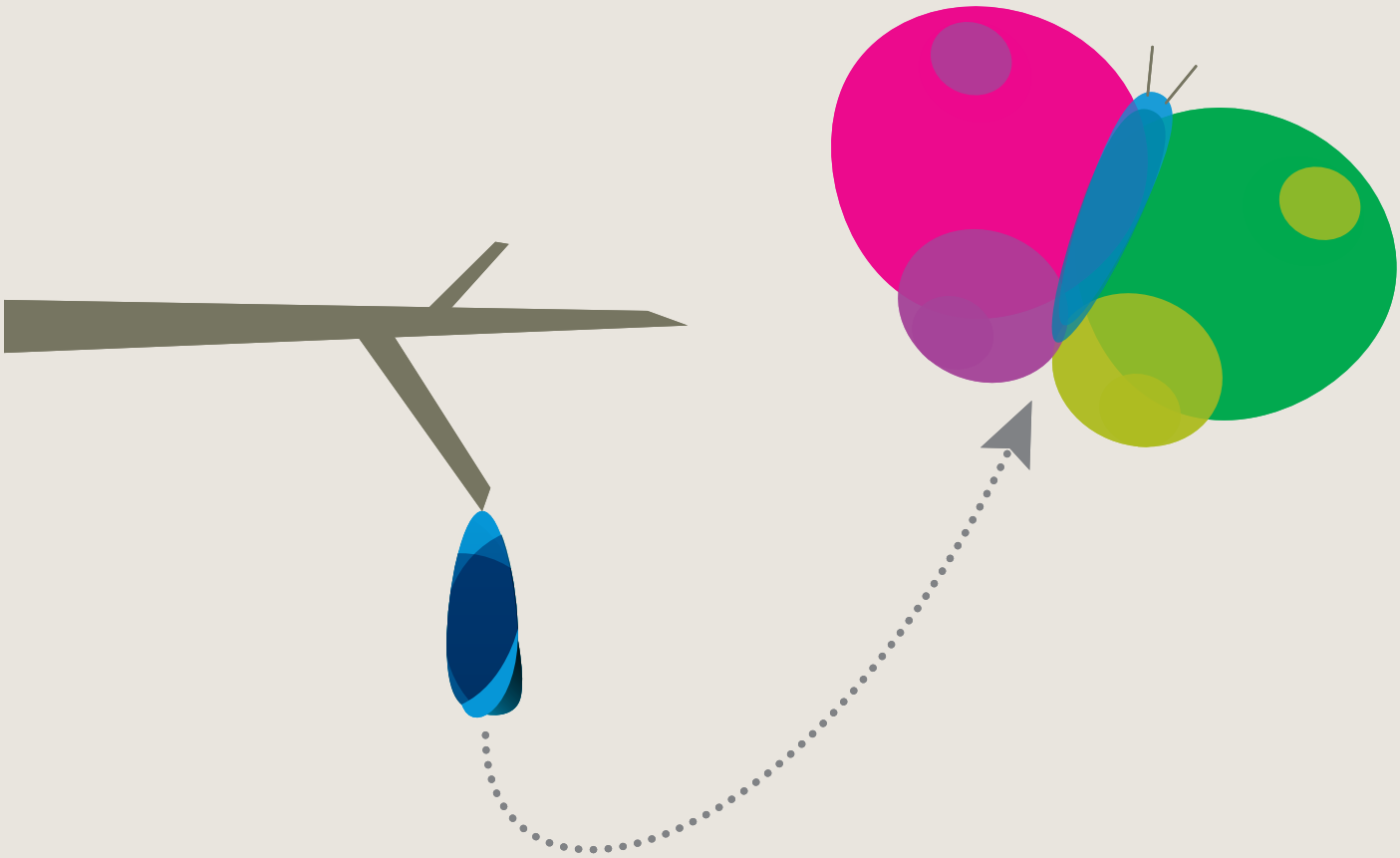
The King's Fund

The Health Foundation

Making change possible: a Transformation Fund for the NHS

The Health Foundation and The King's Fund



Research report

July 2015

This report reflects the work of the following team from across the Health Foundation and The King's Fund:

Anita Charlesworth – Chief Economist, Health Foundation
Richard Murray – Director of Policy, The King's Fund
Laura Bennett – Researcher, The King's Fund
Ben Collins – Project Director, The King's Fund
Natalie Daley – Economics Intern, Health Foundation
Edward Davies – Policy Fellow, Health Foundation
Phoebe Dunn – Research Assistant, The King's Fund
Ben Gershlick – Policy and Economics Analyst, Health Foundation
Helen Gilburt – Fellow, The King's Fund
Matthew Honeyman – Research Assistant, The King's Fund
Adam Roberts – Senior Economics Fellow, Health Foundation
Richard Taunt – Director of Policy, Health Foundation
Toby Watt – Economics Analyst, Health Foundation
Lillie Wenzel – Fellow, The King's Fund

Acknowledgements

We would like to thank all those who generously gave up their time to talk to us and contribute to this report.

Errors and omissions remain the responsibility of the authors alone.

About the Health Foundation

The Health Foundation wants the UK to have a health care system of the highest possible quality – safe, effective, patient-centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

Working at every level of the health care system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change that are all essential for real and lasting improvement.

About the King's Fund

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

Making change possible: a Transformation Fund for the NHS
is published by the Health Foundation, 90 Long Acre,
London WC2E 9RA

ISBN 978-1-906461-65-2

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A Transformation Fund for the NHS: summary and recommendations

There can be no doubt that the National Health Service (NHS) in England is facing a period of unprecedented challenge. Changing population needs and a prolonged funding squeeze have left it under intense financial and service pressures. 'Business as usual' is not sustainable. But that does not mean the NHS is fundamentally unsustainable. As highlighted in the recent *Five year forward view* (Forward view), there are opportunities to run services more efficiently and models of care that will secure high-quality, efficient and effective health care for the population. But these require the NHS to change, and change fundamentally. This has been recognised by national and local leaders, policy makers, commentators and those on the front line for a long time. There is a consensus on the broad models of care that will be needed for the future, but less so on how progress can be accelerated. As a result, change has been slow. Now more than ever we need a new, systematic and comprehensive approach to supporting and implementing change to health services – from simple improvements to more radical transformation.

A new approach requires a robust strategy involving different types of activity. This should include dedicated investment, the right policy context for change and effective practical support of front-line staff. This report largely concerns the first area – how a dedicated Transformation Fund might support change. Both the Health Foundation and The King's Fund have reported on the second and third areas.*

We recognise that providing additional financial support for the NHS is currently exceptionally challenging, especially given the hardships in other areas of the public sector. However, the alternative is to risk a decline in the quality and safety of NHS-funded care and a reduction in access to, or the breadth of, services that the NHS covers. Without resources specifically earmarked for transformation, there is a risk that the NHS will be unable to become more productive and that the bill for additional running costs will only get larger.

To ensure that the substantive changes required can be achieved, we argue that the NHS needs dedicated funding – a Transformation Fund – to deliver the change required, aligned with more effective practical support and the right policy context for change.

* See, for example, *Constructive comfort: accelerating change in the NHS*, www.health.org.uk/publication/constructive-comfort-accelerating-change-nhs; *Building the foundations for improvement*, www.health.org.uk/publication/building-foundations-improvement; *Reforming the NHS from within*, www.kingsfund.org.uk/time-to-think-differently/publications/reforming-nhs-within

About this work

The King's Fund and the Health Foundation both support the concept of a Transformation Fund for the NHS in England. The two organisations came together to undertake a programme of work detailing the key aspects of such a fund.

This report draws on analysis conducted by the two organisations, in particular six case studies of funding transformation, in the health sector and beyond, along with examples of local NHS initiatives. We also captured the experience of NHS leaders and some of those organisations across the NHS that have been at the forefront of efforts to implement changes in the delivery of care.

Our programme of work looked at:

- the need for an overarching Transformation Fund to organise the current arrangements for funding major change in the NHS and to ensure they are fit for purpose for the changes required to health care over the next five to ten years
- the amount of money that might be needed to support transformative change over the next few years, including the key elements of funding required and how these might be phased
- how any such funding might be allocated and administered across the NHS to make sure it achieves its objectives.

Design of the Transformation Fund

Through our work we identified a number of key considerations for the design of the Transformation Fund.

The NHS in England needs a single body (whether within an existing organisation or newly created) to oversee the investment for transformative change in the NHS. This body should work with national NHS strategic leaders to develop an overarching, comprehensive and coherent change strategy, involving all major stakeholders.

The administration of the Transformation Fund would need to work with, but be independent from, other aspects of the NHS management system, such as NHS England, Department of Health and the national regulators. It should be transparent and publicly accountable.

The Transformation Fund should have strong, expert leadership which is credible to clinicians and managers.

The Transformation Fund should work to a small set of clear and measurable objectives at a high level. These should change over time as objectives are met and new priorities arise.

All the existing disparate funding mechanisms for transformative funding in the NHS should be pooled into the Transformation Fund – although this would not provide enough funding on its own and more resources will be needed.

Given the nature of the challenges facing health care, the Transformation Fund needs to develop approaches to support innovation that extend beyond traditional NHS organisations to include social care and other public sector partners, as well as the third sector and, potentially, private sector bodies.

The Transformation Fund would need to ensure proper accountability for public money. This means ensuring that its investments are properly linked to, and measured against, the core objectives, as well as making use of different financing approaches, including staged or match funding.

There would also need to be a balance between accountability and risk. Some element of project failure is inherent in successful innovation – rather than being seen as poor performance, this should be recognised and actively managed.

For the Transformation Fund to be successful, it should adopt an 'active investor' rather than a 'passive grant-giver' approach. The case studies outlined in this report show that to achieve this, the Transformation Fund would need to be appropriately resourced such that it is able to the following:

- **Distribute and manage funding for transformation.** This goes well beyond a bidding or allocation process. Instead, it is the task of ensuring that money is being used across the NHS in the most effective way to meet the goals of transformation.
- **Build the evidence base, identifying what works and how it works.** Funding transformation represents a significant investment in the future of the NHS. Initiatives will generate much-needed evidence about what works in which contexts, and the best ways to spread successful interventions.

It is important that this evidence base is appropriately recorded, collated, synthesised and shared – and the Transformation Fund should be responsible for ensuring this happens. Ongoing evaluation would be a core activity of the Fund. This evaluation needs to include both summative (what works) and formative (how it works) components. It must be 'real-time', not after the event, and feed back to local programmes to shape the evolution of models of care. A failure to evaluate interventions not only has negative impacts locally but also nationally, through a failure to share learning.

The Transformation Fund should make investments based on a realistic appraisal of the full costs and time needed for major transformation. In each of the case studies of major service transformation we examined for this report, the costs and timescales were always underestimated. In particular, the costs of engaging and communicating with staff and other stakeholders were substantial, yet critical for success.

Successful transformative change requires not just dedicated investment, but also a coherent and supportive policy context and practical support for where change is needed, particularly front-line care. Much more effective mechanisms are needed to provide practical support for change. The current arrangements by which NHS organisations can access expert support to help them implement major service changes are being reformed, but in a way which – as yet – is unclear. Furthermore, to date the system has been focused almost entirely on failing organisations. Delivering system-wide change will be very difficult if much of the system is operating in 'crisis management mode'. There needs to be an improvement strategy to support all NHS providers, and in particular the 'forgotten middle' – those in the middle of the performance curve.

The initial objectives of the Transformation Fund

As described above, the Transformation Fund must be accountable for a small set of clearly defined objectives. These would change as objectives are met and new priorities arise. We have made recommendations for the initial objectives for the Transformation Fund, split into two phases.

Phase 1 – 2016/17–2020/21

The most pressing challenge for the NHS over the next five years is to change the way services are delivered across all organisations, to ensure they are run in the most efficient way possible. Demand for NHS services is rising faster than the funding available. The Forward view suggests that savings of around £22bn will need to be made by 2020/21 if the quality of services is not to fall. It is not enough to ask NHS staff and organisations to identify and implement these savings without support.

At the same time, there is strong agreement around the need to identify and test new models for delivering improved, integrated care as well as reorienting activities far more towards secondary and primary preventive care, in part through better population health. This will enable the NHS to better meet the needs of the population, improve quality and deliver greater long-term value for money. These changes will require well-resourced pilots of new models, with appropriate evaluation.

We recommend that over the next five years (2016/17 to 2020/21) the first phase of the Transformation Fund should focus on these related challenges. Our research suggests that a dedicated Transformation Fund of £1.5–2.1bn a year (2015/16 prices) should be established over and above the core resource funding of the NHS. Some of this funding is likely to be available from incorporating existing provisions for transformation, although some additional funding will be required.

In this first phase we propose that the Transformation Fund should have two strands:

- **An Efficiency Strand** – This would support NHS staff and organisations to achieve higher rates of efficiency growth across the NHS, to ensure that current services are delivered in the most cost-effective way possible. This would build on Lord Carter's work on procurement and staffing and extend into examining the efficiency of high-cost and volume clinical pathways. The major goal of this strand would be to achieve annual efficiency growth of 2% a year up to 2020/21. Processes established should be maintained so that continued efficiency growth becomes a long-term focus for the NHS.
- **A Development Strand** – This would invest in developing a range of new models for providing care for a sub-set of the population (we estimate around 20% of the country). The investment would be used to design, implement and evaluate new approaches to find the optimal scale and nature of transformation required to meet the needs of the current and future population. This strand would also help provide practical support to manage change successfully. The strand should be split into two waves, each covering 10% of the English population. The first wave would receive funding from 2016/17 and the second from 2017/18. Both waves must result in a clear set of replicable approaches to delivering care that can be rolled out to the rest of the NHS, building on the work already being done by the Vanguards.

Although we have stated these as separate strands, it is vital that the Transformation Fund does not treat them independently, as each strand is crucial and must benefit from lessons learned in the other.

In practice, different types of transformation require different resources. However, a consistent message from each of our six case studies of major transformations was that there are four key areas that must be properly resourced for any transformation to be successful:

- **Staff time** – time for staff to spend away from the 'day job', to learn and develop new ways of working.
- **Programme infrastructure** – on a national and local level.
- **Physical infrastructure** – predominantly improved use of IT technology.
- **Double-running costs** – to allow new services to be set up while still providing current services.

Funding to invest in the NHS workforce is the key component of our calculations of the cost of the Transformation Fund. It is the largest single component of our estimate of the size of a dedicated Transformation Fund over the next five years. Proper investment of staff time is consistently shown to be the most crucial aspect in ensuring success. This means both engaging staff in the process and releasing them from their day-to-day roles.

The following table shows the results of our costed scenarios for the first phase of the Transformation Fund.

Transformation Fund costing 2016/17 to 2020/21 (2015/16 prices)

	2016/17	2017/18	2018/19	2019/20	2020/21
Efficiency Strand	£1.1bn	£1.1bn	£1.1bn	£1.1bn	£1.1bn
Development Strand	£0.4bn	£0.8bn	£1.0bn	£1.0bn	£0.7bn
Total Transformation Fund	**£1.5bn**	**£1.9bn**	**£2.1bn**	**£2.1bn**	**£1.8bn**

Phase 2 – 2021/22 and beyond

In the longer term, the Transformation Fund must ensure that the lessons learned from the Development Strand are shared and put into practice across the whole NHS. Therefore, we recommend that the second phase, beginning in 2021/22, is focused on widespread roll-out of new models of care that have proved successful.

It is not possible to give precise estimates of the costs involved until the new models of care have been tested. But our work shows that the double-running costs associated with introducing these new models could be substantial and any financial payback in the long term. For example, one scenario would require investment of over £2bn a year for four years, which would not be recouped through savings for over a decade. This reinforces the need for very robust and real-time analysis of the most effective models of care before widespread adoption through the service. It also means that far more work will need to be done to understand how effective models can be spread into different contexts.

Although we have made recommendations for the first two phases of the Transformation Fund, the task facing the NHS is not just a one-off major transformation; it is to become a more adaptive and responsive system that is better able to:

– innovate the models of care to meet continually evolving patient and population needs in future

– create more fertile conditions for spread.

Transformation must not be seen as a one-off project, but as a way of operating – part of the DNA of our health service and its funding system. We therefore recommend that the NHS continues with a Development Strand (with associated ongoing evaluation) as a fundamental part of the system in the long term.

Releasing value from the NHS estate

With financial pressures on the NHS continually rising, the government will need to explore additional, long-term sources of funding. We have examined the scope for releasing value from the NHS estate as a means of raising additional resources for the Transformation Fund.

Our analysis suggests that selling current surplus estate might yield approximately £700m of one-off funding, but would not meet the costs of the Transformation Fund programme over the next five years. However, it is clear from other analysis that the NHS is not using its estate as well as it could do. Therefore, we recommend work to explore the degree of, and reasons for, variations in efficiency. This would enable the NHS to identify opportunities for sharing best practice and raising the overall efficiency of its estate.

We also recommend that work is carried out to explore the potentially significant opportunity to generate value in a more sustainable way, through the development of the estate. Rather than generating one-off capital receipts, this approach – which could be applied to both surplus estate and that still in use – has the potential to provide the NHS with a substantial and sustainable source of new income, and would not require the sale of NHS land and buildings. This would fit with efforts to increase the efficiency of the estate, and over the long term could significantly increase its overall value.

Of course, the practical and other implications of this approach would need to be worked through, but a possible model might involve the Department of Health partnering with a private sector developer. Under this model (similar to that applied successfully by some Crown Estate sites), the Department could offer a partner an equity stake in the NHS estate and a proportion of the income generated, but would not need to give up its ownership or management responsibility for the assets involved. This estate (or part of it) might be used for commercial purposes, or for the development of social housing in line with the government's broader policy agenda.

Although it represents a new approach to the NHS estate, this model may well have the potential to make a major, long-term contribution to funding the later phases of transformation, as well as providing benefits for the wider economy.

A Transformation Fund for the NHS: key recommendations

- The NHS needs a single body (whether within an existing organisation or newly created) to oversee the investment for transformative change in the NHS. It should have strong, expert leadership which is credible to clinicians and managers.
- Existing disparate strands of transformative funding should be pooled into one Transformation Fund.
- The Transformation Fund requires £1.5–2.1bn a year in dedicated funding between now and 2020/21. While bringing together the existing strands will go some way towards this, more resources will be needed above the £8bn increase in NHS funding already announced by the government.
- The introduction of the Fund would involve two phases:
    - The first phase (2016/17–2020/21) would be split into two strands: an Efficiency Strand, which would look to achieve higher rates of efficiency growth across all services, and a Development Strand to invest in new models of care.
    - The second phase (2021/22 and beyond) would focus on widespread roll-out of the successful new models of care. This would include double-running costs associated with these new models.
- The Fund must be properly resourced to support investment in four key areas, which are essential for successful transformation: staff time, programme infrastructure, physical infrastructure and double-running costs.
- The Fund should ensure proper accountability for public money, ensuring its investments are properly linked to, and measured against, core objectives.
- Ongoing evaluation should be a core activity of the Fund. This evaluation would need to include both summative (what works) and formative (how it works) components.
- Further consideration should be given to generating funding through the development of the NHS estate into a long-term sustainable source of new income.

1: Introduction

The current context

The NHS in England, like all health care systems, faces a number of long-term, interconnected challenges:

- How to ensure that the NHS is equipped to respond to changing patterns of health and care needs as the population ages and the burden of health shifts from one-off acute episodic care to supporting people with multiple long-term physical and mental health conditions.
- How to reduce the pressures for additional funding by maximising the efficiency of provision so that every penny is spent wisely.
- How to ensure that the quality of care provided is of a consistently high standard across all the key aspects of care (safety, access, patient experience, outcomes) and that better health outcomes are achieved.

These challenges are not new, but they have been brought into sharp relief by the slowdown in NHS funding growth that followed the global recession and the ensuing programme of fiscal austerity. Health spending has been protected from the full force of the austerity drive but funding has risen much more slowly than the pressures on the service – a situation that is unlikely to change for many years to come.[1]

As NHS system leaders outlined in the *Five year forward view* (Forward view),[2] responding to these challenges will require fundamental changes to all aspects of care throughout the NHS. This is not about restructuring the bodies that oversee the NHS but reforming the way in which care is provided to patients, day in, day out, across every part of the health service. It is a much bigger and more fundamental task than the system reorganisations that have characterised NHS policy over recent decades.

The NHS is very skilled at delivering administrative reorganisation, but it has struggled to reform care to address the long-term challenges of changing population needs and sustained efficiency improvements at the scale and pace required.[3]

The sustainability of the NHS depends on its ability to understand 'what works' to address these challenges and then to implement these new models rapidly and consistently. Identifying best practice and spreading it will be critical for the next five years and beyond.

The Forward view recognised that some of the key barriers to effective change across the NHS were access to funding, skills and capacity to support transformative change, and that creating the right policy environment for achieving this would require government support.

It raised the possibility of dedicated transformation funding, describing the need for 'a model to help pump-prime and "fast track"… new care models'.[2] In response, the government set up a small transformation fund of £200m for 2015/16. Many organisations, across the health policy and practice community, support the call for transformation funding. It is seen as a possible solution to the apparent paradox of widespread support for fundamental changes in the way health and social care is delivered but limited evidence of practical change on the ground.

Objective and methodology

The King's Fund and the Health Foundation both support the concept of an NHS Transformation Fund. The two organisations came together to undertake a programme of work detailing the key aspects of such a fund.

Our programme of work looked at:

- the need for an overarching Transformation Fund to organise the current arrangements for funding major change in the NHS and to ensure they are fit for purpose for the changes required to health care over the next five to ten years
- the amount of money that might be needed to support transformative change over the next few years, including the key elements of funding required and how these might be phased
- how any such funding might be allocated and administered across the NHS to make sure it achieves its objectives.

The work draws on the experience of funding other transformations, in the health sector and beyond, through six case studies. Table 1 provides a short summary of these case studies, while the key learning from them is discussed in chapter 3. Full details are provided in appendix 1.

We also captured the experience of NHS leaders and some of those organisations across the NHS that have been at the forefront of efforts to implement changes in the delivery of care. They helped us to understand the types of changes currently occurring, what is required for change, the barriers to change, what funding gaps exist, and how a Transformation Fund could support more rapid and effective progress. We did this through a mixture of workshops and interviews. Further details of the recent initiatives we looked at are provided in appendix 2.

Table 1: The scale of dedicated transformation funding across six case studies

Case study	Total cost (£) (2015/16 prices in brackets)	Cost per head per year (£) (2015/16 prices in brackets)
Deinstitutionalisation in UK mental health services: Since the mid-1980s, mental health services have been radically transformed. A process of large-scale 'deinstitutionalisation' saw a shift in care and support for people with mental health problems from psychiatric institutions to community-based settings. In the UK, this resulted in the closure of all institutions, where approximately 100,000 people had lived.	Not available	Not available
The National Service Framework for Mental Health in England: In the early 2000s, community mental health services in England underwent a national programme of development that was central to a 10-year plan to improve the outcomes and experiences of people with mental health problems. The programme resulted from public and media pressure to reform community care provision following a series of high-profile adverse events involving people with mental illness.	£700m (978m)	Not available
Canada's Primary Health Care Transition Fund: This CAD800m fund ran from 2000 to 2006, providing transitional costs to support the transformation of Canada's primary health care system. Primary health care in Canada is publicly funded and mostly free at the point of use. Transformation in primary care was deemed a priority after public and political concerns over quality and access.	£360m (503m)	£1.95 (2.73)
Denmark's hospital transformation Quality Fund: In 2007 the Danish government introduced a national Quality Fund of DKK42.7bn (£5.9bn) to build new hospitals over a 10-year period. These would form the basis of a new infrastructure for health and care delivery. The Quality Fund operates as part of a wider set of reforms to health and local government structure implemented in 2007.	£5.3bn (5.9bn)	£96 (107)
The London Challenge: The London Challenge was established in 2003 to improve the quality of education and outcomes in secondary schools in London. It emerged in response to the limited progress being made in London towards meeting government commitments to education, despite a number of national initiatives and policies. Central government ran the Challenge from the Prime Minister's Office and the Department for Education and Skills (DfES).	£80m (105m)	£22 (28)
Girls' Education Challenge (GEC) Fund: This £354m fund was set up by the Department for International Development (DFID) in 2013 and runs for six years. It aims to help up to a million of the world's poorest girls improve their lives through education.	£344m (354m)	£86 (88)

About this report

This report is structured as follows:

- Chapter 2 looks at the current arrangements for funding transformation in the NHS, and the need for a dedicated Transformation Fund.
- Chapter 3 gives an overview of the case studies, and our analysis of the lessons from them.
- Chapter 4 discusses what is needed to support transformative change, and the design/administration principles a Transformation Fund should be based on.
- Chapter 5 explores how the Transformation Fund might be focused over two initial phases (phase 1 from 2016/17 to 2020/21 and phase 2 from 2020 and beyond).
- Chapter 6 discusses the scale of investment needed for the first two phases of the Fund.
- Chapter 7 looks at how additional resources might be realised from surplus NHS estate.

There are also three appendices, giving more details of the work underpinning this report:

- Appendix 1 provides full information about the case studies.
- Appendix 2 explains the methodology used to calculate the size of the Fund and gives details of the local NHS examples of change that we examined.
- Appendix 3 looks at the potential for realising value from surplus NHS estate.

All appendices are available at: **www.health.org.uk/makingchangepossible** and **www.kingsfund.org.uk/makingchangepossible**

2: The need for a dedicated Transformation Fund

Against the background set out in chapter 1, one of the major barriers to transformative change is the current funding system.

Current sources of funding for change in service delivery

At present, there is a patchwork of investment instruments and funds to support improvement as well as new commissioning models, capital investment in services and business change. There are also other arrangements for supporting struggling providers. Table 2 summarises the main current funding mechanisms. However, this list is not exhaustive.

Table 2: Current funding mechanisms to support change in NHS service delivery

Mechanism	Description
Department of Health (DH) loans for capital investment	• Working capital and loans to NHS trusts and foundation trusts to support capital investment • Loans are provided on the advice of the Independent Trust Financing Facility where there is a reasonable likelihood they will be repaid • Trusts pay a low cost for capital, which reflects the cost of government borrowing
DH public dividend capital (PDC)	• Most commonly provided to NHS trusts or foundation trusts in distress, to cover cash shortages • On occasion, provided to cover the costs of change or restructuring • Trusts pay a fixed dividend set by the DH, calculated as a percentage of relevant net assets
Dedicated investment funds	• Some smaller funds were established by the previous government to support the delivery of specific policy initiatives • Examples include the Nursing Technology Fund and Prime Minister's Challenge Fund, as well as the £200m of transformation funding allocated to the vanguard sites for the new models of care set out in the Forward view
Foundation trust surpluses	• In theory, foundation trusts can use their surpluses for major capital investment or business change, but in practice the number with sizeable surpluses is dwindling • Foundation trusts are also discouraged from using cash reserves as revenue • Extensive use of foundation trust surpluses could put the DH at risk of exceeding its department expenditure limit.
Private investment	• Foundation trusts can, in theory, raise debt through the private sector, but this has rarely happened in practice and the private sector has historically been unwilling • There is a high cost of capital for risks that are tacitly or explicitly underwritten by the state • Independent providers can raise private sector investment, but GPs have traditionally been unwilling to take on substantial debt and instead rely on government investment
Revenue support	• There are some examples of NHS England or commissioners providing additional revenue to support business change or transition to new models • It seems unlikely, though, that they would do so to a large extent in the current environment

What are the limitations of the current arrangements?

It is evident from the current arrangements that funding for transformation to date has been fragmented, and that these arrangements have evolved over time in response to different challenges and programmes. This may have served to support individual initiatives. However, the multifaceted nature, scale and complexity of transformation that is now envisaged is not served well by the current funding arrangements. Key difficulties include the following:

- **Financing transformation across multiple different organisations:** It is extremely difficult to raise finance for transformation spanning commissioners and different types of providers, such as independent GPs, foundation trusts and public sector NHS trusts. A number of the existing funds can only provide finance to part of the sector. There appear to be very few funds able to make substantial investment in new commissioning models.
- **Raising the appropriate types of finance for uncertain change:** At present, there are small-scale grants for the development of new models of care and more substantial debt finance (focused on NHS trusts and foundation trusts) for buildings and infrastructure. For public sector providers, there is no scope to raise equity, with public dividend capital (PDC) typically offered only in extremis. It might be particularly difficult to develop convincing business cases to fund the transformations outlined in the Forward view through debt alone, given the uncertainty regarding the scale of the benefits and the payback period. Organisations might be encouraged to downplay the full transition costs in order to secure those funds that are available.
- **Raising funds for valuable changes that deliver wider benefits for the system:** Some of the current instruments mimic private sector finance in that organisations are expected to develop a business case, demonstrate how the investment will lead to increased revenues or cost reductions, and repay the investment as those benefits are achieved. This makes it difficult for an organisation to raise funds for valuable investments where it will not recoup the benefits, either where those benefits are felt by other organisations in the health economy or where the benefits are felt more broadly and not reflected in the payment system at all.
- **Raising funds for complex, transformative programmes:** The current system is ill-equipped to support transformations that require investment in multiple different areas, such as developing new decision making structures, introducing new technology, retraining staff and building new facilities. This is partly because so many of the current funds are earmarked for narrowly defined initiatives rather than for cross-cutting transformation. Overall, the current system is also slanted towards tangible investments in new infrastructure, rather than the intangible investments needed to support major change.
- **Making the transition to new service models:** It is particularly difficult to raise investment to manage the transition from one model to another – for example, to provide for double-running costs as the new model is tested and the old model wound down. It is not clear why this is the case; it may be a consequence of the nature of current financing instruments, or specific restrictions on the use of funds for these activities.

– **The size of the different funds:** Many of the existing funds are very small and thinly stretched. For example, the government provided very small amounts of support for each of the six integrated care pioneers. There is a severe risk that ambitious programmes are underfunded from the start, encouraging them to underestimate or ignore major aspects of the transformation, and increasing the risk of failure.

– **Continuity of investment:** The current system does not easily support long-term programmes of transformation that might take a number of years and move through multiple phases (for example, the initial development of options, testing new models, planning for major transformation and making the changes). It can be possible to gain small grants for the early stages, but it is less clear how organisations would then raise funds for the next phase, with the risk that transformation progresses in fits and starts at best.

What is required of future transformation funding?

There is no single robust, systematic evaluation of the different approaches to funding transformation in the NHS. As a result, establishing a Transformation Fund in England would be, to some extent, an 'act of faith' because it is not possible to produce a robust business case (including a return on investment) that can clearly show what might be gained for any specific level of investment.

However, it is clear that transformative change requires very specific skills and capacity, which will need to be resourced. While achieving transformation requires investment, the Transformation Fund does not in itself create any additional cost pressures; rather, it ring-fences the funding on the basis that this allows more effective management of the process of change.

Recognising the nature and scale of the transformation required, it is clear that funding arrangements for future transformation will need to account for a number of different factors.

Future transformation and, in particular, establishing new models of care will require a range of local organisations to come together and work differently. For example, some commissioners will need to put in place different contracting models, while providers will develop new groupings and new service models. Funding will therefore need to support commissioners as well as providers, while investment in local areas attempting transformation will need to be provided in a joined-up way.

Similarly, transformation is likely to involve a number of different types of provider – independent primary care providers as well as public providers and, potentially, partnerships between a range of public and private providers.* As such, funding will need to be available to support a broad range of providers.

The need to bring together health and social care is well understood, but addressing the changing health needs of the population will also require the NHS to work with a wide range of partners across civil society. This was beyond the scope of our work, but if proposals for a Transformation Fund are taken forward it should be a key strand of further work.

* For example, groups of primary care providers and public sector providers are creating community interest companies to deliver integrated services.

Some of the costs of change are not supported by any of the existing funding mechanisms. It is particularly difficult to raise funds to support the process of transforming from one model of care to another. Such changes will involve some one-off costs to underpin 'enablers' of change (for example, developing new governance systems, new clinical pathways, new business processes and data systems). But they also include double-running costs; these are incurred as the new model is operated in parallel with existing services for a period of time while it is tested and refined. In addition, the impact of the new service on demand for existing services occurs with a lag (for example, more preventive care will not have an immediate off-setting impact on acute care).

Any large-scale transformation will involve a wide range of costs, many of which have historically been underestimated. In particular, the major transformation required will include the substantial costs of engaging with and communicating with stakeholders, retraining staff, and managing the organisational culture aspects of change. Our research suggests that the current system is slanted towards tangible investments in new infrastructure, rather than investments in the more intangible assets – knowledge, skill development and team working – that are essential to deliver change at scale. It is critical that funding is provided on the basis of a realistic appraisal of the full costs and the time needed for major transformation.

The dedicated Transformation Fund that we are proposing would be just one element of a successful change programme. To put such a programme into practice to deliver new models of care, there needs to be a supportive policy context alongside the right mix of practical support to deliver change. This includes, but is not limited to, funding.

The Transformation Fund will need to focus on aligning the policy context, resourcing of change, and helping provide practical support; all of which have been significant barriers to progress. Practical support for change was the subject of a recent review by NHS England,[4] but it is not yet clear how this will be taken forward. At present practical support largely focuses on failing organisations.

We have not examined the pros and cons of any specific way of organising practical support for transformation, but a coherent and well thought out system is clearly essential. In addition, throughout our work on a Transformation Fund, local NHS leaders highlighted the pressures on the system in the short term and the reality that operating in 'crisis management' mode acts as a huge barrier to change. Without addressing these elements of the policy and funding context, any dedicated Transformation Fund is likely to be much less effective.

3: Lessons from previous transformation programmes

The sustainability of the NHS depends on its ability to understand 'what works' to provide a high-quality sustainable service. The approach to transformation and how to support it should be no different. The English NHS is no stranger to transformation and there are a number of past examples to draw on, while internationally many other health systems are tackling challenges not dissimilar to those in England through processes of transformation. Furthermore, transformation is not unique to the health sector and, arguably, there is much we can learn from other sectors. Examining these examples provides invaluable learning on the key requirements of transformation, the processes involved, and where improvements can be made.

This chapter provides a brief overview of our six case studies and the key learning from them (further detail is provided in appendix 1). They incorporate different approaches to administration that we have used to inform this report. Our analysis in each case focused on the context of transformation, its intended benefits, the process and management, workforce considerations, funding arrangements, outcomes and challenges.

Overview of case studies

Deinstitutionalisation in UK mental health services

Since the 1980s, there has been a transfer of care and support for people with mental health problems from psychiatric institutions, to community-based settings. This policy of deinstitutionalisation, which was widely supported, was framed by a number of factors including a growing emphasis on human rights and changing views on psychiatry.

Deinstitutionalisation primarily involved the movement of services from hospitals into the community. New community provision was developed on the basis of future funding from social security payments to ensure sustainability, with additional mechanisms to transfer some NHS budgets to local authorities. Ring-fenced funding from central government was also provided.

The process was primarily implemented at a local level: the NHS and local government drew up five-year plans for the closure of hospitals, including detailed projections of revenue, reinvestment, use of NHS capital funding and new sources of funding. New organisations (including charities and housing associations) were set up to manage the process and were the recipients of the funding. They were given responsibility for brokering

connections between local providers and other organisations to facilitate the change to community-based working. The process had substantial workforce planning implications, requiring negotiation of staff terms and conditions, and the development of new management structures and training in line with the new services.

The process of deinstitutionalisation is largely considered a successful one. However, it took considerable time and, despite the initial impetus in the 1960s, closures did not start until the 1980s and went on until the 1990s. Financial projections often took into consideration the release of funding from estates, but this rarely delivered within the planned timescales. Overall, deinstitutionalisation did not result in spending reductions, because the higher-quality care in the community often turned out to cost more. Subsequent analysis has highlighted some unintended consequences, including increased mortality among some groups.

The National Service Framework for Mental Health in England

In the early 2000s, community mental health services in England underwent a national programme of development to improve the outcomes and experiences of people with mental health problems. The programme was the result of public pressure to reform community care provision following a series of high-profile adverse events involving people with mental illness. The National Service Framework for Mental Health (NSF-MH), an evidence-based plan developed by a group of experts, set national standards and defined new service models; it established programmes to support local delivery, and developed milestones and performance indicators with agreed timescales to measure progress.

A national agency was established to oversee and support implementation. This included five programmes (financing; workforce planning; training; research; and information and clinical support systems), while at a local level implementation teams were established to develop plans for meeting national and local milestones. Implementation of the NSF-MH required substantial workforce increases (up to 18,000 over 10 years). Staffing levels were set nationally and best practice guidance was developed to support individual organisations.

A total of £700m was allocated from central funds over three years to implement the NSF-MH, along with £120m from a modernisation fund. The funds provided included unified allocations for new service development and revenue-only grants to support and improve existing provision. Funding was also distributed for national innovation initiatives including regional mental health development programmes and NHS 'Beacons'. Local authorities were required to contribute 30% of the funding for core and partnership grants.

The NSF-MH achieved significant transformation of community mental health services in a relatively short period of time. However, it faced challenges in ensuring that a sufficiently large and appropriately trained workforce was available to staff the services, and targets for full implementation were not met within the deadline. A lack of evaluation has limited the extent to which lessons can be learned – particularly where services have not delivered the expected outcomes – and has left provision vulnerable to further reconfiguration, often at the expense of effectiveness.

Canada's Primary Health Care Transition Fund

Canada's CAD800m Primary Health Care Transition (PHCT) Fund (worth £503m in 2015/16 UK prices) was implemented from 2000 to 2006. It was part of a package of spending and reforms initiated in response to concerns over quality and access in primary care.

The fund aimed to support projects linked to one of five aims, which included access, better coordination of primary care and other services, and the prevention and management of long-term conditions. A small proportion of the fund was used for national-level projects, with the majority (75% or CAD600m) allocated on a per capita basis to provinces, with additional top-up funds for smaller provinces to ensure sufficient scale. Provinces were required to submit proposals in line with the fund's aims (including a yearly budget and funding timetable); these were overseen and signed off by a national working group. Subsequent allocation of funding was determined at a provincial level and included grants, directed funding and investment in infrastructure.

Relatively strong engagement from medical associations meant clinical leadership was present from the fund's inception. Funding was used for a range of items, including pilots, knowledge sharing events, project management, IT, new equipment, and research and evaluation. The fund was specifically targeted at transitional costs and could not be spent on anything requiring ongoing investment, such as new buildings or new clinical personnel.

The PHCT Fund is credited with focusing the attention of policy makers, system managers and researchers on primary care, promoting relationships and knowledge sharing, and providing an opportunity for transformation following a period of austerity. However, budgetary and timetable requirements led to funds being spent quickly, with little strategic planning or oversight. This has drawn criticism for insufficient accountability and some projects have struggled to sustain practice beyond the timescale of the funding.

Denmark's Quality Fund

Denmark's national Quality Fund of DKK42.7bn (worth £5.9bn in 2015/16 UK prices) was introduced in 2007 as part of a wider set of health and local government reforms, and provided support to build new hospitals over a 10-year period. The driver for transformation was a political and clinical consensus on the need to have a hospital system which supported a move away from hospital-based care. The fund was intended to support the centralisation of provision through the development of a new system of hospitals, leading to improved quality of care and productivity.

Plans for hospital construction are developed locally and, once assessed by an expert panel, recommended to the Ministry of Health for approval. The application process involves two stages, with the final investment decision based on a plan agreed with regional government. Hospitals are expected to realise a specified set of productivity improvements within a year of their completion.

These projects represent the largest capital investment ever made in Denmark. Of the DKK42.7bn, DKK25.5bn (£3.5bn) is earmarked for government co-financing, with the remaining 40% contributed by the

regions. Funding is also provided through loans, estate sales and expected productivity gains. Central funding is released at intermediate deadlines and can be withdrawn by the Ministry of Health if the deadline is not met. Overall supervision of the projects lies with the Ministry, with regions responsible for planning and managing construction within budgets.

As the projects have progressed, they have experienced challenges over timescales and in agreeing on the anticipated productivity savings. Likewise, the inflexibility of the fund has caused problems in that actual costs have overrun budgets.

The London Challenge

The London Challenge was established in 2003 to improve the quality of education and outcomes in London secondary schools following the limited progress made by a number of previous initiatives and policies. The Challenge was run from the Prime Minister's Office and the Department for Education and Skills (DfES) with three clear objectives: to reduce the number of under-performing schools; to increase the number of schools rated 'good' or 'outstanding' by Ofsted; and to improve educational outcomes for disadvantaged children.

The London Challenge included a combination of approaches: resources and programmes available to all schools; tailored support for 70 of the most disadvantaged schools; and intensive work with schools in five London boroughs to help reform their secondary school provision. The Challenge was led by the Minister for London Schools and the London Schools Commissioner. A team of civil servants led on identifying schools for intervention and policy development, while a team of expert advisers was appointed to liaise with schools, develop improvement plans and broker funding with DfES. A leadership development programme was set up to develop school clusters in which head teachers from good or outstanding schools could share their expertise.

Funding comprised £15m for each of the first three years and £80m in total over the eight years of the Challenge. Schools submitted plans to the management team, and reported on their progress. Funding was agreed by advisers and officials at DfES, with larger sums of £25,000 and £50,000 signed off by officials and the Minister for London Schools respectively. Funding was used to help schools achieve their goals, including through support with the use of data, support for leadership development, and teacher coaching.

The London Challenge was credited with contributing to the dramatic improvement in London schools between 2000 and 2014.[5] Engaging the workforce, particularly headteachers, proved to be an effective strategy.

Girls' Education Challenge Fund

The £344m Girls' Education Challenge (GEC) Fund was set up by the Department for International Development (DFID) to run between 2012 and 2018, with funding focused on a four-year cycle (2013-2017). It is the UK's main contribution to the Millennium Development Goal of eliminating gender disparity in primary and secondary education. The fund provides grants to fund or match-fund projects that are expected to increase girls' participation in primary and secondary education.

Potential recipients compete for funding on different criteria based on the type of project. The fund operates three main 'windows' that support step change, innovation and strategic partnerships. Two-thirds of the fund is earmarked for step change projects that involve applying proven approaches to new contexts. One-third is reserved for innovation projects and strategic partnerships, including match-funding for projects in partnership with private sector companies, and seed funding for projects involving new and untested approaches.

Each funding window has a clear set of objectives and criteria for applications. Applicants are also required to develop a theory of change, outcomes and a timeframe. Fund allocation and performance management represent a balance of risk and investment between the tailoring and upscaling of existing interventions and development of new and innovative solutions. A proportion (around 10%) of step change funding is not released until results can be demonstrated, and there is an expectation that the GEC will cease to provide funding to some projects if it becomes clear that they are not going to meet their objectives.

The fund is managed independently of DFID by a consortium led by PwC UK. Administration costs account for 10%–17% of the overall fund value, reflecting the core purpose of learning and evaluation within the fund, and ensuring that appropriate expertise is available to evaluate proposals and measure performance and impact. Fund managers are expected to support potential applicants and successful organisations to minimise risk and maximise success.

Lessons for the design and administration of transformation processes

Drawing together learning from across the case studies, it is clear that there are some common lessons as well as individual insights that highlight a number of factors that need to be considered in relation to support and management of transformation as a whole. The characteristics of successful transformation processes include the following:

Having clear and coherent objectives

A common factor across the case studies was the need to ensure that allocation of funds is built on clear and coherent objectives. This includes the objective of transformation itself and having a narrative that supports transformation, in addition to the objective of the funding. In the case of the Danish hospital transformation fund and the UK process of deinstitutionalisation, the clear overarching objective was around transformation of the hospital system – in the former case, to build or reconstruct hospitals, and in the latter, to close them. The objectives of these large-scale transformations are relatively straightforward; however, it is of note that there was general consensus (and/or a lack of opposition) on the direction of change from stakeholders, including patients, clinicians and politicians. Additional support, including clinical and legislative developments, provided a context that validated the objective of transformation.

In other, more complex cases, clear objectives were apparent in the specification of the intervention (as with the implementation of the different models of care as part of the NSF-MH) or as part of the specification of the funding. Canada's Primary Health Care Transition

Fund, the GEC Fund and the London Challenge all had relatively broad aims with little specification about the interventions. However, in each case, the purpose of the funding was inherent in the application process and the mechanisms for defining success.

Engaging stakeholders in transformation

There is little evidence of stakeholder groups successfully challenging the actual transformation processes within our case studies. This is surprising, particularly in relation to the large transformation programmes. However, it is notable that public opinion was influential in the impetus for transformation in both mental health case studies: deinstitutionalisation emerged as a result of shifting social attitudes towards detention in large asylums, while the NSF-MH was developed as a direct result of issues raised by the public and media in relation to public safety. In the latter case, an acknowledgement at a national level of the issues involved, and the development of an expert group to identify solutions, provided legitimacy for the transformation that occurred as a result. In practice, the transformation process itself was largely achieved within mental health services and, although it sought to achieve outcomes of public value, did not impact the public generally.

The process of deinstitutionalisation, however, had a much wider impact. Our case studies highlight the value of engaging with the public, building a dialogue about the process of change, and actively addressing concerns as a means of building confidence in future provision and facilitating transformation.

The deinstitutionalisation process also highlights the importance of engaging other stakeholders. Addressing people's accommodation requirements, support requirements, and funding for their care required the involvement of local authorities, housing associations and other voluntary sector providers. The ability to bring together these organisations as part of a collaborative approach was central to securing the components of transformation.

Leading change

Effective leadership was key to driving change and delivering on implementation. Most of our case studies highlight the value of local leadership. This was conducive to the bottom-up development of transformation plans and seeing them through to implementation; but it was not always present from the outset of large transformation plans, so needed to be developed. In the case of the NSF-MH, the national project implementation plan required mental health providers to develop a tier of local leadership to oversee the process, with additional implementation leads in individual provider organisations. The deinstitutionalisation process saw the development of new local organisations to draw on the involvement and expertise of local stakeholders, while taking an independent lead for transformation at a local level.

Leadership at the national level was also important. The London Challenge was spearheaded by the then prime minister, who ensured strong and consistent leadership throughout. This was important in setting and maintaining the programme's direction as well as in mediating challenges to delivery. The establishment of a National Director for Mental Health

to oversee NSF-MH implementation provides a further example. In both cases, the considerable experience and legitimacy of the appointed leaders was important in engaging staff and supporting transformation.

Evidence-based planning

It is notable from our case studies that a core part of the transformation and the allocation of funding was founded on an established evidence base. This is most notable in the case of the NSF-MH, where an expert group was established to examine the evidence for improvement across a number of key areas in order to develop a transformation plan. In contrast to this top-down approach, regional applicants to the Danish Quality Fund submitted their own transformation plans, which were evaluated and approved by a national expert panel. In both cases, establishing the validity of plans for implementation was based on the expertise of those involved and the best evidence available. This was important in supporting transformation, but they also came under criticism as to the level of evidence required to support implementation at scale.

Using the available evidence is one consideration but, in many cases of transformation, the question is what to implement, rather than how. The London Challenge adopted an experimental approach by creating a culture of learning and knowledge sharing. The GEC Fund alternatively aims to meet both agendas by taking a stepped approach to the requirement for evidence. Plans to implement an intervention at scale must demonstrate the use of existing evidence on implementation and replicability; they are evaluated by fund managers according to the evidence base, including projected activity, costs and outcomes. However, applicants submitting plans to develop and/or test an intervention are required to demonstrate that this is underpinned by a clear theory of change. Fund managers assess these applications in line with the proposed theory of change, weighing up a number of factors to arrive at a funding decision. These different approaches are written into the structure of the GEC Fund and enable a level of flexibility around the use of evidence. They require the availability of sufficiently broad expertise in order to judge plans appropriately.

Balancing implementation, innovation and risk

Examples of transformation in the health system suggest that both implementation and innovation are important. Service models that support greater provision in the community, such as those outlined in the Forward view, largely represent implementation. They are likely to be high in cost and have a widespread impact on those involved, but are necessary in order to meet the future care needs. However, evidence from high-performing health systems, such as the integrated care consortium Kaiser Permanente in the US, highlights the key role of innovation in developing new solutions to existing problems and in delivering cost efficiency.

Although evidence plays an important role in determining the approach to transformation and allocation of funding, it is by no means unique. Our case studies demonstrate different approaches to risk. Some of the models of care within the NSF-MH were underpinned by more evidence than others, but the impetus to address concerns around public safety and deficits in services precluded this and the services were mandated nationally. Within the GEC Fund, the funding focused on primary

innovation has an explicit expectation of failure, and processes for withdrawing funding are built into its management systems, forming an incentive for projects to maximise effort. These represent different activities and levels of risk, but are key in determining the appropriate level of support for transformation activities.

Scale of funding for transformation

The level of funding provided for transformation in the case studies varied considerably. The Danish Quality Fund was by far the largest, at £5.9bn (in 2015/16 UK prices), in a system serving 5.6 million people. The fund was expected to support the reconfiguration of the entire hospital system, with the promise of productivity savings within 10 years. The transformation as such was not simply one of moving care, but of redesigning care provision from the foundations (quite literally) up. Management of this scale of funding requires a significant level of political and public scrutiny, something that the Danish transformation continues to struggle with.

At the other end of the funding scale, the London Challenge allocated sums as small as £3,000 for individuals and projects. This funding was about supporting incremental change, with improvements in quality and efficiency, rather than wholescale transformation; but the smaller scale allowed pilots to flourish without suffocating them in unnecessary bureaucracy.

Our case studies demonstrate that the amount of funding available has to be commensurate with the scale of transformation expected. However, there are a number of key lessons. First, in each case of major service transformation, the costs were underestimated. Second, although in several cases mechanisms for releasing funding included sale of estate, improvements in cost efficiency and reduced service use were core components of the original cost estimates. In practice, though, they largely failed to materialise.

Allocation of funding for transformation

The case studies highlight a diverse range of funding mechanisms. These may reflect the ability to move and allocate funding commensurate with the type of transformation activity. The London Challenge and GEC Fund used relatively simple mechanisms whereby the funding allocated was fixed and transformation projects could be judged as a matter of value for money in relation to their scale and risk. Deinstitutionalisation, however, involved channelling funding from multiple stakeholders into new entities, with complex arrangements and long-term financial frameworks tied to land sales, dowry payments and joint finance initiatives.

One lesson for the development of funding arrangements is the sustainability of transformation. The Canadian Primary Health Care Transition Fund allocated funds solely for transition costs to support change, but this often failed to account for the longer-term running costs of new provision. The process of deinstitutionalisation used transitional costs in the form of a dowry and joint finance initiatives, but navigated the problems of sustainability by taking into consideration the funding allocation that individuals living in the community would receive as a basis for developing the new services. This was important given that funding forecast from the sale of estate rarely fulfilled these requirements.

A second lesson concerns the need for flexibility. Several of the case studies highlight the value of different streams of funding with different purposes. This is most notable in the London Challenge and GEC Fund, but is also reflected in the funding framework for the NSF-MH, in which funding was allocated through unified allocations, grants, targeted funds and partnership funds, each with different purposes. In the case of the former two, the funding streams were established from the outset; but in the latter (and in the case of deinstitutionalisation), new funding streams developed in response to emerging requirements.

The case studies also provide valuable insights into areas in which funding was required. A key lesson from mental health transformations is the need to provide double-running costs, taking into account the time and capacity required to establish new services while maintaining but gradually reducing provision of old services. Both the London Challenge and the Canadian fund included these as core costs, along with other 'transitional costs' such as cover for frontline staff and managers to engage in transformation activities. In both cases, this capacity to engage in service redesign, project management and retraining activity was reported to be essential to success. That much of this transformation has occurred in spite of ongoing financial challenges is an important factor; the ability to ring-fence transformation funding is important in enabling improvement work and in ensuring that funding is not used to plug existing deficits and perpetuate unsustainable service models.

Considering workforce requirements

Two themes emerge in relation to the role of the workforce in transformation. The first is the need to engage and support staff in the process. As with the public and patients, many of the case studies highlight the need for a narrative that engages frontline staff. The evidence-based medicine approach used in the development of the NSF-MH provided a strong rationale to clinical staff for implementation of models of care as part of transformation; in Canada, the involvement of clinical staff promoted ownership of the transformation plans as they were being developed. In the latter case, ensuring appropriate involvement of professional bodies was noted to be of importance in facilitating transformation. Perhaps the London Challenge provides a unique example, since mechanisms to transform quality overtly targeted professional development; as such, efforts to approach and engage those at the front line were identified as a high priority.

The second theme relates to the workforce implications of transformation itself. The allocation of funds as part of the London Challenge and Canada's primary care transformation highlights the need to release staff from their day-to-day roles in order to attend training and engage in new approaches to delivering care. The workforce implications in the two mental health case studies are perhaps most notable. Those involved in the process of closing asylums not only had to manage the movement of patients but also the redeployment of staff. This required a consideration of the location, role, skills, culture, status and preferences of staff, and the subsequent development of appropriate management and training to facilitate the transition. The process required considerable negotiation and time. In both cases, this was led at a local level; however, the speed and coordination of

implementation as part of the NSF-MH was greatly facilitated by focused attention on workforce provision. At a national level, a dedicated team was working alongside professional bodies to consider the workforce requirements of the new services and develop guidance, such as that on new roles and skills diversification, to support delivery.

Investment in learning and evaluation

Several of the case studies highlight a failure to ensure appropriate evaluation and effective mechanisms for disseminating learning. Many of the measures associated with implementation of the NSF-MH, for example, were process indicators, but a lack of outcome indicators left the models open to criticism. It is clear that some models were ill-suited to their location, which led to them being adapted over time. However, without an understanding of the key elements required for the model to be effective, these adaptations may have inadvertently negated their impact. This same criticism has been raised by those involved in primary care transformation where there was a focus on proposals but insufficient evaluation as to whether proposals delivered improved patient care. Failure to evaluate interventions has negative impacts at a local level, but the impact at national level – through a failure to share learning – is equally problematic, and disempowers those seeking to transform care.

Two of the case studies demonstrate how learning and evaluation can be built into the infrastructure of a Transformation Fund. The London Challenge used data to underpin improvement at every level. Schools were encouraged to use existing data to guide the identification of areas that needed improvement. In addition, there was heavy investment in training staff to ensure that effective use of data to support transformation became a 'common preoccupation' among participants. This represented a transformation in which the use of data for evaluation was embedded into the infrastructure of improvement. The GEC Fund also sets stringent requirements for projects to monitor and record outcomes of their interventions. This includes mechanisms to establish a baseline level of activity, against which progress can be evaluated at regular intervals. Additional capacity within the fund administration has been important in being able to achieve this. These evaluations form a core part of the funding allocation, and funding can be withdrawn if impact is judged to be limited.

Accountability

A second major weakness identified across several of the case studies is the deficit in accountability. The scale of Denmark's Quality Fund has attracted significant amounts of attention, and the initial difficulties with accountability arrangements are thought to have led to a proliferation of political and financial arrangements introduced after the fund's inception. It also experienced difficulties with determining accountability at a local level for delivering projects and their associated outcomes.

The issues raised in relation to accountability are twofold. The first concerns the allocation of funding. The requirement of the Canadian Fund to allocate funding within a time-limited period led to insufficient scrutiny of proposals and funds being committed with little appreciation of the outcomes that would be delivered. The NSF-MH was also criticised around the allocation of funding. The process of allocating funding for the

development of new services through existing funding mechanisms, such as within unified allocations, meant that not only was the impact of the funding difficult to account for, but the funding for transformation itself was often not transparent.

The second issue is the subsequent management and delivery of transformation projects. It is clear, from the lessons on evaluation, that this is critical in ensuring funds are allocated appropriately and that there is clarity about the expected outcomes of projects and funding. Our case studies demonstrate a range of mechanisms that have been used to improve accountability. In four of the cases, matched funding was used to ensure appropriate investment of stakeholders and to embed transformation within organisations. A second mechanism is the use of milestones. The NSF-MH is probably the most notable example, whereby national and local milestones were outlined from the outset, with a clear deadline for implementation. The GEC Fund also required projects to have milestones, but the responsibility for developing and justifying these lay with the applicant. Funding allocation was based on a shared agreement between fund managers and applicants.

Beyond projects led by individual organisations, the allocation of responsibility among multiple stakeholders can create tensions. The London Challenge made a clear effort to avoid a 'name and shame' culture over performance by basing accountability on peer-to-peer support and outcomes data. Those involved in the process of deinstitutionalisation went one step further and set up independent organisations that became the conduit for funding and the transformation process, mediating between each of the stakeholder groups.

Timescale

In terms of the time needed to achieve the transformation envisaged, all four of our case studies from health care exhibited delays beyond their original plans. Interviewees from Denmark emphatically stated that 'it takes longer than you think', so some realism about timescales is important. Denmark's projects do not anticipate productivity improvements materialising until 2017 at the earliest, almost 10 years after the Quality Fund started. Despite the need to set deadlines for funding and transformation, the experience of Canada's primary care transformation is that this, in itself, can also limit the value of transformation. The process of deinstitutionalisation provides a valuable indicator of the different factors that affect timescale. Its relative success suggests that time spent on developing comprehensive plans, getting stakeholders on board and addressing workforce issues can be substantial but of great value in delivery. However, at the same time, setting deadlines can be of value in ensuring delivery, particularly where achieving key milestones has consequences for subsequent funding.

Ultimately, the timescale of a fund should have a logical relationship to its objective. Our interviewees from the GEC reported that project impacts had to be measured over an education cycle, which was sufficiently long for an evaluation to detect effects in participation rates among girls and to elicit lessons about the success (or failure) of the models for future funding cycles.

National vs local administration

Both of the mental health transformation case studies demonstrate a strong national focus. In the case of the NSF-MH, this went as far as developing a top-down infrastructure for delivery, defining implementation and allocating finances in line with this. This support was crucial to successfully driving change, particularly in areas where service development had been limited or slow.[6] The regionally administered funds in Denmark and Canada appear to have met with reasonable success, with the allocation of funding overseen nationally. The smaller London Challenge and GEC Fund had the greatest focus on local leadership, but it is notable that they included significant overarching infrastructure to support planning, maximise accountability and ensure learning. Indeed, approximately 10%–17% of the GEC Fund was spent on administration. A key component of this is ensuring access to the right expertise, including knowledge of service delivery and international development, in order to provide appropriate support, subsequent oversight of projects, and overall management of the fund.

The need for national vs local administration appears to reflect the size and scale of transformation. However, it is important to note the value of appropriate expertise and support in ensuring that projects are capable of delivering the intended outcomes and that they are sustainable. Furthermore, where transformation requirements impinge on areas under the remit of national bodies (such as workforce, payment and outcomes), national guidance can be important in supporting progress.

Unexpected consequences

Despite the best planning, our case studies demonstrate that there are always unknown and unintended consequences of transformation. In the case of the NSF-MH, for instance, some models did not translate to different localities; or, in the case of the Canadian primary care transformation, although benefits were realised from the funding, they were not necessarily those that were originally intended. The GEC Fund builds consideration of this into the funding envelope support for innovation, but there can be limitations when funding can only respond to issues that emerge as a result of transformation. Evaluation is a key part of this process; however, as the mental health case studies demonstrate, ensuring an appropriate response requires ongoing investment in expertise as well as financial support in order to respond to emerging evidence. The value of establishing dedicated leadership and organisational support, such as was achieved as part of the NSF-MH and London Challenge, should not be underestimated.

4: Key features for a successful Transformation Fund

Drawing on the experiences of the case study transformations, on our analysis of the limitations of the current arrangements (discussed in chapter 2) and on our discussions with national and local NHS leaders, we propose that the NHS establishes a dedicated Transformation Fund for England. This should be a long-term feature of the NHS funding system, recognising that the task facing the NHS to maintain and improve quality is not a one-off change programme designed to move from one steady state to another. Technological change, population dynamics and expectations are not static; they will continue to evolve, and a successful and sustainable health care system needs to evolve in parallel. This means that the task facing our health system is to become a more adaptive system that can innovate and spread new models of care and reflect continually changing needs and opportunities.

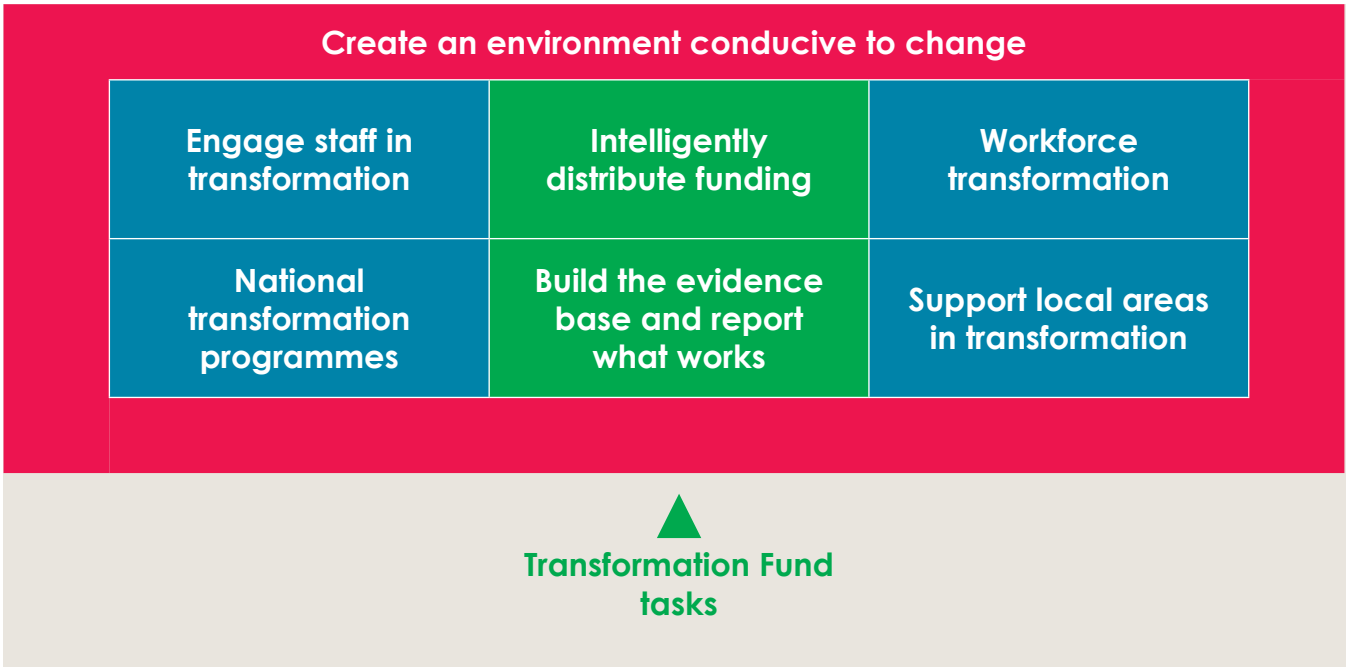
Our analysis also shows that the task and approach required for innovation is fundamentally different from that required to spread best practice. To adapt, the NHS needs to be supported to do both. We therefore propose that the Transformation Fund should have innovation and spread as twin goals, but should tailor its approach accordingly.*

Administration principles

To be successful, a dedicated Transformation Fund needs to be administered effectively. This is harder than it might appear. A fund cannot do all of the work of transformation, or solve all of the problems of the NHS, and some transformation tasks will sit outside of the Fund. Each of the national statutory NHS bodies has a role to play in making the NHS environment conducive to change and in actively supporting local areas – and they should be accountable for their results. Alongside intelligently distributing funding for transformation, support for change, a workforce strategy and broad action to engage NHS staff in change will all be needed (see figure 1 overleaf).

* The Girls' Education Challenge (GEC) Fund provides an interesting example from a different sector of how a single fund can operate differently to support these twin goals.

Figure 1: National tasks needed for NHS transformation



Our work has identified two activities that are vital for distributing funding intelligently, which should be the responsibility of the Transformation Fund:

- **Distributing and managing funding for transformation.** This goes well beyond a bidding or allocation process. Instead, it is the task of ensuring that money is being used across the NHS in the most effective way to meet the goals of transformation.
- **Building the evidence base and reporting what works.** Funding transformation represents a significant investment in the future of the NHS. Initiatives will generate much-needed evidence about what works in which contexts and the best way to spread successful interventions. It is important that this evidence is appropriately recorded, collated and synthesised – and the Transformation Fund should be responsible for this. Evaluation would be a core activity of the Transformation Fund. A failure to evaluate interventions not only has negative impacts locally but also nationally, through a failure to share learning. This is equally problematic and disempowers those seeking to transform care.

There is a case for the Transformation Fund to deliver other activities alongside these 'core tasks' – for instance, support to manage change, or national programmes for improvement. But equally, these could be provided separately by other organisations. However they are organised, they need to be closely aligned to ensure that the Fund behaves as an 'active investor' in development rather than a passive giver of grants.*

In our analysis, we focus on the core tasks of the Transformation Fund, and argue that keeping these distinct allows for clarity of purpose, and guards against scope creep.

* An active investor dynamically spreads risk over a wider range of investments in the knowledge of higher risk but seeking greater returns on average and over time, compared to the passive investor who will put money on steady and secure investment and then sit back.

As discussed in chapter 3, our analysis of the existing funding arrangements for transformative change and lessons from the six case studies suggest that there are some fundamental issues that will need to be addressed in the design of the administration of transformation funding. While there are likely to be many options for how the Fund's tasks are delivered, our work shows that there are some key principles that should be included.

- **Clear objectives:** All of our case studies emphasise the importance of clear and coherent objectives for funding, to which all transformation projects should be aligned. However, these can be specific or fairly broad.
- **Accountability:** Accountability (particularly demonstrating value for money from the investment) was challenging in all six cases. However, some benefited from a demand for national and local milestones, outlined from the outset and with a clear deadline for implementation; others used matched funding and data analytics to build accountability.
- **Leadership:** It is important that any transformation fund has effective leadership. Our case studies highlight the importance of ensuring that leadership is credible, not just in relation to the task of managing the Transformation Fund, but also – perhaps most importantly – in relation to health care managers, clinicians and professionals.
- **Expertise:** The Transformation Fund must have relevant expertise, including clinical expertise, as well as experts in delivering transformation, assessing the quality of proposals and methods of evaluation.
- **Evaluation:** Evaluation is a core component of developing the evidence base to support innovative models of care. Robust and appropriate ongoing evaluation of innovation was key in a number of the case studies. For example, although the NSF-MH did include some aspects of evaluation, it was repeatedly criticised for evaluating processes rather than outcomes. Conversely, the London Challenge is very highly regarded for its strong evaluation component, which invested heavily in both the collection and analysis of data.
- **Consider workforce requirements:** It is essential to engage and support staff in the process of transformation, as well as the public and patients. The workforce implications of transformation itself also need to be considered, particularly the need to release staff from their day-to-day roles in order to attend training and engage in new approaches to delivering care.
- **Phasing and timescale:** The outcomes expected of transformation are likely to require at least five to ten years to be realised. Moreover, a key lesson from our case studies was that transformation – particularly at scale – always takes longer than you think. A realistic assessment of timescales is essential.
- **Risk management:** The large amount of funding, the longitudinal nature of the funds, and the developmental processes involved suggest the need for a greater appreciation of the balance between risk and delivery of outcomes.

– **National vs local administration:** The balance of national vs local administration is closely linked to the size and scale of transformation. All the funds we examined had an element of both. However, it is important to recognise the importance of appropriate expertise and support to ensure that projects are capable of being delivered, provide the defined outcomes and are sustainable. This will often need to be provided at a devolved level either geographically or to relevant expert groups. Furthermore, where transformation requirements impinge on areas under the remit of national bodies (such as workforce, payment and outcomes), national guidance can be important in supporting progress.

– **Unexpected consequences:** Despite the best planning, our case studies demonstrate that there are always unknown and unintended consequences of transformation. Models may not translate to different localities as expected or the benefits realised from the funding may not only (or even primarily) be those originally intended.

The Transformation Fund in practice

Bearing these administration principles in mind, our research has led us to conclude that the Transformation Fund would be best administered by a new and independent function that has expertise and credibility with NHS clinicians and managers, who would need to be at the forefront of successful change. While this new function should link into the wider system and be publicly accountable, it is also clear that transformation requires a different approach to the traditional operational performance management and regulation of the NHS undertaken by national bodies. Upward accountability for spending, to the Department of Health and/or Treasury, would be important, as would clear accountability to those in the NHS who are seeking to implement change.

Transformative change inherently involves risks; not every good idea, even if well executed, will deliver its intended benefits. If the system takes no risks, it is unlikely ever to innovate. But these must not be unmanaged risks, and value for money and proper standards for the use of public money are essential if the system is to succeed. Our work suggests that some of the approaches taken by innovator funders, such as social finance organisations, have generated valuable lessons for the management of risk and innovation. Typically, this is a much more active and engaged approach to investing than the public sector allocation systems, which focus more on *ex ante* business cases and less on team track record and expertise. These more innovative approaches often provide phased funding, and work much more closely with projects as they develop.

Part of the risk involved would relate to the flexibility and long-termism of the funding. Sitting outside traditional funding streams and timelines would be crucial to give innovations the time and space to flourish. However, accountability would be important to avoid inefficient and ineffective change.

Alongside accountability, evaluation and learning are fundamental to the value of the Transformation Fund. Any evaluation programme must include both summative and formative learning so that the system is able to learn not just what works, but how it works as it develops. Such learning should also identify any barriers to effective implementation of new models arising from issues in the national policy or regulatory framework, so that these can be addressed.

This would require a high level of expertise and leadership; the credibility and experience of those administering the Transformation Fund would be paramount. This does not just relate to the obvious clinical expertise needed to guide development of new models of care, for example, but goes broader, in terms of expertise in administering funds, managing change programmes and understanding evaluation.

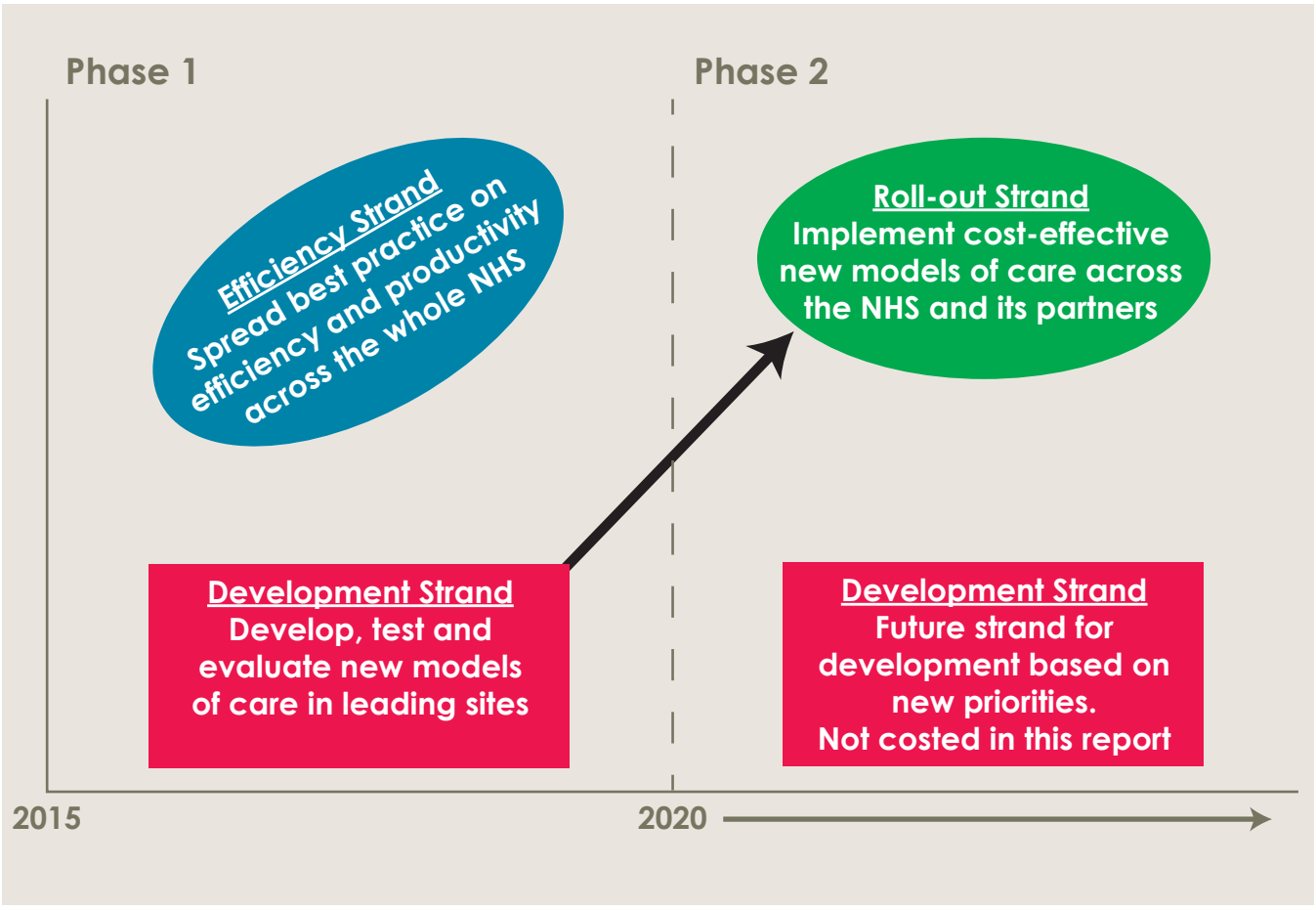
Finally – and this is of paramount importance – the Transformation Fund must be given, at its inception, a small number of very clear objectives. The multiple strands we have proposed may mean that each has slightly different objectives, but all should fall within the broad objectives of the NHS – efficiency, innovation and transformation to meet the changing needs of patients and the public.

Clearly, there are trade-offs inherent in our administration principles, and the form and nature of the Transformation Fund would depend on how those trade-offs are balanced. In designing the structure, officials would also need to balance the advantage of specific funds against complexity of organisation. Strands according to scale or project, geography, type of transformation or sector could all be considered.

5: The initial priorities for the Transformation Fund

The objectives for the Transformation Fund would necessarily change over the long term to meet new challenges facing the health system in England. The Fund's priorities must strike a balance between adapting to changing needs of the NHS and ensuring that existing priorities do not suffer from reduced focus. For this report, we have explored what the initial set of priorities should be for the Transformation Fund over the next decade, split into two phases. Figure 2 below shows how we envisage these different phases, and the strands of funding within them, being organised.

Figure 2: An NHS Transformation Fund – phasing and strands



Phase 1: 2016/17 to 2020/21

Over the next five years the NHS has two clear imperatives:

- It must change the way services are delivered across all organisations to ensure they are run in the most efficient way possible. Demand for NHS services is rising faster than the funding available. The Forward view suggests that savings of around £22bn will need to be made by 2020/21 if the quality of services is not to fall. It is not enough to ask NHS staff and organisations to identify and implement these savings without support.
- It must identify and test new methods for delivering improved, integrated care and it must reorient activities far more towards secondary and primary preventive care, in part through better population health. This will enable the NHS to better meet the needs of the population, improve quality and deliver greater long-term value for money. These changes will require well-resourced trials of new models, with appropriate evaluation.

To ensure progress, these two imperatives should be set as the first two objectives for the Transformation Fund over the next five years. We therefore propose that the Transformation Fund is initially set up with two strands:

- An **Efficiency Strand** – to support implementation of plans to achieve higher rates of efficiency growth across all services and organisations in the NHS, to ensure that current services are delivered cost-effectively.
- A **Development Strand** – to invest for a subset of the population in a range of new models of care that can test the optimal scale and nature of transformation required to redress the balance in how services are delivered to meet the needs of the future population.

The Efficiency Strand

The key aspect of the Efficiency Strand would be to identify known best practice and extend this across all organisations in order to unlock so-called 'catch-up' efficiency savings. These were identified by Monitor as offering a one-off additional savings of 5–5.5% of NHS spending in addition to the longer-term trend rate of efficiency improvement.[7]

Delivering above-trend improvements in efficiency for a sustained period will almost certainly require a very different approach to that taken in the past. It will involve a shift from setting the NHS a target, followed by tough performance management (previously described as 'targets and terrors'[8]), towards a more enabling approach – providing evidence of what works and supporting people to deliver change, while using national policy to remove barriers to effective implementation. At its heart, this is about recognising that improving efficiency is just as much a task of transformative change as the new models of care.

Lord Carter of Coles is currently undertaking a review of NHS efficiency. His interim report identified scope for around £5bn of efficiency improvements across the NHS, ranging from improved procurement practices, medicines management, employment and use of skilled staff time, and better patient flow.[9] While some of these savings may be achieved through central initiatives, most will require changes to working practices throughout the NHS.

The NHS needs to drive adoption of best practice throughout the provider system, building on existing quality improvement work and the interim results from the Carter review. This is important in the context of the financial challenge facing the NHS over the next five years, but it is also fundamental in underpinning the delivery of new models of care. These new models must be built on a platform of efficient and sustainable services in the community; in particular, it is clear that in key areas (notably primary care) current models are struggling to deliver existing core services, and without major change they are unlikely to be in a position to adapt to, and fulfil, the needs of new models of care.

The Development Strand

Testing and developing new approaches has most of the characteristics of an innovation fund; while the opportunity to improve care is clear, the practical models that can effect this change are less clear. The Forward view recognised this and, as a result, set up the Vanguard programme.[10] This programme is not the sole innovation activity across the NHS – for example, there are also integrated care pioneers, established in May 2013,[11] and nascent proposals for testing different approaches for urgent and emergency care pathways,[12] among others. Crucially, while the Efficiency Strand specifically aims to release savings for the NHS, the focus for the Development Strand is to improve both the system-wide efficiency and the quality of services provided, therefore improving value for money.

This development would be on a smaller scale to the Efficiency Strand to allow for a number of different models to be tested. We propose that this occurs in at least two waves of organisations, each representing around 10% of the population of England, with the second wave beginning a year after the first.

Phase 2: 2021/22 and beyond

The Roll-out Strand

Beyond the first phase, there would need to be a second phase of dedicated funding for change. During this second phase, the NHS would seek to roll out the successful programmes identified in the Development Strand in order to improve system efficiency and quality and, therefore, value for money across the whole of the NHS in England.

In phase 2, a **Roll-out Strand** would be required to embed the innovative models of care that have been found to deliver the best value for money, in terms of improved quality, across the NHS and partner organisations. Due to the nature of these changes – often seeking to shift care from acute settings and episodes to early, sustained support in community and home settings – there is likely to be a substantial need for double-running costs. The likely extent of these would be informed from the results of the learning and evaluation that is intrinsic to the Development Strand. This need for double-running costs was evident in our case studies, particularly in building new hospital estates in Denmark and in the deinstitutionalisation of UK mental health services.

While much of our research focuses on NHS care, there is an ever-increasing need for new models to work jointly with social care*. It is envisaged that the first phase of the Transformation Fund should collate learning on how best to do this and in what context. In the second phase (Roll-out Strand) this would be pushed further. However, until the evaluation of phase 1, the value and efficacy of more integrated care models will not be well evidenced, and so we do not make recommendations on how best to do this. Our work has sought to give some sense of potential social care costs during phase 2, but these are indicative and should be part of the detailed testing and evaluation of new models of care over the next few years.

We are keen to acknowledge that the key aim of the Roll-out Strand would be to improve the quality of services provided by the English NHS. Although in theory better quality of services should produce financial benefits, it is not necessarily true. Therefore, decisions on the level of investment should be taken with regard to value for money, rather than ability to save money.

* The interim report of The Barker Commission on the Future of Health and Social Care in England outlines the case for a single health and social care system -- www.kingsfund.org.uk/publications/new-settlement-health-and-social-care-interim

6: The size of the Transformation Fund

The scale of investment in a dedicated Transformation Fund

It is important to be clear upfront that we are unable to offer a definitive answer about the size of the Transformation Fund that would be required. Instead, we have explored scenarios, under certain assumptions, to help inform discussion around the level of investment that should be made available. Obviously, any changes to the assumptions would change the size of the Fund required. In this chapter we provide the high level results of this work. Appendix 2 contains further details of the methodology, scenarios and assumptions used.

Our case studies demonstrate that the amount of funding available has to be commensurate with the scale of transformation expected. However, there are a number of key lessons in establishing what is realistic. The first is that in each case of major service transformation, the costs were always underestimated. Second, although in several cases mechanisms for releasing savings (including sale of estate, improvements in cost efficiency and reduced service use) were a core component of the business case, they often proved hard to realise in practice – and certainly within the timescale initially envisaged.

Our analysis has been guided by the scale and spread of change required over the next five years to achieve the aims related to efficiency and innovation to improve quality. We have then calibrated this with the funding levels in the case studies and tested out these assumptions through workshops with those in the NHS who have experience of delivering major change. We have focused on services for four key groups: people at the end of life, people experiencing mental health problems, people living with other long-term conditions, and frail and elderly people. Experts in services for these groups have worked with us to develop scenarios for how these services might change to support the improved outcomes envisaged in the Forward view (see appendix 2 for more details).

In determining the costs associated with transformative change, we have drawn on our own work, including a study undertaken recently by The King's Fund on achieving better value through changes in clinical practice,[13] and the experience of the Health Foundation as a major grant funder of national improvement programmes across the NHS.[14] Finally, we sought to compare our findings with some of the early thinking emerging from some of the vanguard programme sites about the cost of developing and testing their new models of care.

Our analysis has identified four areas of investment that are common to all transformation programmes. These are:

- **staff time** – time for staff to spend away from the 'day job', developing new ways of working
- **programme infrastructure** – on national and local levels
- **physical infrastructure** – predominantly improved use of IT
- **double-running costs** – to allow new services to be set up while still providing current services.

To estimate the size of a potential Transformation Fund, we have included the costs of programme infrastructure, staff development and physical infrastructure (specifically IT) in our calculations for both the Efficiency and Development Strands.

Phase 1: Improving efficiency and developing new models of care – 2016/17–2020/21

As described in chapter 5, we have proposed that phase 1 should consist of two strands:

- **An Efficiency Strand** – to support implementation of plans to achieve higher rates of efficiency growth across all services and organisations in the NHS, to ensure that current services are delivered cost-effectively.
- **A Development Strand** – to invest for a subset of the population in a range of new models of care that can test the optimal scale and nature of transformation required to redress the balance in how services are delivered to meet the needs of the future population.

The Efficiency Strand

We assume that the whole of the NHS in England will require transformation funding to support the changes needed to deliver a rate of efficiency improvement between 2016/17 and 2020/21 that is higher than in previous periods. The key objective for this strand is to achieve efficiency growth across the NHS of 2% a year between 2016/17 and 2020/21, by supporting staff with the time and tools required to identify and implement areas for improvement.

The main area of additional investment required from the Transformation Fund has been calculated as the cost of frontline staff having blocks of time away from their day jobs to learn new ways of working. Almost all change programmes have, at their heart, the need for those working in the NHS to operate in different ways – either individually or, more commonly, as part of a team. This is as true for improving the efficiency of care as it is for developing alternative models of care. The need for investment in staff time was also a key recommendation in Lord Rose's review of NHS leadership, which stated, 'everything comes down to its people, both right now and in the future: so we must pay attention now if we are to expect results in 10, 15, 20 years.'[15]

The importance of supporting staff to develop and learn new ways of working has been widely evidenced and supported in our research. But it is much more difficult to find hard evidence to quantify this. Our work has calculated the cost of backfilling all staff for 2.5 days a year. This is not to

imply that all staff should have a standardised 2.5 days – some in clinical leadership roles will require more time to devote to developing and leading these changes, while others will need less time. Perhaps the biggest barrier to the pace and effectiveness of change will be the feasibility of releasing front-line staff from their day-to-day work for blocks of time when the NHS is finding it difficult to recruit and retain sufficient staff in key groups. Our analysis factors in a cost premium for backfilling staff of around 30%, but it still may be difficult to get sufficient staff with the requisite skills to change ways of working at the pace envisaged by the Forward view.

We also considered the area of IT investment. Despite concerns about the legacy of major IT projects in the NHS and wider public sector, it is clear that new technologies offer significant scope to improve efficiency in service delivery, and the NHS has a long way to go to realise the potential savings in a systematic way across the service. The most intensive investment in IT in the NHS to date was the National Programme for IT (NPfIT). Between 2002 and 2012, the total investment was around £9.3bn (2015/16 prices)[16] or £900m a year. We do not foresee further investment on this scale in the next 10 years, but we used this as a guide, assuming that the required investment is worth around a quarter of this.

We estimate the programme infrastructure costs based on a benchmark of £5 per head of population in England per year. This is below the level of most of our case studies (see table 1), but is predicated on much of the existing leadership, finance and operational management resources in the NHS being focused on this issue.

This provides a cost estimate for the Efficiency Strand at just over £1bn a year between 2016/17 and 2020/21. This level of investment would be made in the expectation of it increasing the rate of efficiency growth from recent trends to the 2% outlined in the Forward view. Studies show that recent performance has been significantly below this rate; research estimates range from 0.4% to 1.2% a year.[17]

The Development Strand

The purpose of the Development Strand would be to support the development and testing of innovative models of care to improve the quality of NHS services. We have assumed that these programmes would be split into two waves, each covering 10% of the English population. The first wave would receive funding from 2016/17 and the second from 2017/18.

We have assumed that the investment programme infrastructure and IT are proportionally similar to the phase 1 Efficiency Strand described earlier. But we assume that these areas will require a greater investment in staff time due to the complexity of the changes to working practices and roles (including cross-organisational roles). We have therefore costed staff time at five days a year, instead of 2.5 days, focused on developing and learning new ways of working.

We have then included an element of double-running costs, to increase capacity in out-of-hospital systems. They include, among other things, additional GP consultations and community health service contacts. The method for estimating these is briefly described in the phase 2 section below, and described in more detail in appendix 2.

We have assumed that sites included in the first wave will already have well-developed plans for transformation of services, and so will begin investing in new services immediately. Therefore, we have included double-running costs from in the first year. However, those in the second wave, beginning in 2017/18, are likely to need additional time for planning, and so we have not included double-running costs until 2018/19.

Under these assumptions, the Development Strand would require funding that increases from £400m a year in the early stages and peaks at around £1bn between 2018/19 and 2019/20, before falling back in 2020/21 to £700m as some off-setting savings are realised.

Table 3 shows the level of funding that should be dedicated for transformation across these two strands over the next five years. It increases from £1.5bn a year in 2016/17 to £2bn a year towards the end of the decade. This is around 1.3% of all NHS resource funding.*

Table 3: Transformation Fund costing 2016/17 to 2020/21 (2015/16 prices)

	2016/17	2017/18	2018/19	2019/20	2020/21
Efficiency Strand	£1.1bn	£1.1bn	£1.1bn	£1.1bn	£1.1bn
Development Strand	£0.4bn	£0.8bn	£1.0bn	£1.0bn	£0.7bn
Total Transformation Fund	**£1.5bn**	**£1.9bn**	**£2.1bn**	**£2.1bn**	**£1.8bn**

Phase 2: The roll-out of new models of care – 2021/22 and beyond

For this report, we have focused on one strand for phase 2: the Roll-out Strand. The key aim of this strand would be to roll out across the rest of the NHS in England the innovations that were shown to be successful in the Development Strand. By this time, we envisage that the Transformation Fund would be imbedded in the NHS funding system. It is likely that new priorities would require additional strands alongside the Roll-out Strand, but we have not speculated on these here.

As in phase 1, the Roll-out Strand would require investment in staff time and in physical and programme infrastructure. In addition to this, the Roll-out Strand would also need a substantial budget for double-running costs as new models of care are rolled out. Because of this, the investment required would be likely to be much higher than in phase 1, with less scope for financial return on investment. It is crucial to make decisions on this phase with regard to quality of services and value for money, rather than a pure focus on reducing costs.

It is unrealistic to assume that a large-scale investment in more community and primary care-based services designed to reduce hospital care would have an immediate impact. Rather, current services will need continued funding while the new services are established. This is a strong message coming from the experiences of transformation in our case studies, and

* Planned Resource Department Expenditure Limit for the NHS in 20151/6 is £112bn (Summer Budget 2015: www.gov.uk/government/uploads/system/uploads/attachment_data/file/443300/50325_HMT_Red_Book_Complete.pdf)

one that was reinforced through our workshops and meetings with experts. The level of double-running costs, precise timing, and the scope and magnitude of off-setting savings are all subject to significant uncertainty. As recent work by Monitor has highlighted, much of the gain from new models of care may be in quality rather than direct cost savings.

We have undertaken some scenario modelling to explore the potential scale and timing of double-running costs beyond this decade; further details of these scenarios are provided in appendix 2. This modelling is highly speculative and is included to provide a sense of scale for the numbers. A true picture of the scale of investment required would only be available after the results from evaluation of the Development Strand of phase 1.

The scenarios explore how patterns of service use might change for key groups of patients (those with mental health problems, the frail and elderly, those at the end of life and those with long-term conditions) as delivery of services are redesigned to better meet their needs.

Our approach builds on a model that we use to create projections for total spending on different NHS service types to build a bottom-up estimate for total spending.* By adjusting the assumed rate of growth in spending on different services** under different scenarios, we can create a range of estimates for possible investment in double-running costs. Table 4 sets out at a high level the range of assumptions we explored for different services, showing adjustment to trend growth that we tested. By taking different combinations of these assumptions, we estimated a range of scenarios of the total investment required.

We estimate the scale of additional costs over and above the current trend of demand for NHS services (this is the red area above the trend line in figure 3, overleaf), having allowed for some off-setting efficiency gains to account for the results of phase 1. These new models are then estimated to result in lower use of some services, mainly due to reduced hospital admissions (represented in figure 3 by the shaded green area below the trend line).

The scale of any double-running costs is therefore dependent on three factors:

- upfront costs associated with new services
- the time lag between new services being put in place and the demand for existing services changing (for example, how long before more proactive management of chronic disease reduces the proportion of patients requiring admission to hospital for emergency care?)
- the scale and value of the impact of new models of care on patients' overall use of health services.

* Initially developed by the Nuffield Trust (Roberts et al. 2012) and further developed by the Health Foundation for the NHS Funding Projections Overview (Roberts 2015)

** Including admission to hospitals, outpatients, A&E, GP visits, mental health contacts, community services, pharmaceuticals

Figure 3: Illustration of double-running costs beyond 2020/21

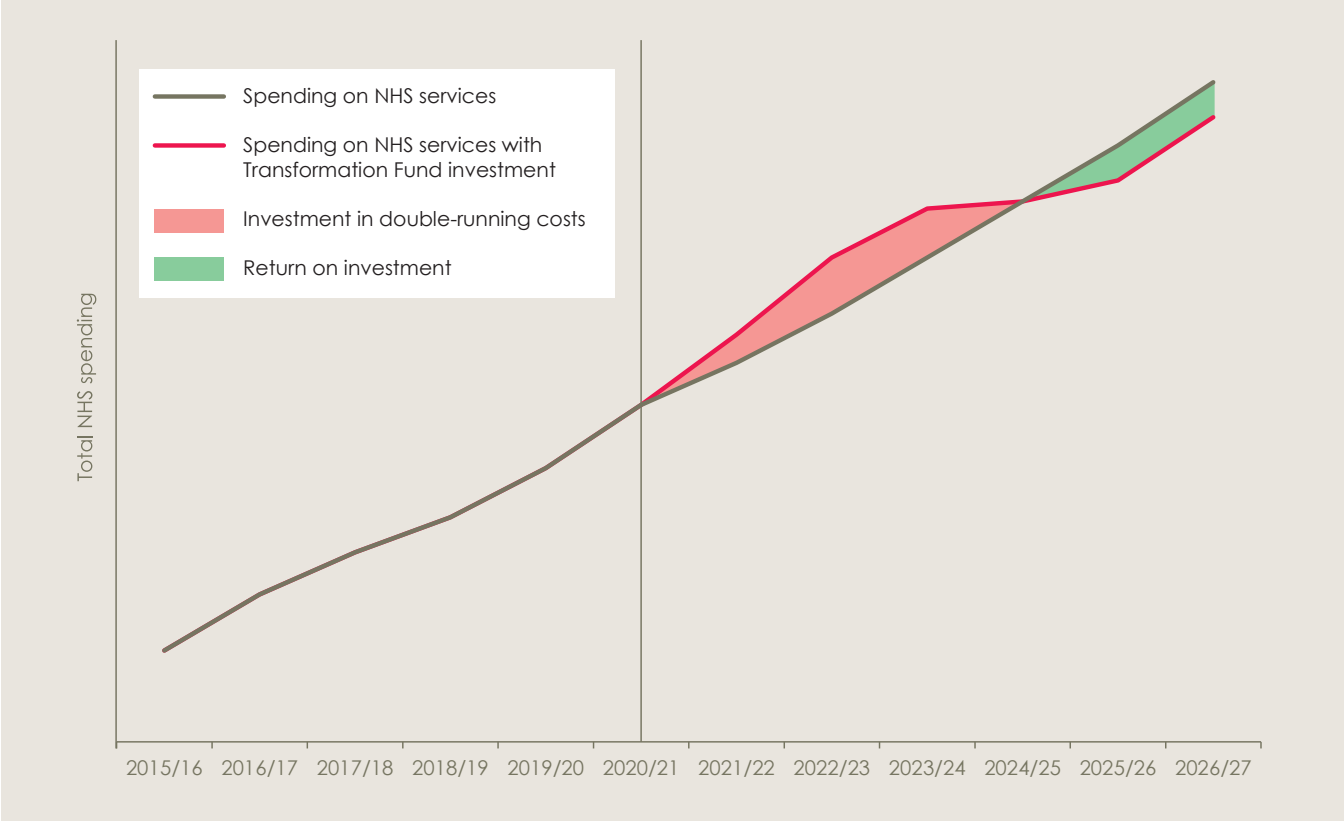


Table 4: Assumed changes to trend in demand for services

Section	Lower bound	Base case	Upper bound
GP visits (growth in number of visits per person for the over-70s)	0.5 visits	1 visit	2 visits
Prescriptions (% increase proportional to GP visits)	Linked to proportional increase of GP visits		
Community (% growth in activity)	5%	10%	15%
Mental health (% growth in prevalence)	5%	10%	15%
Outpatient visits (% reduction in visits)	-10%	-15%	-20%
Average length of stay (reduction – calculated from economic model as share of difference between population group and the 'base')	1/4	1/2	3/4
Non-elective inpatients (% reduction)	-10%	-20%	-25%
A & E (% reduction)	-5%	-10%	-15%

Our analysis shows that under plausible assumptions, double-running costs might range from:

- a central scenario of £2.5bn a year, for four years. The benefits mean that this would be recouped due to cheaper running costs after 13 years
- a best-case scenario of £1bn a year for two years, recouped after four years
- a worst-case scenario of £5.5bn a year for four years, which results in a more expensive system and therefore is never recouped.

This reinforces the point from all our case studies that savings from new models of care are not guaranteed. This does not necessarily mean that the investment should not occur, as it can result in a dramatic improvement in quality and therefore an increase in value for money. However, it is essential that the NHS rigorously learns what works, how it works, and understands the full range of benefits, before embarking on a widespread roll-out of particular programmes of transformative change.

Impact of new models of care on the costs of social care

In this report we have focused on the costs involved in improving the way that NHS services are delivered. However, there are clearly other aspects of social investment that will have an impact on NHS services, most notably social care.

While we have not specifically modelled the costs of social care, recent projections from the Personal Social Services Research Unit (PSSRU) show that public spending on adult social care would need to rise by £8bn between 2015 and 2025 to meet rising need under the current system (2015/16 prices).[18]

If we further assume that the Roll-out Strand of the Transformation Fund requires extra investment in social care at the same rate as for community services (ie, an extra 10% above trend between 2021/22 and 2023/24), this would require an additional £2bn on top of the £8bn estimated by PSSRU.

We acknowledge that other areas of social spending, such as education and social housing, will have an impact on health care services, but this was beyond the scope of our work.

7: Resourcing the Transformation Fund from surplus NHS estate

While it is not possible to determine the exact size of the Transformation Fund required, it is clear that overall investment in the NHS needs to be much greater than it is currently. This may require the government to look at additional sources of funding.

Unused NHS estate is often cited as a potential source of additional funding. As part of our work we explored whether, in the context of a Transformation Fund, it might be possible to release capital relatively quickly by selling surplus estate and pooling this at a national level to fund transformation across the NHS. According to data submitted to the Department of Health in 2014, just over 650 hectares of NHS trust and foundation trust estate was surplus or potentially surplus, while NHS Property Services listed 59 sites as available for disposal.

Our detailed work on the potential for using surplus estate to resource a Transformation Fund is included in appendix 3. Below, we set out the key issues and conclusions from this part of our work programme.

Releasing value from surplus estate

A simple calculation of the value of the estate (using information from previous estate sales to derive an average value per hectare) suggests that selling estate reported by NHS trusts and foundation trusts as surplus in 2014 could generate approximately £700m. Applying a similar calculation to the 59 vacant sites held by NHS Property Services (albeit based on the number of sites, rather than hectares) suggests that these might generate approximately another £30m.

However, it is unlikely that these figures reflect the full value of surplus NHS estate. They do not capture unused estate that has not been reported as surplus, or land and buildings that would become surplus with only moderate investment or reconfiguration. Moreover, these figures exclude the potentially huge value that might be generated by improving overall levels of estate utilisation and management across the NHS – something that currently varies significantly between organisations – in order to free up additional land and buildings.

Some methods used to calculate the value of surplus NHS estate (and some other assets) have sought to capture this additional value and, consequently, have produced figures significantly higher than £700m. In its 2013 report *Closing the NHS funding gap: how to get better value health care for patients*,[19] Monitor estimated that the potential value released if all

trusts were to manage their assets as efficiently as the best half or quarter (across the acute and mental health sector) could be up to £7.5bn. However, it noted that it would be difficult to fully realise these savings in practice for several reasons, including the challenge of selling portions of assets.

Recognising these complexities, it appears that surplus NHS estate is most helpfully considered in three broad categories, as follows.

- **Surplus estate that is immediately saleable:** This refers to vacant land and buildings that have been identified as available for sale within the next one or two years. On the basis of previous sales, it is possible to estimate a value of approximately £700m–£750m.
- **Vacant or underused estate that could be released in the medium term with some reconfiguration and/or development:** This includes land and buildings that are disused but have not yet been reported as surplus, as well as sites that are underused and could be released in the medium term through moderate strategic reconfiguration. The potential value of this is not known, but even if it were to double the total volume of estate currently identified as surplus, it would generate only another £700m–£750m.
- **Estate that could be released in the longer term if significant changes were made to its configuration and management:** This recognises the huge variations in the utilisation and efficiency of the NHS estate, and the absence of clear incentives for individual organisations to release land and buildings. It is not possible to estimate the value of this estate with any accuracy.

In addition, there may be opportunities for realising value from surplus estate other than through sale. NHS organisations could seek to generate revenue by working with other local organisations or the private sector to develop and/or lease out estate they no longer use. There are some examples of this already, such as trusts leasing land to housing developers in return for a share of the rental income generated. NHS Property Services is also beginning to take on a role in strategic projects at a local level that seek to link estate development with improved health outcomes.

Moreover, it may be possible to take forward this and other more innovative approaches at a national level as a means of generating a new, long-term funding stream for the NHS. For example, the Department of Health could enter into a partnership or joint venture with a private sector developer, offering shares in the NHS estate in return for equity. This would provide funding for the development of NHS estate, either for social housing or commercial purposes, thereby generating an ongoing revenue stream for the joint venture. As the majority shareholder, most of this would flow back to the Department. This model could be applied to surplus estate or estate still in use by the NHS. It would have the advantage of the Department of Health retaining ownership (and management responsibility) of the estate, while increasing its overall value and keeping the option of sale at a later date.

Of course, the practical and legal implications of this approach are likely to be significant and would need to be worked through in detail. It is therefore unlikely to provide the support required for transformation in the immediate

term. However, there are examples of this model having been successfully applied in other contexts, such as land held by the Crown Estate*, and it undoubtedly warrants further exploration. In the longer term, this type of approach may be able to make a major and sustainable contribution to funding the later phases of transformation (the Roll-out Strand).

A final consideration in the context of any approach to unlocking value from the NHS estate is the incentives for individual NHS organisations to participate. Within the current system, foundation trusts and NHS trusts are usually entitled to retain the proceeds from a disposal (although NHS trusts need approval from the NHS Trust Development Authority to retain receipts above £5m). NHS trusts and foundation trusts typically use the proceeds from sales to invest in services and existing estate, and any plans for disposing of land or buildings tend to be linked to plans to develop new or existing services. As such, there are currently limited incentives for trusts to return the proceeds from land sales to central government, or even to pool these at a regional level. Any system seeking to pool these resources would therefore need to consider how individual organisations could be incentivised to participate.

What does this mean for resourcing a Transformation Fund?

It appears that the value that could be realised from surplus estate in the immediate term (when it is needed) is not of sufficient scale to support the transformation needed. A different approach will be required to ensure that a Transformation Fund is sufficiently well-resourced to support the changes required.

It seems likely, however, that significant further value could be released from surplus estate through reconfiguration and improvements in estate management over the longer term. We suggest that detailed work is undertaken to develop a clear understanding of estate utilisation and the factors that drive this, and to identify options for increasing utilisation levels across the NHS.

In addition, there may be significant opportunities to use innovative approaches to release revenue from all NHS estate, rather than capital receipts. These approaches are relatively new and require further exploration. However, given the potential gain, we recommend that significant work is undertaken to understand the full implications and potential of joint ventures as a new and innovative approach to raising funds for the NHS, as well as generating benefits for the wider economy.

Finally, as noted, there are currently limited incentives for NHS trusts and foundation trusts to return capital receipts to central government, and in recent years policy has seen the increasing devolution of responsibility for land to local NHS organisations. Reversing this trend would mean a fundamental shift in culture/relationships between central government and local areas. This issue would therefore need to be considered carefully in any plans to use these resources for a Transformation Fund, and in arrangements for its administration.

* For example the Regent Street Partnership, established in 2011, which saw Norges Bank Investment Management acquire a 25 per cent leasehold interest in the street. www.thecrownestate.co.uk/urban/regent-street/

8: Conclusion

There can be no doubt that the NHS is facing a period of unprecedented challenge. Changing population needs and a prolonged funding squeeze have left it under intense financial and service pressures. 'Business as usual' is not sustainable. But that does not mean the NHS is fundamentally unsustainable. As the recent Forward view made clear, there are sustainable models for the health service that will secure high-quality, efficient and effective care for the population. But these require the service to change fundamentally. For years, this has been recognised by national and local leaders, policy makers, commentators and those on the front line, but progress has been slow. The imperative to change is strong, but it is not sufficient to transform a service that affects every citizen in our country and employs more than a million people. Now, more than ever, we need a new explicit strategy to accelerate needed change: we argue this should include dedicated funding to support transformative change, aligned with more effective practical support and the right policy context to enable change.

While the challenges facing the NHS are urgent, the need to change is also enduring. A successful health and care system will be one that can adapt and respond to the needs of the population it serves and the environment in which it delivers care. Transformation must not be seen as a one-off project but as a way of operating – part of the DNA of our health service and its funding system.

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The Health Foundation
90 Long Acre
London WC2E 9RA

T 020 7257 8000

Registered charity number: 286967
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For more information, visit:
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The King's Fund
11–13 Cavendish Square
London W1G 0AN

Tel: 020 7307 2400

Registered charity number: 1126980

For more information, visit:
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ISBN 978-1-906461-65-2