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How Monitor's strategy supports new models of care

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ABSTRACT

The Future Hospital Commission has identified growing consensus behind the need for fundamental changes to models of NHS care. Harnessing the energy and imagination of clinicians will be crucial to achieving these changes. Several ideas for new models of care are familiar to innovative clinicians: the hard part so far has been making change happen. Monitor has learned about the obstacles facing NHS innovators at first hand in its ten years of regulating NHS foundation trusts. This article sets out what Monitor is doing to remove those obstacles in its role as sector regulator for health services in England. Working closely with its national partners, Monitor is trying to help health sector innovators at the front line by: taking a local health system perspective on change; aligning rules and incentives so they pull all parties in local systems in the same direction; and being more 'joined up' with its partners at the centre. Important difficulties remain, especially the questions of how to fund a transformation in care models and persuading the wider public this is worthwhile for patients. But Monitor is committed to fostering the conditions for making worthwhile change happen in the NHS. Innovative clinicians can be optimistic about making the 'hospital of the future' a reality over the next ten years.

KEYWORDS: Monitor, new models of care, Call to Action, innovation, regulation, barriers to change, incentives, integrated care, NHS pricing, procurement, patient choice and competition regulations

Introduction

The Future Hospital Commission (FHC) report[1] makes a compelling case for changing the model of care traditionally provided by the acute general hospital. Meeting the needs of a growing and ageing population with a system designed largely to meet the health needs of the last century is becoming increasingly difficult. NHS staff work hard to bring good care to patients, but our health services struggle to provide consistently the 'safe, high-quality, sustainable care centred around their needs and delivered in an appropriate setting by respectful, compassionate, expert health professionals' that the FHC recognises all patients deserve.[1]

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That struggle to provide consistent quality is made harder by an unprecedented financial squeeze. The number of NHS foundation trusts in deficit almost doubled over the course of the last financial year to reach 39 by the end of the third quarter.[2] The Department of Health predicts a zero underspend on the NHS budget for 2013/14 for the first time since 2006/07. The next financial year looks even more difficult, and in 2015/16, all hospitals will experience further pressure on their incomes as a result of the Better Care Fund. This will earmark £3.8 billion for local health and social care services to spend together on better integrated care. But the budget is not new money and for most CCGs it will mean redeploying money currently spent on NHS services, especially in acute hospitals. Monitor's own research indicates that, if current trends continue unchecked, the NHS as a whole could face a £30 billion financial shortfall by 2021.[3]

Hospitals are already finding significant efficiency savings in response to the financial climate, but overcoming the financial challenge and at the same time achieving the consistent, sustainable high levels of patient safety and quality that all involved in the NHS want to see, requires fundamental changes to the models of care across the health service. Monitor's strategy over the next three years is therefore intended to help the whole sector redesign itself, working closely with our national partners, particularly NHS England, the NHS Trust Development Authority (NHS TDA), the Care Quality Commission (CQC) and the Department of Health.[4] Together we are aligning the rules and incentives that inform decisions taken by front-line clinicians, managers and commissioners. Our aim is to create a stable framework of incentives that supports these decision-makers in designing and implementing new patterns of care.

With NHS England and NHS TDA, we are sponsoring the sector-wide debate on what form these new models of care might take.[5] It is not the role of regulators or others at the centre of the system to specify the detailed models that each care economy needs. Ultimately, those are for commissioners, clinicians and NHS managers to determine. We do, however, want to support them by setting out broad patterns of care that should provide patients with consistently high quality care in an affordable way.

No one in the sector really believes that 'no change' is any longer an option, but readers should be forgiven if they feel somewhat sceptical about the chances of success. After all, none of the design principles for new models of care to come out of the central NHS organisations' *Call to Action*[6] last year (now incorporated into NHS England's planning guidance

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for commissioners[7]) are new. Many physicians have for years advocated, for example, better integration of care, increased use of communications technology and the concentration of appropriate services in dedicated centres of excellence. The hard part has been making such changes happen. The NHS has an impressive record of innovation, but each new idea has had to overcome a familiar series of hurdles and many never reach the finish line. So it is fair to ask, why should things be different now? Those at the front line are arguably weary of change and with no new money in sight, they must respond to the findings of the three recent inquiries concerning patient safety and quality[8–10] while still adapting to a major change in the organisation of commissioning.

However, it is our view that the energy and imagination of clinicians are among the most powerful forces for redesigning the NHS. Without them, no transformation is possible. This opportunity to set out what I believe makes change more likely to happen this time, and especially what Monitor is doing to support it alongside the other system leaders, is welcome. Big unknowns remain – particularly how to win the support of the public and politicians for change, and how to fund the necessary transition costs. However, investment in what will be a more efficient and effective healthcare system will be better for patients and enable the NHS's money to go further.

What makes change difficult in the NHS: the example of the struggling trust

Over Monitor's 10 years as the independent regulator of NHS foundation trusts and during its first year (since April 2013) as health sector regulator, it has had direct experience of the obstacles confronting NHS innovators – and acknowledges that the organisation itself has sometimes been seen as one. Finding a sustainable model for health services in areas where a foundation trust is struggling illustrates well many of the main barriers.

When trusts get into serious difficulties, either clinical or financial, a diagnosis of the causes shared by all the local parties is the starting point in identifying a solution. A shared vision for how services should be delivered in the future is the next step, but local parties rarely have the same understanding of the problems or the same vision for the future. While local patient groups and MPs worry about access for patients, and clinicians may focus on the quality of care, commissioners and trust boards are likely also to be concerned with getting value for money to ensure their budgets stretch as far as possible. That partial divergence of objectives may be mirrored among the central bodies involved in a local reconfiguration.

Even when all parties can agree on the direction of change, it can be hard to decide exactly what to do. Change proposals may sometimes be less radical than they could be because of uncertainty about how the sector's rules on choice and competition work in practice. An activity-based payment system, designed originally to encourage overall activity in hospitals, may get in the way of delivering care in the right setting.

Whatever plan is agreed eventually, winning the case for change among the local public is usually challenging, and if they are unconvinced, local politicians often support their resistance.

Strong leadership helps to overcome all these barriers and the NHS already has some outstanding change leaders. However, the day-to-day demands of leading NHS trusts are already hard enough. Long-term planning is particularly difficult given uncertainty over future policies and funding. Day-to-day clinical work is hugely demanding too. Not surprisingly, relatively few clinicians have so far led programmes to transform healthcare systems, although the report of the Future Hospital Commission suggests this may change. Lowering barriers to transformation should help more such leaders to emerge.

Supporting change in the NHS

Our strategy for 2014 to 2017 explains how, working with partners, we will use our powers to do what we can to dismantle these long-standing barriers to change and help decision-makers at the front line of the NHS reshape services. Clinicians trying to introduce new ideas should notice three differences in particular: Monitor will work with our partner organisations to take a local health economy approach to change; we will also work with them to align rules and incentives so they pull all parties in the same direction; and, more generally, we will work hard to be more joined up at the centre.

Taking a local health economy perspective on change

We have learned from trusts in trouble that their problems often arise from the structure of the local health economy, and not entirely from within. By the same token, new patterns of care that cross the boundaries between social, community, primary and secondary care will necessarily have to work from a local health economy perspective: providers will have to liaise with each other and with commissioners to design the right patterns and manage the resulting changes in local flows of patients and funding. So we aim to fulfil all our responsibilities by taking a health economy perspective, starting with the way we approach strategic planning.

Last December, for the first time, NHS England, Monitor and NHS TDA made sure that the planning guidance that each of us published was aligned. We are now triangulating the two-year operational plans that trusts and clinical commissioning groups (CCGs) submit in April 2014, to assure both sides in each local health economy that the types of services commissioners are planning to procure fit with what providers are planning to supply for the next two years.

We have also asked CCGs, NHS foundation trusts and NHS trusts to develop consistent long-term strategic plans covering the next five years. This is the pre-emptive approach we are taking in the Milton Keynes and Bedfordshire area, where there are signs of clinical and financial stress across primary and secondary care provision.

Evidence on how local health economies work and what makes them break down is scarce, and we are conducting research to fill the gaps. For instance, we have been looking at whether small acute trusts are under systematically greater clinical and financial pressures than larger hospitals, and if so why. Whatever conclusions the evidence supports we will apply pragmatically in patients' best interests. For example, should we find that remote small acute care providers will always struggle to break even while providing services at national prices, we may consider providing for a capacity payment to help cover the costs of their infrastructure and

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make sure they continue to provide essential services for their isolated communities.

There is little hard evidence to demonstrate which models of integrated care work well, but we know that some local health and social care organisations are beginning to identify some that do. To capture their experience of patient-centred integration, Monitor and its partners have signed these organisations up as 'integrated care pioneers' and will provide tailored support to them. In return, we ask them to inform us and the rest of the sector how they are achieving this across the whole of their local health, public health, social care and voluntary systems.

To evaluate any plans for new models of care that they propose, local commissioners and providers need high quality data concerning cost, activity and patient outcomes. In recent years, many healthcare organisations have started to retrieve data of this type from patient level information costing systems (PLICSs), which record the costs of individual patients' care, and from service line reporting (SLR; that is, reporting the income and costs of discrete medical service lines). We have been encouraging trusts to embed PLICS and SLR for several years and have seen the benefits that this can bring: better use of resources and a culture of continuous improvement. Moreover, our medical advisory groups have told us that where SLR is employed, clinicians become much more involved in managing resources, and younger clinicians gain valuable experience of management.

However, for better quality data to make a difference across a local health and care system, commissioners and providers need to be able to see information about all a patient's touchpoints in the system. That depends on bringing together the relevant data from different organisations. We are currently working with pilot sites developing a 'how to' guide for creating what are termed local person-level linked data sets. Our hope is that the majority of local health economies will create one of these within the next 12 months.

Aligning incentives

Success in setting up sustainable new models of care will depend on aligning incentives across the healthcare system. As a regulator, Monitor creates incentives by setting and enforcing rules, such as the conditions of the provider licence, or the Procurement, Patient Choice and Competition ('section 75') regulations governing co-operation and competition in the NHS, or the rules governing the payment system.

We are now adapting our approach to risk to make sure we consistently incentivise innovations that benefit patients, rather than punish organisations for breaching one or other set of rules. For example, we intend in future to work with trusts planning a merger much earlier in the process, not to delay the proposal nor add to the regulatory burden, but to help trusts make sure they have identified well-evidenced patient benefits to support their case should it go to the national competition regulators at a later stage. Similarly, when we assess applications for foundation trust status, we will be open to plans to adopt new models of care in the early years, as long as the patient benefits are clear and the plans are sound. We will also assess applicants' capacities to deal with change, since planning and implementing new forms of care will be a critical skill we seek to instill among foundation trusts in coming years. To strengthen innovation skills at foundation trusts, we will continue to sponsor training courses for board members and develop training tools in, for example, strategic planning.

Our work with NHS England on the NHS payment system perhaps provides most scope for making sure incentives work effectively. In the past, providers keen to develop a new model of care have been deterred because the new form of service had no defined currency, and would not be priced within the national tariff. The 2014/15 tariff therefore allows providers and commissioners to make 'local variations', that is, to vary from national prices should they need to create a new service to meet a previously unmet need. We are also reviewing what kind of local variations are best to support innovation. For example, allowing a prime contractor to be paid for integrated services provided by subcontractors, or pricing an expensive form of care or a totally new intervention in a way that fairly remunerates a provider in a start-up phase (even if prices come down as more people adopt them) should assist. Moreover, we do not specify the details of local variations, but insist only that they are arranged in the best interest of patients, that the arrangement is transparent and accountabilities are clear, and that providers and commissioners engage constructively with one another when undertaking such arrangements. Lastly, we insist that providers and commissioners tell us what new models of care they are developing so we can track the most successful and help to spread them.

Being joined up at the top

The Health and Social Care Act 2012 made substantial changes to the healthcare system, at the centre and clinical front line. New bodies were created and the remit of existing ones such as Monitor substantially altered. However, if we are all to be effective we have to fulfil our remits in a joined-up fashion so that local providers and commissioners can shape future patterns of care within a stable framework of aligned incentives. This is a more demanding way of working for all of us, but we have now developed collaborative agreements which will avoid burdening the sector with contradictory or duplicative requirements.

To illustrate, Monitor and the NHS TDA are liaising to eliminate duplication in our processes for making sure NHS trusts reach foundation trust status. Similarly, the CQC and NHS TDA are developing with Monitor a joint quality framework for trusts to follow.

Collaboration on research and development is also necessary. Following last year's 'Call to Action', Monitor jointly sponsored with NHS England a debate on new models of care.[11] On the development side, in conjunction with NHS TDA and the Faculty of Medical Leadership and Management, we asked medical directors what management training they felt they needed. They told us, for example, that new clinical members of trust boards often lack the kind of training we offer to new non-executives of trust boards, which we will aim to address.

Tensions in these partnerships can occur, because the partners have been given deliberately counterbalancing remits. For instance, we work side by side with NHS England on developing the payment system; in enforcing the Procurement, Patient Choice and Competition Regulations, we also regulate NHS England as a commissioner, to make sure it follows best practice

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when procuring NHS services centrally. As a group of partners we are learning how to resolve conflicts like this in a principled and effective way.

Looking ahead

Despite the growing consensus behind the case for change now articulated by the Future Hospital Commission, important hurdles remain. In particular, how the transitional costs of creating a consistently high quality, financially sustainable NHS will be met remains unclear. Equally, we have yet to persuade all NHS staff, patients, politicians and the media that changes in patterns of care are worthwhile.

Despite this, organisations at the centre of the NHS are committed to being better co-ordinated and more agile at aligning the rules and incentives that shape front-line decisions. Conditions for favourable change in the NHS now exist and, although sometimes overplayed and certainly unwelcome, the sense of looming crisis is a powerful spur to action. Clinicians today have both a better chance and more reason to make the 'hospital of the future' a reality over the next 10 years than at any time in their careers so far. ■

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