinicians, to deliver more integrated services in the community.

In assuming greater responsibility for commissioning and providing care, MCPs would need to demonstrate that they have the capabilities to manage the contract and deliver the expected outcomes. These capabilities include skills in contract negotiation and management, financial management, utilisation management, and the management of clinical quality. Also important is well-developed clinical leadership and access to real-time information about how the budget is used.

As multispecialty providers, MCPs would include in their membership specialists currently based in hospitals where there is scope for more care to be provided in the community. Examples include geriatricians, paediatricians and ‘office-based’ specialists such as diabetologists, dermatologists, rheumatologists and respiratory physicians (see [Robertson et al 2014](#)). Multispecialty medical practice holds out the prospect of savings in the cost of hospital care because of the opportunity it creates to provide proactive care in the community and rapid responses to crises.

Integrated commissioning would be needed to implement the new contract for MCPs. This means bringing together funds currently controlled by clinical commissioning groups (CCGs) and NHS England (for primary care provision), as well as some of the funds controlled by local authorities if social care is to be delivered by MCPs. Plans by NHS England to develop co-commissioning by CCGs already indicate the direction of travel, and it will be important to ensure CCGs have sufficient resources to take on these additional responsibilities.

Potential conflicts of interest also need to be managed, for example by practices involved in bidding to provide services under the terms of the new contract being excluded from the process of commissioning these services. It would also be important to develop transparent governance and accountability to avoid any suggestion that GPs are gaining inappropriately through their involvement in MCPs.

There needs to be sufficient time to implement and evaluate how an MCP contract might work, based on early testing with federations, networks and super partnerships willing and able to work in this way. As with the innovations in commissioning and contracting described above, emerging MCPs would also need expert support. This might include learning from other systems like New Zealand and the United States where models of this kind already exist.

Recommendation

NHS commissioners should work with interested and capable general practices operating at sufficient scale to establish MCPs that take control of a capitated budget to deliver integrated out-of-hospital services. National bodies should provide access to learning from relevant experience of other health care systems.

Primary and acute care systems

Another care model outlined in the Forward View is primary and acute care systems (PACS), described as ‘single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services’. It is suggested that these might be formed in a number of ways including hospitals opening their own GP surgeries with registered lists and MCPs taking over the running of hospitals.

Our research into the role of acute hospitals in emerging integrated care systems in England illustrates the complexities of bringing primary and secondary care together (Naylor *et al*, forthcoming). Perhaps most important are longstanding cultural differences between GPs and their teams on the one hand and hospital clinicians on the other, as well as differences in the way that these services are commissioned, contracted and organised. Bringing mental health and other community services into PACS adds to the challenge of aligning the contributions of different professions behind a common purpose.

As small businesses responsible for running their own affairs, general practices enjoy a large measure of autonomy and flexibility in how they organise their work. Practices typically have flat structures with limited formality and, at their best, an ability to adapt quickly in response to changing circumstances. Hospitals, by contrast, are much larger bureaucratic organisations with more complex reporting lines. Further difficulties are likely to emerge as a result of existing contracting arrangements in primary care, as well as different employment arrangements between general practitioners and hospital staff.

Having made these points, some acute hospitals already run community health services following the changes that resulted from the policy on transforming community services; others have begun to work more closely with GPs either through employing GPs or creating joint ventures. In some cases, collaboration between hospitals and GPs has been helped by the parallel development of networks and federations in general practice.

The time needed to establish these arrangements and to realise the benefits should not be underestimated. The prominence of acute hospitals in the NHS means that GPs and staff running community services are sometimes fearful that they will be

the poor relations within integrated care models. Persuading GPs to take part will require discussions with one practice at a time to understand and address these and other concerns.

One option would be for PACS to be established as virtual organisations rather than as single merged organisations. This might involve acute trusts working closely with networks of general practices through joint ventures or other contracting arrangements. As with MCPs, there are major questions about how virtual PACS of this kind would be commissioned and funded, and the nature of relationships between providers within the networks.

PACS are similar in some respects to health maintenance organisations and accountable care organisations in the United States. Experience in the United States shows the potential benefits of a single organisation (real or virtual) taking responsibility for the health of a defined population with a capitated budget. These benefits include the ability to focus on the health of the population and not just the treatment of sickness, and to use the capitated budget flexibly to meet that population's need.

In the current context in England, PACS that encompass community services, GPs and social care also have the potential to speed the flow of patients into and out of hospitals to remove some of the blockages that are behind pressures in the urgent and emergency care system. To realise these benefits, PACS will need to heed the warning signs from the United States by understanding the factors that caused some integrated delivery networks to fail in the 1990s. These factors included inadequate attention to change management processes. This prevented emerging networks from emulating the achievements of long established integrated systems like Kaiser Permanente (Burns and Pauly 2012).

Both MCPs and PACS will have to run the gauntlet of rules on procurement and tendering, discussed further below. PACS in particular could fall foul of the competition regulators if they emerge as monopoly integrated providers of NHS care in their area. One way of handling this would be to tender the management of PACS for a period of 10 years or more in a form of competition for the market, analogous in some ways to the example of Alzira mentioned earlier.

As large integrated providers, PACS would pose fundamental challenges to commissioning as currently organised. In previous work ([Ham et al 2013](#)) we have argued that strategic commissioning would be needed to counteract the power of fully integrated providers whether real or virtual and to ensure they are held accountable for the delivery of defined outcomes. This includes avoiding an acute hospital mindset dominating primary and community care providers working within PACS. Innovations in care models may therefore require commissioning to be organised differently if they are to deliver on their promise.

Recommendation

Different options for PACS should be explored, recognising the cultural differences between GPs and hospital clinicians and concerns that community services and GPs could become the poor relations. These options should include PACS being established as virtual organisations as well as single organisations.

Incentives to support new models of care

Care delivered within the NHS is currently paid for through a mix of payment systems including Payment by Results for much routine acute hospital activity, block contracts for community and mental health services, and funding for specialised services provided by NHS England through a separate tariff. Many GPs are paid through a contract that combines capitation payments, pay for performance, some item of service payments, and reimbursement of costs such as for premises and staffing. Other GPs are employed on a salaried basis, while dentists and opticians work under their own contracts.

The variety and complexity of current payment systems reinforces the fragmented nature of NHS provision. These systems also contain conflicting incentives. Payment by Results was originally designed to reward hospitals for higher levels of activity, while pay for performance was intended to reward GPs for improving the quality of care provided to patients, through the quality and outcomes framework (QOF). Successive additions and refinements to payment systems such as the cut in prices paid to hospitals for emergency admissions over the 2008 benchmark and changes to the size and composition of the QOF have sought to alter the incentives for providers.

In previous work, we have argued that payment systems need to be flexible and adjusted in the light of their impact, changing policy objectives, and changes in the context in which they operate ([Appleby et al 2012](#)). Nowhere is this more important than in relation to Payment by Results, which was introduced at a time when the NHS budget was increasing rapidly and when a core objective was to reduce waiting lists and waiting times for hospital care by treating more patients. With NHS funding now tightly constrained, and the focus having shifted to how care can be better integrated around the needs of people with long-term conditions, much more emphasis needs to be given to payment systems that support this objective.

This has been recognised for some time and lies behind the interest in developing bundled payments and year-of-care tariffs for some forms of care. Talk about these kinds of innovations in payment systems has far exceeded change on the ground despite repeated exhortations from various sources on the need to align payment systems with changing policy objectives. The need to move from exhortation to action is now urgent.

In our view, there needs to be active testing of capitated budgets under which MCPs and PACS take on responsibility for services delivered to defined populations. These budgets would pool resources currently allocated through separate funding streams including social care. As discussed earlier, multilateral risk-sharing arrangements would be put in place so that budgets could be managed effectively.

Pooled budgets also have a part to play in supporting health and social care integration, extending the joint commissioning arrangements established in a number of areas and promoted by the Better Care Fund. One of the risks to be managed here is that transfers of NHS funds into pooled budgets may result in deeper cuts in social care funding than would otherwise have occurred as local authorities seek to cope with further reductions in grant support from central government. Putting in place shared governance through health and wellbeing boards or other forms of partnership working may help mitigate these risks.

Urgent and emergency care networks would similarly be funded through a budget under which providers would decide how best to deliver this care in the right place at the right time. A budget taken on by an alliance of providers linked to the delivery of defined outcomes (and therefore different from old-style block contracts) has much more potential to deliver timely and co-ordinated care of the right quality

than the current tariff-based system. The providers in the alliance would determine how the budget would be shared between them and the balance to be struck between paying for activity and rewarding quality of care. In so doing, they would need to take account of the balance between fixed and variable costs in different providers and other relevant considerations.

New incentives could also play a part in empowering patients and service users to be key agents in making a reality of new models of care. Building on the experience of direct payments in social care and personal health budgets, integrated personal commissioning will enable people to make their own choices about the care they need and where to get it. Integrated personal commissioning is a practical example of an innovation that could be seen as a ‘disruptive innovation’ in moving towards the ambitions set out in the Forward View.

The pressures facing acute hospitals as a result of successive changes to Payment by Results, including reduced payments for emergency admissions above the level recorded in 2008, and more recently the decision to extend a similar principle to the funding of specialised services, underline the importance of putting in place new ways of paying for care. This has been recognised in the plans published by NHS England and Monitor to reform payment systems ([Monitor and NHS England 2014a](#), [2014b](#)). Both bodies should ensure this work is given priority by strengthening their own capabilities in this area.

Recommendation

NHS England and Monitor should accelerate the development of new payment systems such as capitated budgets, pooled budgets and integrated personal commissioning. They should strengthen their own capabilities for doing this work.

How the NHS is regulated

Assessing the quality of local systems of care

Many of the models of care outlined in the Forward View require care to be much more integrated than it is now. One of the challenges in migrating towards these new models is to ensure that the behaviour of the regulators facilitates their development. Nowhere is this more important than in relation to the Care Quality Commission (CQC) and its role in inspecting the quality of health and social care.

The CQC currently discharges its responsibilities through chief inspectors of hospitals, general practice and social care and the teams that support them. While there is a logic to this way of organising inspections, particularly in the context of well-publicised failures in performance in hospitals and care homes, it reinforces current organisational and service silos. The CQC may therefore unintentionally inhibit the emergence of integrated models of care by requiring organisations to focus on their own performance almost regardless of the impact on other providers in their area.

A particular weakness of the CQC's current approach is that it pays relatively little attention to the experience of people whose complex needs lead them to seek help from different providers. These people are often older and frailer patients and service users with a number of needs that require treatment both in hospitals and other settings. Each contact with a health or social care professional may be of a high standard but the experience of patients may suffer through lack of effective co-ordination or poor communication.

For these reasons, the CQC needs to move quickly to fulfil its commitment to assess how well care is integrated, building on recent work on the care of people with dementia ([Care Quality Commission 2014](#)). This requires the development of a methodology for inspecting the performance of local systems of care with a particular focus on the experience of patients and service users who seek help from different providers of care. Other measures such as emergency admissions and

readmissions are also important but need to be viewed in the context of service users' experience as they are uniquely well placed to assess how well care is co-ordinated.

A good starting point would be to survey patients and service users in order to understand their experience and whether or not their care was well co-ordinated, for example in relation to timely admission to and discharge from hospital, sharing of information between health and social care professionals, readmissions, and outcomes of care. These issues are particularly important to the growing numbers of older people using health and social care services. To avoid the risk of over-inspection and intrusive regulation, a balance would need to be struck between the CQC's current approach and a focus on local systems of care.

Recommendation

The CQC should move quickly to assess how well care is integrated in local systems of care for groups such as older people. It should survey patients and service users to understand their experiences of whether care was well co-ordinated.

A whole-system intervention regime

The number of organisations in financial difficulties has risen sharply over the past year. Much of this increase has been driven by the exceptionally challenging environment that has combined rising demand for NHS services and little real-terms growth in spending. However, within this group are also several organisations whose difficulties run much deeper and who, even in relatively good times, struggled to maintain financial balance and/or deliver high-quality services.

There is good evidence that many cases of persistent underperformance arise from weaknesses in leadership ([Murray et al 2014](#)). The NHS can intervene, and often has, to change the leadership of struggling organisations. Indeed, it has sometimes done so too often and too quickly, leaving too little time for new leaders to turn the organisation round. It also now has a sophisticated early warning system operated by Monitor and the NHS Trust Development Authority (NHS TDA) (on finance) and the CQC (on quality), to identify organisations that appear at risk and to intervene early.

All of these tools and powers, and others such as the trust special administrator (TSA) regime, are primarily directed at the organisation in distress. This is all well and good where the solution lies within the power of this single, challenged organisation. However, in an increasing number of cases difficulties in one organisation arise from more fundamental misalignment across a whole health economy. This may include weaknesses in social care and local government services, which may face even greater challenges than NHS services.

Already, NHS England, NHS TDA and Monitor have come together to provide additional support to 11 challenged health economies as part of the 2014 planning process and these bodies have summarised the learning from this work (**Monitor et al 2014**). Also, the existing contingency planning team approach used before any decision to invoke the TSA does look across a health economy. More recently, Simon Stevens (2014) has set out plans for a ‘success regime’ rather than a ‘failure regime’ that will help challenged areas rather than individual challenged organisations. The effectiveness of these forms of support, including the use of management consultants, needs to be evaluated.

Any new regime will need to help areas develop a recovery plan that both diagnoses the underlying problem and then goes on to propose a solution. With the models of care set out by the Forward View there will soon be a menu of potential options to help local areas design this new configuration of services, although it is important that any plan must still have real local ownership and local leadership in order to succeed. This plan then needs a new approach to whole health economy governance to ensure that each stakeholder delivers on its commitments, including partners in local government and the third sector.

One of the lessons from experience to date is that recovery plans in challenged health economies call for both reconfiguration of services and integration of care (Hazell 2014). This means that alongside existing performance metrics for each organisation, there is a need for new, whole health economy metrics that capture the progress towards more integrated services and new models of care. To ensure consistency these will need to become a coherent part of the regulatory system managed by all the national bodies acting in concert. Regulators must avoid intervening in individual organisations in ways that conflict with health economy solutions, particularly given the bewildering complexity of regulation noted in the Berwick report (**National Advisory Group on the Safety of Patients in England 2013**).

Recommendation

NHS England, Monitor and the NHS TDA should extend the use of interventions in whole health economies. They should avoid intervening in individual organisations in ways that conflict with this.

Procurement and tendering

One of the legacies of the Health and Social Care Act 2012 is a statutory framework building on other legislation designed to ensure that anti-competitive practices are tackled and new care providers are able to enter the market. This includes rules on procurement and tendering under which commissioners in certain circumstances are required to test the market when they let contracts. How these rules operate in the context of the Forward View needs to be reviewed to ensure they do not inhibit the development of new care models like MCPs and PACS.

As the sector regulator, Monitor has sought to clarify when commissioners need to use tendering; its detailed guidance runs to more than 70 pages ([Monitor 2013](#)). Monitor has also issued guidance on integrated care and competition, making clear that the two are not mutually exclusive ([Monitor 2015](#)). Notwithstanding these efforts, there remains uncertainty among both commissioners and providers on how competition rules operate in practice, and a concern that they create barriers to the development of new care models.

To date, for some organisations, ‘ask forgiveness, not permission’ has been cover enough to take forward local initiatives. Others have been willing to invest their own time and get legal advice for developments such as prime contractor arrangements or federations in primary care. However, for many in the NHS the potential risks around ‘asking forgiveness’ and the undoubted costs in time and money of due diligence around every novel initiative will be a disincentive to experimentation and implementation.

The Forward View looks to a set of early adopters to explore and develop the new models of care and provide learning for the rest of the NHS. National bodies should clarify as a matter of urgency how they expect early adopters to do this while not falling foul of rules on procurement and tendering. In some cases, national bodies

should consider giving commissioners and providers a waiver to depart from rules that are barriers (real or perceived) to the development of new care models. For this to happen, there needs to be greater clarity about the scope for waivers in relation to EU rules and how these are changing.

There is also a case for making central legal advice available to local areas as they develop and implement their plans. The alternative – extensive written technical guidance – may not be sufficient. This could extend to providing support around options for payment systems (as discussed above). These will also be areas where gaining local experience is difficult and where there is scope to learn from other parts of the country. Without this active support, the NHS risks making both slower progress and incurring more cost than necessary at a local level.

Recommendation

NHS England and Monitor should review current rules on procurement and tendering to remove any barriers to the development of new care models, and provide access to legal advice. Where appropriate they should provide a waiver to enable commissioners to depart from these rules.

How improvements in care are delivered by local leaders

Leadership and improvement expertise

In previous work we have argued that reform of the NHS should rely less on external pressures and stimuli like targets and inspection and more on support for leaders and staff to bring about improvement from within ([Ham 2014](#)). Two main forms of support are needed: first, in developing leaders at all levels of the NHS; second, in providing the 1.4 million staff who work in the NHS with the skills needed to improve care for patients.

The review of the work of the NHS Leadership Academy and NHS Improving Quality set up by NHS England provides an opportunity to consider how national expertise in these two areas can be effectively aligned behind the Forward View. The experience of the NHS Modernisation Agency between 2001 and 2005 demonstrates the risks of taking improvement expertise out of NHS organisations and placing it in a national body, which in effect becomes an agent of government rather than a source of advice and expertise for the NHS itself. Although the Modernisation Agency carried out some good work, it was soon superseded as greater emphasis was placed on improvement programmes being led from within the NHS both at the regional level and in NHS providers themselves.

Our analysis of high-performing health care organisations and systems in the NHS and elsewhere underlines the importance of this observation and shows that there is no substitute for every NHS organisation taking its own responsibility for the development of its leaders and for providing staff with skills in quality improvement. Larger organisations like Salford Royal NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust have developed their own capabilities to do this. Others have collaborated to get the expertise they need through agencies like Advancing Quality Alliance (AQuA) in the north-west of England.

Some of the most effective forms of national support are provided by organisations like the Emergency Care Intensive Support Team (ECIST). Its frontline practitioners visit challenged providers to offer advice on how improvements in urgent and emergency care can be achieved. The team is small and agile and appears to be effective in large part because of the expertise and credibility of the people who work in it and their experience in delivering the services they are asked to review. Any plans to strengthen national support on quality improvement should build on this example and resist the temptation to recreate a large national improvement body like the Modernisation Agency.

Support for areas of the country to fast-track the development of new care models could come from many different sources; there is now a much more extensive and diverse market offering support than was the case when the Modernisation Agency was set up. Funds currently locked up in agencies like NHS Improving Quality could be released to enable NHS organisations and systems to buy in the expertise they need instead of them having to select from a limited menu. One approach would be for local and regional sources of expertise within the NHS, including academic health science networks, to form a virtual improvement and support system to promote learning and sharing of scarce expertise.

Much the same applies to leadership development. Responsibility for talent management, succession planning and leadership development rests with every NHS organisation working either individually or in collaboration with other organisations. Vacancies in senior leadership positions across the NHS are an indication of the failure of recent approaches to leadership development at a national level, including the Top Leaders Programme which was intended to increase the supply of qualified people for these roles (Janjua 2014).

Most of the resources of the NHS Leadership Academy would be better deployed by NHS organisations themselves with national support focused only on those activities that cannot be better undertaken at a local or regional level, such as the graduate management training scheme. NHS organisations should be required to account publicly for their leadership development including the resources they commit to it. In many cases, they may choose to work with other NHS organisations to bring together the expertise needed to fulfil their responsibilities, for example through regional leadership academies.

National bodies should develop an explicit strategy for quality improvement and leadership development in collaboration with NHS leaders. This would draw on Lord Darzi's work for the previous government ([Department of Health 2008](#)) as well as proposals for a national quality programme for the NHS in England advanced by the Nuffield Trust ([Leatherman and Sutherland 2008](#)). Such a strategy could benefit from the experience in the NHS in Scotland where work on quality and patient safety is well established ([Healthcare Improvement Scotland 2015](#)). Plans to revitalise the role of the National Quality Board in England provide an opportunity to revisit these ideas and ensure they encompass leadership development as well as quality improvement.

These changes could contribute to the NHS becoming a learning organisation, as advocated in the Berwick report on patient safety ([National Advisory Group on the Safety of Patients in England 2013](#)). As the report noted, the current over-emphasis on regulation is unlikely to deliver the sustainable improvements in the quality of care and safety that are needed. What is required is to strengthen leadership and to change cultures to work towards the aim of the NHS becoming a zero-harm organisation. The resources used to support leadership development and quality improvement need to be aligned behind the Forward View.

Recommendation

National bodies should develop a strategy for quality improvement and leadership development for the NHS in England to enable it to become a learning organisation. This should be based on the presumption that the main responsibility lies with NHS organisations, with national support for improvement being provided through small teams of credible experts.

System leadership

Many of the new models of care outlined in the Forward View require different ways of working in which organisations collaborate to achieve closer integration of care. Collaboration may involve GPs working with specialists and other clinicians in MCPs, hospitals and primary care providers coming together in PACS, and a range of organisations and services establishing urgent and emergency care networks.

New kinds of leadership will be needed to make a reality of new models of care. Specifically, leaders of different organisations will need to work together to provide leadership across local systems of care, however these are defined. The challenge this presents is that most NHS leaders are first and foremost organisational leaders rather than system leaders, and they will have to learn new skills to operate effectively in the NHS of the future.

They also operate in a context in which regulators and other national bodies have demands and expectations that may work against collaboration and integration. This is especially the case when changes in the interests of the whole health economy impact adversely on the performance of individual organisations. As noted earlier, it is essential that regulators work in concert to avoid this happening through a single and coherent system of regulation and intervention.

The new skills required by leaders include how to exert influence in the absence of hierarchical controls and positional authority. Related to this, system leadership is often designed to enable collaboration between agencies to deliver integrated care, and may run counter to attempts to stimulate greater competition. Handling the tension between collaboration and competition is therefore critical.

Our research into emergent models of system leadership in the NHS has identified several lessons (Fillingham and Weir 2014). These include adapting and applying the principles of complexity science and understanding the importance of learning by doing. System leadership is more likely to develop where there is a shared focus on a particular community and when effort is put into the development of many system leaders at multiple levels of the system concerned.

Many areas are already seeking to fill the gap in system leadership by establishing partnership boards and leaders' groups that bring together commissioners and providers. The composition and role of these boards varies but their existence signifies the complexity of governance and accountability at a local level following the changes brought about by the Health and Social Care Act 2012. Health and wellbeing boards are used in some areas to promote partnership working, but the absence of key stakeholders such as NHS providers in some areas means that the right leaders are not always around the table.

Mechanisms are needed for handling conflict, and time is required to build the will, skills and relationships needed to make integrated care systems a success. Although the NHS has relatively little experience of system leadership, there are lessons from local government where these principles are often well understood, as well as from the third and the private sectors. The NHS therefore needs to be open to learning from other sectors, for example in leadership development programmes and work shadowing arrangements (Senge *et al* 2014).

These ideas are being discussed and implemented in a context in which most top leaders in the NHS employ a pace-setting style that reflects the dominant approach to leadership in the past decade or more. Pace-setting is unlikely to be conducive to effective system leadership and these leaders will need to use a wider repertoire of styles including coaching and facilitation. They may also find value in agreeing an explicit compact with fellow system leaders, setting out values and behaviours to be aspired to.

System leadership is one example of the collective leadership we have argued the NHS needs. Leadership of this kind must be both shared and distributed and based on a willingness to negotiate and accommodate rather than command and control. Developing system leadership ‘in place’ between the guiding coalitions that will deliver the new models of care in the Forward View should be the priority, ensuring that all relevant stakeholders are included.

Recommendation

National bodies and NHS organisations should prioritise the development of system leadership both for the NHS as a whole and in local health economies. This should include learning from other sectors and moving beyond the pace-setting styles that have been dominant in the recent past.

Provider leadership

The new care models outlined in the Forward View will present major challenges for providers as greater emphasis is given to integrated care and providers come together in alliances and networks to deliver this care. As discussed above, innovations in commissioning and contracting are likely to lead to the development

of supply chains, for example when prime contracts are used. NHS leaders and their peers in other sectors will need to develop new ways of working in these supply chains to be able to respond to the demands of commissioners and to work collaboratively.

Similar challenges exist in the development of MCPs and PACS. In many cases, MCPs will be built on the foundations of emergent federations and networks of general practices, where the tensions involved in preserving sufficient autonomy for practices within a collective endeavour are already being worked through. These challenges will increase as MCPs reach beyond practices to encompass other staff working in the community, and some hospital-based specialists. Leaders of MCPs (many of whom are likely to be GPs) will need exceptional skills in managing diverse professional groups to realise the potential of this new model of care.

The same applies to PACS where the longstanding separation between primary and secondary care needs to be bridged. Hospital leaders cannot assume that a style of leadership that has served them well in one context will work in a very different context. Many GPs will have concerns about the potential loss of autonomy and will need reassurance that they will benefit from working in a new, more integrated system of care. Developing GP leaders to work with hospital leaders, as well as bringing all GPs and other staff into the fold of PACS, will take time and diplomacy to avoid any sense that one organisation is taking over others.

Alongside the Forward View, the Dalton review has outlined a range of organisational models for providers (Dalton 2014), and these also call for new forms of provider leadership. Like the Forward View, the Dalton review is permissive not prescriptive but with a clear expectation that providers will wish to collaborate through chains, joint ventures, buddying, integrated care organisations and other means where this brings benefits. In some cases, providers will choose to merge, as has already happened in the case of acute hospital services in north London and in Berkshire and Surrey.

While the NHS may be able to learn from other sectors in implementing these new provider models (Crump and Edwards 2014), the challenges in making them work in practice should not be underestimated. As we have noted, leaders whose careers have been built on progression to ever more senior roles in individual organisations will need to adapt quickly to the quite different environment of working across

organisations, often with their own distinctive cultures and values. It cannot be assumed that skills that work well in one environment will transfer easily to another.

National bodies should offer support to provider leaders, acting on the recommendations of the Dalton review and ensuring that sufficient time and freedom from burdensome regulation is allowed for new care models to get established. Particularly where challenged organisations come together with organisations performing well, there is likely to be a dip in performance before the benefits are realised. Regulators have often been slow to recognise this and to tailor their interventions to different circumstances.

They have also resorted too quickly to ‘enforcement’ actions and special measures in intervening in challenged providers rather than offering practical support to leaders to find a solution. The effect has been to add to the pressures on organisations already in considerable difficulty, often resulting in leaders being replaced. In a context in which the NHS faces growing problems in recruiting to executive-level board roles, the loss of experienced leaders will only accentuate these problems.

Recommendation

New care models and the organisational models outlined in the Dalton review require new styles of provider leadership. These must be supported by national bodies to avoid the wrong kind of regulation and to avoid leaders being deterred from applying for executive-level board roles.

How might a transformation fund contribute?

To help facilitate change, The King's Fund has argued for a transformation fund to provide financial support through transition ([Appleby et al 2014](#)), and the scale and ambition of the new models of care set out in the Forward View reinforce this need. This case is increasingly accepted, with the Autumn Statement providing a first £200 million for transformation next year. However, funding and running a transformation fund is not straightforward.

To begin with, funding for transformation should not be confused with emergency support for troubled health economies. Rather, its principal purpose should be to pump-prime the development of new care models by covering their running costs ahead of existing models being decommissioned.

Any transformation fund also needs to be flexible enough to handle the complexity of change in the NHS. This includes recognising that in many health economies different organisations may gain and lose; some organisations of the future may not yet exist.

Many changes will also require co-ordinated action across multiple organisations and stakeholders, with success dependent on joint ownership of a delivery plan. This is likely to require a new whole health economy approach to the governance of delivering change as well as more resources. Developing such an approach means developing a cadre of system leaders able to work across organisational and professional boundaries, as discussed above.

Mental health achieved a fundamental redesign of services, switching from a system based on hospital care to one focused on community services (Gilbert *et al* 2014) in a process that benefited from funding to cover double running costs. Working with The Health Foundation, The King's Fund is investigating this and other examples to recommend how to establish and run a transformation fund. Some of the funding may come from within the NHS itself if existing unused assets can be unlocked and resources released back into transformation.

A transformation fund is likely to be particularly beneficial in areas of care where improvements in current ways of working offer most potential to relieve pressure on both the NHS and social care, and deliver better outcomes for service users and patients. A good example is care of older people, who account for a high proportion of need and demand and where there is evidence of inappropriate use of services, often because of the lack of alternatives. Analysis by The King's Fund has described what good integrated health and social care for older people looks like (Oliver *et al* 2014), and the systematic adoption of known best practice would go a long way towards fulfilling the ambitions of the Forward View.

This is likely to include investing in the provision of services in the community to provide realistic alternatives to hospitals for older people who can be supported appropriately in this way. A transformation fund should be used to enhance both health and social care services in view of the role of social care in admission avoidance and supported early discharge from hospital. It should also be used to fund innovations in care that support greater integration, including information and communication technologies, as has been seen in areas that have made use of telecare and telehealth to enhance care in people's homes and in nursing homes (as is already happening in Airedale – see Naylor *et al*, forthcoming).

Recommendation

NHS England should work with other national bodies to put in place a transformation fund to support NHS leaders and their partners to implement new care models. This should learn from experience in mental health and ensure that resources are used for transformation, not to keep existing services solvent.

Where next?

The ideas outlined in this paper describe some, but by no means all, of the changes needed to support implementation of the Forward View. We have focused deliberately on the implementation challenges of the Forward View because of the historic neglect of these challenges in the development of health policy, and the urgency associated with resolving them. In so doing, it is important to emphasise that policy changes and support from national bodies are necessary but not sufficient conditions in making a reality of new models of care. Even more important is leadership within the NHS, without which even the most supportive and aligned policy context will make little difference.

To make this point is to acknowledge that implementation of the Forward View should involve a process of discovery and not design. By this we mean that national bodies should keep faith in their expressed wish to support ‘diverse solutions and local leadership’ and should resist the temptation (or indeed pressure) to prescribe what should be done and how. The NHS has suffered over many years from the mistaken belief that change should be driven from the top down, with the unfortunate consequence in some places of learned helplessness in which leaders of NHS organisations wait to be told what to do rather than taking the initiative themselves.

To avoid this happening, the care models set out in the Forward View should be seen as a starting point for debate rather than the end of the story. For example, in some areas there may be interest in going beyond MCPs and PACS to establish integrated care for whole populations. This possibility is recognised in the Forward View in the context of the development of accountable care organisations in other countries; if implemented thoughtfully it has the potential to make a bigger impact than the other models that have been proposed. National bodies should actively support options of this kind as part of a concerted effort to put integrated care at the heart of the policy agenda, as The King’s Fund has argued for some time ([Ham and Curry 2010](#)).

Planning guidance issued in December 2014 defined three types of areas to take forward the Forward View: vanguard sites to fast-track the new care models with support; a new regime of intervention for challenged systems; and support for other areas to develop a shared vision and create the conditions ‘for rapid early adoption’ (NHS England 2014). For all areas the guidance indicated that national bodies would have developed a better understanding of how far critical conditions for transformation are present in each part of the NHS by April 2015.

As this happens, it will be critically important to evaluate experience in different areas in real time and invest time and resources in sharing the emerging learning. In the case of innovations in commissioning and contracting we have proposed that a community of practice should be established and a similar approach is likely to bring benefits in the other work streams discussed in this paper. If the NHS aspires to be a learning organisation, then now is the time to use both evaluation and sharing of experience to accelerate progress in the direction set by the Forward View.

The difficulties of acting on the ideas set out in this paper should not be underestimated. Each of the policy changes we have discussed presents its own challenges, and working on them all and at the same time is daunting to say the least. It is also the case that transformational changes of the kind set out in the Forward View are almost invariably emergent in nature, requiring adaptability and flexibility as they are implemented. National leadership of the highest order is therefore needed to align policies with the plan and to avoid the Forward View gathering dust on the shelf.

This is particularly the case in the context of an NHS in which operational pressures around finance and performance are increasing. The focus of leaders within the NHS on dealing with financial deficits, A&E pressures and performance against waiting time targets is understandable but is crowding out the time and space needed to attend to the opportunities offered by the Forward View. The risk is that these opportunities will be missed because, in the time-honoured phrase, the urgent takes precedence over the important.

National bodies have a responsibility to avoid this happening by making it clear that delivery of the Forward View is as important as operational performance and by supporting leaders in the NHS in the ways we have described in this paper. Leaders within the NHS also have a responsibility to release key staff, including clinicians, to work on the development of new care models and to provide them with the support and skills they need to convert plans into practice. Too often the NHS has failed to create the implementation and improvement capabilities required to take forward new strategies. This risk must be recognised and managed without resorting to expensive external support from management consultants and others.

The importance of focusing on the execution and implementation of the Forward View is underscored by experience in the United States of establishing integrated delivery networks in the 1990s, referred to earlier. As Burns and Pauly (2012) observe in their assessment, ‘Much of the evidence shows that strategic change needs to be carefully implemented. Unfortunately, implementation and execution are poorly understood processes. Providers may need to put greater effort into change management going forward’ (p 2414). National bodies in England should heed this insight by acting on our recommendations.

Recommendation

Implementation of the Forward View should involve a process of discovery and not design. There should be a commitment to real-time evaluation and learning throughout the process.

Summary of recommendations

- **National bodies should support NHS commissioners to implement new forms of commissioning and contracting. This should include establishing a community of practice to share learning and expertise, and offering expert legal and other advice.**
- **NHS commissioners should work with interested and capable general practices operating at sufficient scale to establish MCPs taking control of a capitated budget to deliver integrated out-of-hospital services. National bodies should provide access to learning from relevant experience of other health care systems.**
- **Different options for PACS should be explored, recognising the cultural differences between GPs and hospital clinicians and concerns that community services and GPs could become the poor relations. These options should include PACS being established as virtual organisations as well as single organisations.**
- **NHS England and Monitor should accelerate the development of new payment systems such as capitated budgets, pooled budgets and integrated personal commissioning. They should strengthen their own capabilities for doing this work.**
- **The CQC should move quickly to assess how well care is integrated in local systems of care for groups such as older people. It should survey patients and service users to understand their experiences of whether care was well co-ordinated.**

- **NHS England, Monitor and the NHS TDA should extend the use of interventions in whole health economies. They should avoid intervening in individual organisations in ways that conflict with this.**
- **NHS England and Monitor should review current rules on procurement and tendering to remove any barriers to the development of new care models, and provide access to legal advice. Where appropriate they should provide a waiver to enable commissioners to depart from these rules.**
- **National bodies should develop a strategy for quality improvement and leadership development for the NHS in England to enable it to become a learning organisation. This should be based on the presumption that the main responsibility lies with NHS organisations with national support for improvement being provided through small teams of credible experts.**
- **National bodies and NHS organisations should prioritise the development of system leadership both for the NHS as a whole and in local health economies. This should include learning from other sectors and moving beyond the pace-setting styles that have been dominant in the recent past.**
- **New care models and the organisational models outlined in the Dalton review require new styles of provider leadership. These must be supported by national bodies to avoid the wrong kind of regulation and to avoid leaders being deterred from applying for executive-level board roles.**
- **NHS England should work with other national bodies to put in place a transformation fund to support NHS leaders and their partners to implement new care models. This should learn from experience in mental health and ensure that resources are used for transformation, not to keep existing services solvent.**
- **Implementation of the Forward View should involve a process of discovery and not design. There should be a commitment to real-time evaluation and learning throughout the process.**

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