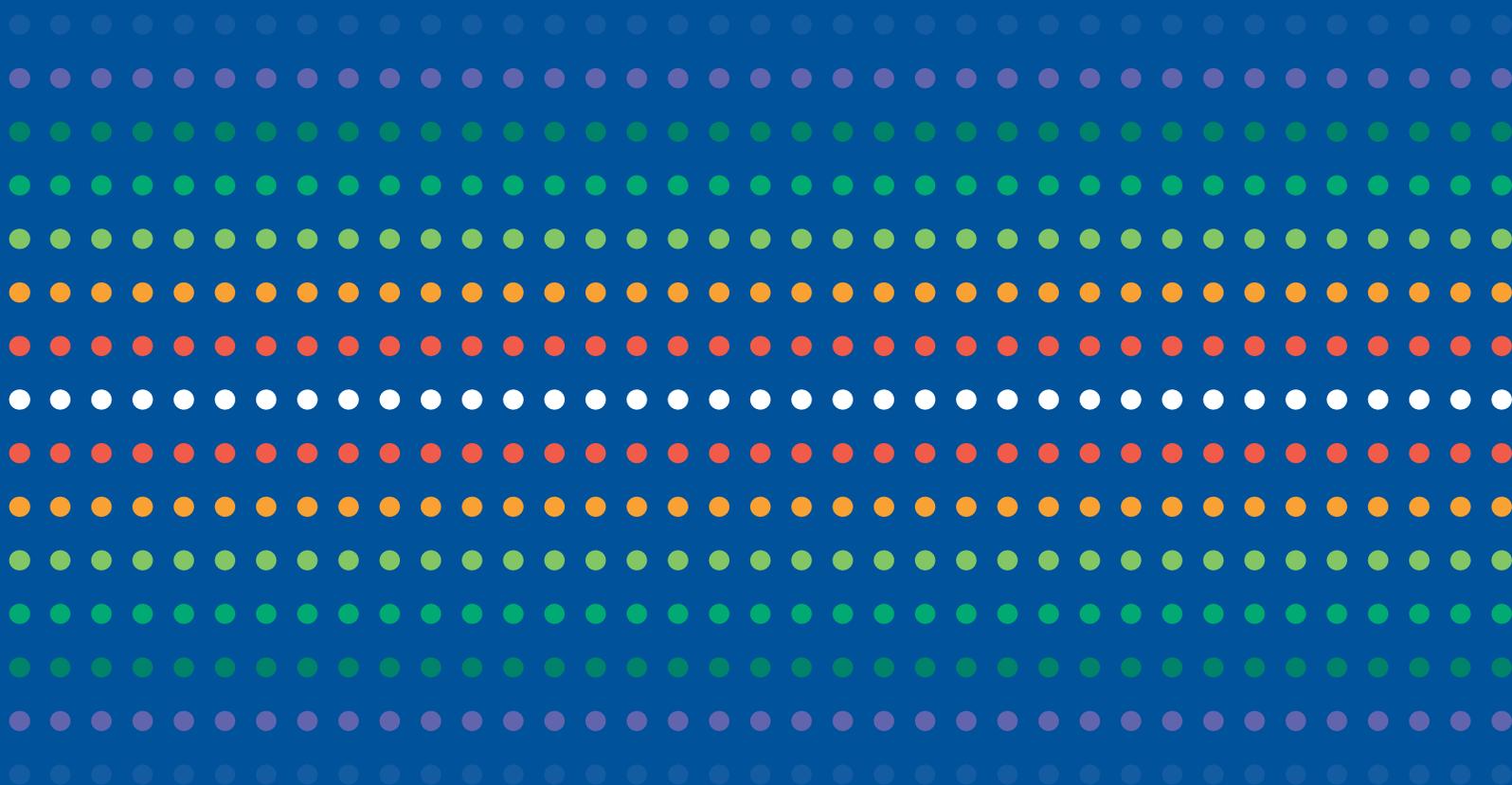


NHS 2010–2015: from good to great. preventative, people-centred, productive.





NHS 2010–2015: from good to great. preventative, people-centred, productive

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
December 2009

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Foreword by the Secretary of State for Health



Fifteen years ago, the National Health Service had sunk to such a low ebb that many voiced doubts over its long-term survival.

Today, it is in a strong position with high levels of public support.

It is a huge turnaround in fortunes and a great success story. A decade of investment has given the country a capable, resilient and self-confident health service ready for the challenges of a new era.

Yet, while we celebrate its progress, it would be wrong to over-claim for the NHS. It has gone from struggling to generally good. But I know it can be even better.

For all its strengths, it can at times still put its own convenience before that of its patients. It is not yet as good as it could be at promoting good health. And, in places, care has fallen below the standards all patients have a right to expect.

So, as we approach a new decade, it is time to set a new ambition: to take our improving NHS from good to great. For me, this means a new drive towards a more preventative

and people-centred service – better for patients, but also more productive.

Meeting the productivity challenge is crucial to its continued success. Where once it was all about building up capacity, now all our efforts must be on getting more for the public and the taxpayer from this expanded system.

This five-year plan maps out how this journey of improvement in our NHS will continue in a new financial era. It is intended to give people working in the NHS a clear sense of direction and time to plan for the challenges ahead.

Next year, the NHS will receive a substantial increase in funding and the Pre-Budget Report has confirmed that this uplift will be locked in to frontline budgets for the two years that follow.

This means we can lock in the achievements of the last decade. Our waiting times targets will become permanent rights in the NHS Constitution.

But we will go further and give patients more choice, convenience and control over their care. And we will make the symbolic shift towards an NHS that puts people first by linking payment to patient satisfaction.

The NHS has cause for optimism – but we must be under no illusions about the scale of the challenge before us. Services will need to be reshaped if we are to achieve this vision. And, because of this, we will be more dependent than ever on the resourcefulness and commitment of NHS staff.

The NHS is all about people and its staff are its greatest asset. I know that it matters to staff at every level that they work for the NHS. So I want to support them through this period of change and empower them to make the changes we need.

The NHS, and the values it proclaims to the world, is one of the best things about Britain today. It is by recommitting ourselves to the task of improving it in the next decade that we will secure public support for a universal service based on those values over the course of this century.

A handwritten signature in black ink that reads "Andy Burnham". The signature is written in a cursive, flowing style.

Andy Burnham
Secretary of State for Health

chapter 1

implementing our vision: a preventative, people-centred, productive NHS



Introduction

- 1.1** The NHS is entering a new era. It has expanded and improved over the past decade. Now, to keep moving forward, we will have to focus our energy on getting more for the public from a much-expanded, more capable and resilient system.
- 1.2** The NHS has made huge progress over the last decade. Benefiting from unprecedented, sustained investment, and drawing on the outstanding hard work of its staff, it has put right a decade of neglect. The care the NHS provides to patients has demonstrably improved, moving in the broadest sense from sometimes poor and occasionally good, to largely good and occasionally great.
- 1.3** Now our challenge is to accelerate this quality improvement, creating services that are not just good, but universally great, increasingly designed around the needs of the individual and accessible to all. In doing so, we will continue to ensure that NHS values are at the heart of what we do and we remain committed to tackling inequalities and promoting equality.
- 1.4** To keep the NHS moving forward in the next period, services must also be more productive. This will mean change on an unprecedented scale for patients and staff. It will mean hard choices about resources and priorities. We will help people through change, protecting patients and supporting staff. More productive services can and should also mean better services for the public – more preventative and people-centred.
- 1.5** This will be the greatest challenge the NHS has taken on in its history. Our ambition must match this. It demands an acceleration of the improvements in quality we seek and a deepening of our programme of reform. To achieve this, the NHS will need to work with a wide range of partners. One of the most important will be social care services. However, here we focus on the challenge for the NHS.
- 1.6** Building on and implementing Lord Darzi's vision set out during the NHS Next Stage Review, this document makes clear that meeting this challenge means putting more power in the hands of patients and continuing to harness the skills and leadership of NHS staff to the full. It provides us with a route map to take us into and through a new, challenging period for the NHS. It gives NHS organisations a clear sense of the challenges ahead for the next five years, and through these proposals, a strong basis on which to plan for the future. And, as we set out in *Building Britain's Future*, it gives patients and the public certainty that a high-quality, prevention-focused NHS will be there for them when they need it.

Building on firm foundations

- 1.7** By 1997, the NHS was suffering from decades of underinvestment. Waiting times were high, quality in its broadest sense was variable and a 'postcode lottery' had developed, as local NHS organisations took different spending decisions.

- 1.8** Compared with countries around the world, the NHS was underfunded. Putting this right was a prerequisite. A decade of record, sustained investment means that funding has doubled in real terms over the last 12 years and is now on a par with countries around the world – health expenditure is now almost exactly the average among OECD countries. A decade ago it was 10% less than the average.¹ Funding is now close to EU average spending levels, meeting the goal we set a decade ago.
- 1.9** This funding has allowed the NHS to grow and to renew its infrastructure. The NHS workforce is now at its highest-ever level – 1.4 million in 2008. Compared with 1997, there are now over 89,000 more nurses, 44,000 more doctors and 10,000 more consultants.
- 1.10** National targets on waiting times and national standards for the major killer diseases – cancer and heart disease – were set to respond to patients’ concerns. NHS Direct was established to provide health advice and information 24 hours a day, 7 days a week.
- 1.11** Reforms were put in place to give patients greater choice and control over their care, as well as access to far more information about the quality of that care. Over 125 NHS foundation trusts have been set free from central government control, and third sector organisations, social enterprises and the independent sector are delivering more care, in new ways. Payments to hospitals and rewards to GPs now more accurately reflect the work they deliver and have improved efficiency. There is a transparent system of regulation to ensure that, wherever patients choose to go, services meet basic requirements on safety and quality. More services have been put in place to support people to stay healthy, such as an extensive network of NHS Stop Smoking Services, which have helped 2.4 million people to quit smoking in the last 10 years.
- 1.12** And, as a result, care has improved. Fewer people now die from heart disease and cancer – with mortality rates among under-75s decreasing by 47% and 19% respectively, since 1995–97.² We are making good progress on delivering our Public Service Agreements, with numbers of methicillin-resistant *Staphylococcus aureus* (MRSA) and *C difficile* infections continuing to fall.
- 1.13** NHS waiting times are now the shortest they have been since NHS records began.³ The average wait for inpatient treatment is now 4.5 weeks compared with over 13 weeks in 1997. The 18-week target was achieved early at a national level and is now routinely met across the NHS.
- 1.14** Variation in access to drugs has been significantly reduced through the

1 *Health at a Glance 2009*, Organisation for Economic Co-operation and Development, 2009, www.oecd.org/dataoecd/55/2/44117530.pdf

2 *Mortality target monitoring: update to include data for 2008*, Department of Health, October 2009, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_106776

3 www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/18WeeksReferraltoTreatmentstatistics/index.htm

creation of the National Institute for Health and Clinical Excellence (NICE) and the introduction of a specific patient right to NICE-approved drugs. Where once these decisions were left to be taken locally, they are rightly now taken nationally.

- 1.15** Patients' ratings of the overall quality of care they receive are high. Some 91% of patients treated in hospital consistently rate the overall quality of care as 'good', 'very good', or 'excellent', and 91% of patients are 'satisfied' or 'very satisfied' with the care they receive at their GP surgery or health centre.
- 1.16** These improvements have been internationally recognised. The recent Commonwealth Fund survey⁴ interviewed primary care physicians from 11 countries about their perceptions of their country's primary care system. The UK ranked between first and third on the majority of the areas discussed.
- 1.17** This impressive progress gives the NHS a strong platform on which to face the challenges of the future.

Facing the challenges ahead – accelerating quality improvement for all

- 1.18** Standing still is not an option. As Lord Darzi last year identified in *High Quality Care for All*,⁵ despite the improvements over the last decade, particularly in cardiac care, mental health care and cancer care, there is

considerable room for improvement. Convenience for the system too often takes precedence over convenience for patients. There is still too much variation in the quality and safety of care, for example in stroke care, as the latest OECD report shows.⁶ And there are cases where care has fallen below acceptable standards. There is much more to do in terms of access, for example to increase the very poor screening rates for patients with disabilities, and to do so in a way that is centred on the needs and personal situation of the patient, not at the convenience of the service. There is still too much care organised in hospitals, which best practice shows could be organised around patients at home or in community settings. Care provided by different professionals and organisations is insufficiently well integrated around patients. While improved quality and reduced costs have resulted from some improvements, such as the reductions in rates of MRSA, this now needs to apply more broadly. Over all, services are not as preventative, people-centred and productive as they could be.

- 1.19** The NHS has to respond to the six challenges faced by all modern healthcare systems: ever higher patient expectations; an ageing society; the dawn of the information age; the changing nature of disease; advances in treatments; and a changing workforce.

4 Schoen C et al. 2009. A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences. *Health Affairs Web Exclusive*, 5 November: 1171–1183, www.commonwealthfund.org/Content/Publications/In-the-Literature/2009/Nov/A-Survey-of-Primary-Care-Physicians.aspx

5 *High Quality Care For All: NHS Next Stage Review Final Report*, Department of Health, June 2008, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

6 OECD Health Data 2009, www.oecd.org/document/30/0,3343,en_2649_34631_12968734_1_1_1_37407,00.html

1.20 This improvement in quality must be accelerated to ensure that the NHS is fit for the new era. Now that funding levels have caught up with comparable health systems in developed countries, they can now stabilise. Our challenge is to adjust the system to this period of lower growth.

1.21 Spending on the NHS has more than doubled in real terms since 1997. We are already committed to substantial growth in NHS resources next year and there will be no going back on that commitment. We are now taking that further and we will protect front-line NHS spending for the following two years to 2012/13. By making tough efficiency savings this will mean we can continue to increase real term resources available for patient care, year by year.

1.22 Alongside this commitment to increase frontline NHS funding in line with inflation, we have also set out the quality and productivity challenge the NHS needs to meet. As the NHS Chief Executive, David Nicholson, set out, this requires the delivery of £15-20 billion in efficiency savings over the three-year period from April 2011. There is an interim challenge of £10 billion efficiency savings by 2012/13, including quality improvements. This combination of funding and efficiency will allow us to accelerate quality improvement across the NHS.

1.23 Savings will have to be made in every part of the NHS. We recognise that this scale of transformation cannot be delivered from Whitehall: the NHS locally and regionally is best placed to identify savings based on their circumstances and priorities. Work so

far has already identified specific areas of potential, including on the following:

- Creating an empowered, flexible, healthy and productive NHS workforce. We estimate that enabling all hospitals to meet the levels of staff productivity currently achieved by the best could annual deliver savings of up to £3.5 billion.
- *Putting the frontline first: smarter government*, published earlier this week, made clear the Government's intention to drive down the costs of management, back office support functions and procurement across the public services. The NHS must lead the way in this and we estimate that annual savings of up to £1.8 billion are achievable.
- Our vision will require significant transformation in the way in which care is delivered in the future. Transforming the care and lives of those with long term conditions and delivering truly integrated, efficient and people-centred community services has the potential to improve the quality of millions of peoples lives. It will also release annual savings of up to £2.7 billion by enabling people to better manage their own conditions, treating them closer to their own homes and avoiding unnecessary hospital visits.

1.24 We will also continue to test all SHA and DH funding for further efficiencies and pass over these additional savings to the NHS. But critically we must also ensure that pay and workforce contracts are also aligned with the needs to release savings and we outline our approach at paragraph 3.30.

1.25 Every penny of these savings will remain within NHS budgets, allowing us to respond to rising demand and to realise our vision of high-quality care for all. In particular, it will allow us to:

- implement the ten regional Next Stage Review visions for improving services across eight key patient pathways;
- ensure that patients have access to all NICE-approved drugs and technologies and approved vaccines; and
- respond to increasing pressures resulting from changing demographics and rising patient expectations.

The NHS will draw on the creativity and ingenuity of its staff to redirect resources across the system.

1.26 In previous periods of financial challenge, patients have borne the brunt of the impact – through longer waiting times, reduced availability of drugs and treatments, and, ultimately, poorer-quality care. That course of action is indefensible when the scope for improving quality and productivity is still so great. Patients should not pay the price of change.

1.27 Achieving this will only be possible if NHS staff, and particularly clinicians, lead the changes we require. Clinical teams will need to look at their own practice and, in many cases, change it to make sure that it is fully in line with current best practice. And they will need to work together with managers to take responsibility for care along whole pathways, not just within the organisation they work in – diverting resources further upstream. Roles for NHS staff will also change as models

of care change in this way. But we are committed to supporting staff to make the changes necessary to shape services around the needs of patients.

1.28 This will mean widespread change to the way that the NHS will look and feel. More care will be provided closer to people's homes and those services must be better integrated around people's needs. Hospital-based care will be re-structured to support this change and concentrate on providing care for the sickest patients. Patients and the public will need to engage in a debate around the future shape of the NHS and the need for services to change, in order for the NHS to deliver increasingly preventative, people-centred and productive services.

The NHS 2015

1.29 Our focus will therefore be on protecting and improving frontline services, supporting NHS staff to make these services more preventative and people-centred, to lock in the progress made in the last decade, and to focus on creating productivity gains on a scale never before achieved by the NHS.

1.30 Our commitment remains to implement the vision set out in *High Quality Care for All* and put quality at the heart of the NHS. The NHS must treat all its patients safely and effectively, ensuring that their experience of the care they receive is as positive as possible. Providing high-quality care for all patients has always been important to clinicians. This is now the basis on which the whole system must be organised – and as productively as possible. Delivering this vision across the NHS will require

co-ordinated, complex action, driven from every part of the system, starting with every clinical team, and leading to fundamental change.

1.31 Our starting point must be to build on the improvements we have already made. The NHS Constitution⁷ both locks in these improvements, ensuring that the NHS cannot slip back to the poor standards of the past, and reinforces our ambition to create truly preventative, people-centred and productive services. It brings together in one place what the NHS does, what it stands for and the commitments it should live up to. It describes the values and enduring principles of the NHS and gives individual, legally binding entitlements to staff, patients and taxpayers – the public – so that they know exactly what they have the right to expect of the NHS.

1.32 By putting power in the hands of people we have created a powerful engine for reform. Where once we had to rely on national targets to drive improvements, we can now drive change through the influence of patients. This will be the basis on which we renew our vision for the future.

1.33 We will make more use of information-based technologies to design new models of care as well as improving the performance of existing services. We will integrate information around the patient, deliver relevant information at the right time to clinicians and use technology to drive efficiency for both patients and clinicians.

1.34 Research and innovation have a key role to play in delivering our vision. That is why the NHS Constitution restated the commitment of the NHS to innovation and to the promotion and conduct of research to improve the current and future health and care of the population. As we move into a more challenging financial climate, research and innovation will become even more important in identifying the new ways of preventing, diagnosing and treating disease that are essential if we are to continue to increase both the quality and productivity of services into the future. However, the impact of the NHS reaches much wider: the NHS is a key contributor to the economy through the local jobs it provides and the medicines and medical technologies it purchases. The growing partnership between the NHS and the life sciences industries in the areas of research and innovation is of vital importance in providing the UK with the international competitive advantage necessary to increase national wealth as well as increasing national health over the coming period.

1.35 Additionally, we consider that a more productive health service is also a sustainable health service for the future, in societal, economical and environmental terms. Indeed, ensuring that environmental impacts are taken into account in the design and delivery of healthcare will encourage reduction in wasteful products and services and will maximise the use of all types of resources for the most beneficial health gains.

⁷ *NHS Constitution for England*, Department of Health, January 2009, www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm

1.36 Whether it is the values that drive what we do or the processes that determine how we do it, we will remain committed to tackling inequalities and promoting equality. There is, however, a good deal we need to do to ensure that the NHS attains the highest possible standards of care for everyone, regardless of individual preferences or place. This means challenging perceptions and attitudes and fulfilling the legal responsibility of each NHS organisation to tackle discrimination and to promote equality. The Equality Bill sets the scene for delivering high-quality public services for all, taking full account of disability, age, race, gender or any other characteristic requiring protection from discrimination. It provides an unprecedented opportunity for the health and social care system to build on the progress already made, truly eliminate age and disability discrimination and take further strides to ensure that care is personal and meets the needs of each individual and their carers, regardless of age. Ending age discrimination and promoting age equality are as much about changing the attitudes and behaviours of individuals and the culture and practices of organisations.

1.37 Building on the progress made over the last decade to empower patients and on the direction set out in *Putting the frontline first: smarter government*,⁸ people must be given

rights and entitlements, with greater control over their own health and care. People with long-term care needs must be supported to have a clear understanding of their condition and of what they and their families can do to manage it.

1.38 Finally, *High Quality Care for All*⁹ made it clear that, for the NHS to be sustainable in the 21st century, it needs to focus on improving health as well as treating sickness. This is now not just the right thing to do for patients, but it is also a financial necessity. As the Wanless Report of 2002 showed,¹⁰ the dividend created by an NHS that promotes health, self-care and early intervention, and that integrates services around patients, is potentially sizeable, amounting to billions of pounds.

1.39 The NHS will need to work more effectively with national and local partners, including local authorities and the third sector, to make a stronger contribution to promoting health and to ensure easier access to prevention services. The NHS will also need to think innovatively about how it can engage with other stakeholders, such as the life sciences industry, to achieve these aims.

1.40 The vision set out here may seem indisputable. The actions that underpin it – such as keeping people healthy, treating patients earlier to avoid future complications and reducing waste and errors – may seem obvious. Many

8 *Putting the frontline first: smarter government*, HM Government, December 2009, www.hmg.gov.uk/frontlinefirst.aspx

9 *High Quality Care For All: NHS Next Stage Review Final Report*, Department of Health, June 2008, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

10 *Securing our Future Health: Taking a Long-Term View*, D. Wanless, April 2002, www.hm-treasury.gov.uk/consult_wanless_final.htm.

of these aims are not new. However, delivering them is not easy. They require complex changes which must be co-ordinated across the system. Those reforms will be substantial and at times uncomfortable, but our commitment is to support people – patients and staff – through them.

What this will mean – a plan to meet the challenges and achieve the vision

1.41 The following chapters in this document set out what this will mean for patients, their families, the public, NHS staff, and the system as a whole. Our plans are based on the intensive engagement that has taken place across the NHS over recent months. In response to a letter from the NHS Chief Executive, David Nicholson, every NHS organisation has been working with its staff to prepare for these challenges and to support them to respond.

1.42 This process has also highlighted the need for us to respond in a number of ways, including continuing to focus on early intervention and prevention; supporting integrated services; and ensuring that payment systems and other incentives support the delivery of our vision.

1.43 The proposals in this document therefore respond to those requests and focus on where national action can and will support the NHS to drive large-scale, rapid change across the whole service. It does not attempt to describe every service or to cover every profession. Nor does it try to describe comprehensively the contribution that a wide range of partners will also make.

1.44 Chapter 2 describes what this will mean for patients and the public, including:

- more rights for patients – to choice of hospital, and – subject to consultation – to a personal health budget, health checks and to choose where to spend their last days of life;
- accelerated improvements in quality across five key areas of care – cancer, cardiac care, stroke care, maternity care and patient experience;
- transformed services for those with a long term condition (such as diabetes, COPD, dementia); and
- ensuring up to 10% of hospitals' income, over time, is dependent on patients' experience and satisfaction with services.

1.45 Chapter 3 describes what this will mean for NHS staff. Building on the success of the NHS Next Stage Review, we want to empower staff to make necessary changes. Staff will need to work flexibly, but we will provide support to them to do so. Through our social partnership model of working, we will support them by:

- ensuring that NHS staff are provided with a healthy workplace, implementing the findings of the Boorman review, and the staff satisfaction is measured systematically;
- providing the right training and skills to develop, and to deliver care effectively, including investing in the development of leaders across the system;

- retaining national pay bargaining and continuing to help the lowest paid staff; and
- working with NHS employers and trade unions to explore the pros and cons of offering frontline staff an employment guarantee locally or regionally in return for flexibility, mobility, and sustained pay restraint.

- 1.46** Chapter 4 describes what this will mean for the system as a whole – the ways we can support NHS staff and NHS organisations to make the changes we seek and to ensure that those changes are made on the scale and at the pace required. We will:
- ensure payment systems supported improved quality and efficiency;
 - help staff through change;
 - strengthen regulation and deal with failure;
 - create leaner, stronger commissions;
 - integrate services and support high-performing organisations;
 - streamlining the reconfiguration process; and
 - driving innovation.

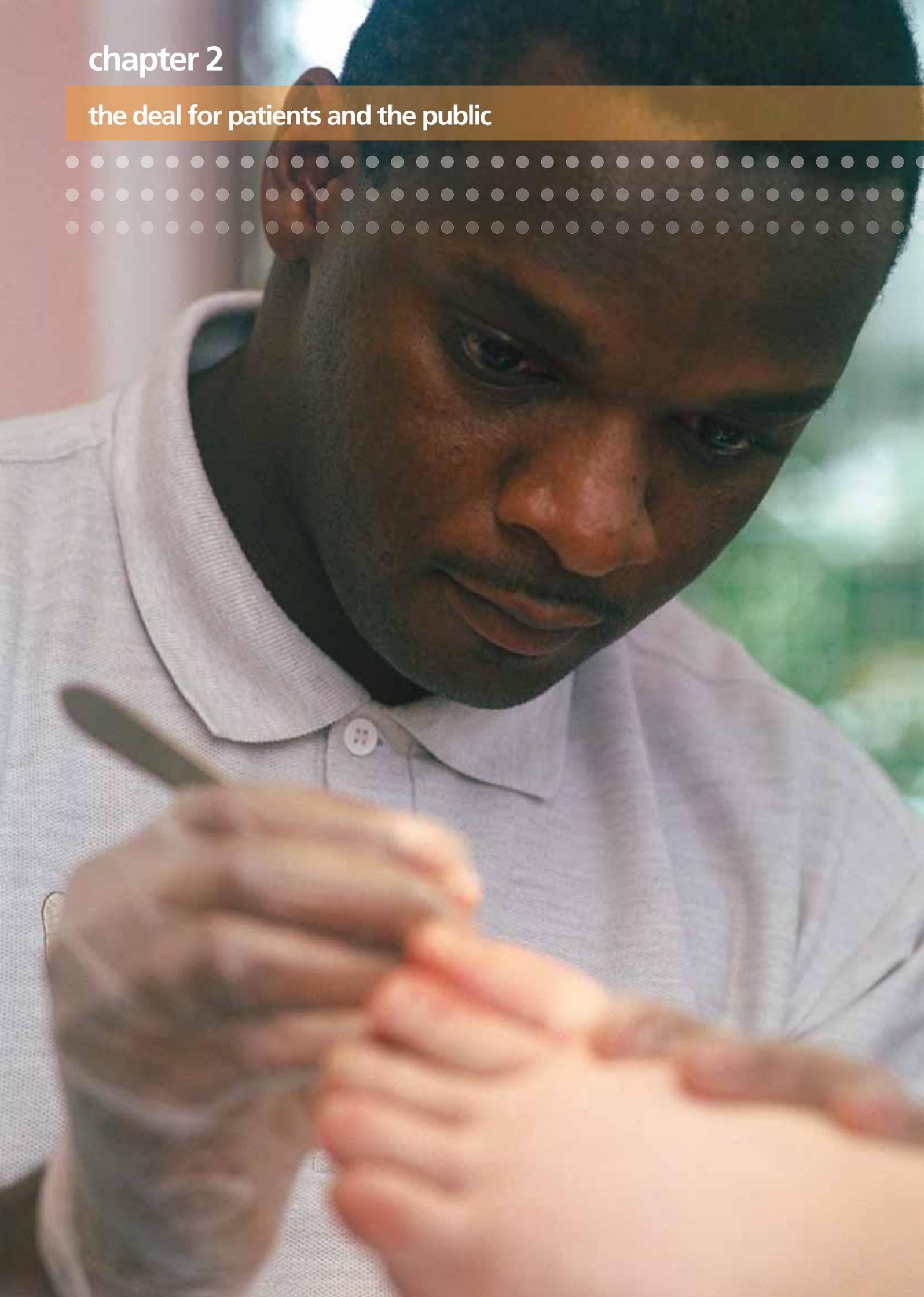
- 1.47** This plan will be hard to achieve. But the NHS can be confident in approaching its delivery. First and most important, it is founded on strong values that bind us all together. The NHS will continue to be based on these values and provide care based on need and not on ability to pay. It has an impressive track record of achievement over recent years, providing a solid foundation for accelerating improvement. Indeed, aspects of our system, such as our primary medical services, are already

world leading. It has largely driven out deficits and underlying financial problems. As a single, integrated system, the NHS is also able to drive nationwide progress in a systematic and fair way that would not be possible in a more fragmented or market-based system. And, finally, we have the time – and the resources next year – to prepare for tighter financial times from 2011 onwards.

- 1.48** These changes should always be for the benefit of patients and taxpayers, driven by clinical reasons, locally led and always based on the founding NHS principle of care available according to need and not ability to pay.
- 1.49** This is our vision. The following chapters set out our plan for delivering it.

chapter 2

the deal for patients and the public



NHS 2015 – the deal for patients and the public

Patients and the public will have a clear set of rights. They will have full choice of primary and secondary care services. We have proposed that critical waiting standards will become legally enforceable entitlements, with the offer of alternative provision wherever possible if the NHS fails to meet these entitlements. Early diagnosis of cancer and other life-threatening conditions will be much improved. More services will be provided in the community or in the home and at more convenient times (for example through availability of GP appointments in the evenings and at weekends). These improvements will mean changes to local services, particularly in hospitals. People will be expected to use services responsibly at all times – a high-quality NHS for all is only affordable if we take out just what we need. And we will ask people to take more personal responsibility for improving their own health – taking advantage of new opportunities to become more physically active, eat healthily and stop smoking.

- 2.1** This chapter sets out the roles and responsibilities of the NHS and its partners, including government, and also of patients and the public in helping to make this vision a reality.

Rights for patients

- 2.2** The NHS Constitution¹¹ brings together in one place what the NHS does, what it stands for and the commitments it should live up to. It describes the values and enduring principles of the NHS and gives individual, legally-binding entitlements to staff, patients and the public, so that they know exactly what they have the right to expect of the NHS.
- 2.3** The NHS Constitution takes us from a system based largely on targets and central direction to one where the power is placed in patients' hands. It is a system where patients and carers can exercise their rights and have things rectified when they go wrong.
- 2.4** The NHS Constitution will lock in the improvements described in chapter 1, ensuring that we cannot slip back to the poor standards of the past. In addition to this, the focus on entitlements, enshrined in law, reinforces our ambition to create truly people-centred, responsive services. Finally, the NHS Constitution gives us a base on which to extend our ambition for the NHS. It will not be a static document. We will update it as the NHS moves towards our vision, as set out in chapter 1. We will enshrine new rights as they become possible, as we have demonstrated with our recent consultation on adding new rights to waiting times and NHS Health Checks.¹²

¹¹ *The NHS Constitution for England*, Department of Health, January 2009, www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm

¹² *The NHS Constitution: A consultation on new patient rights*, Department of Health, November 2009, www.dh.gov.uk/en/Consultations/Liveconsultations/DH_108012

Patient rights contained in the NHS Constitution

1	You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.
2	You have the right to access NHS services. You will not be refused access on unreasonable grounds.
3	You have the right to expect your local NHS to assess the health requirements of the local community and to commission and put in place the services to meet those needs as considered necessary.
4	You have the right , in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner.
5	You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age.
6	You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.
7	You have the right to expect NHS organisations to monitor, and make efforts to improve, the quality of healthcare they commission or provide.
8	You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you.
9	You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.
10	You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.
11	You have the right to be treated with dignity and respect, in accordance with your human rights.
12	You have the right to accept or refuse treatment that is offered to you, and not to be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests.
13	You have the right to be given information about your proposed treatment in advance, including any significant risks and any alternative treatments which may be available, and the risks involved in doing nothing.
14	You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure.

Patient rights contained in the NHS Constitution	
15	You have the right of access to your own health records. These will always be used to manage your treatment in your best interests.
16	You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.
17	You have the right to express a preference for using a particular doctor within your GP practice, and for the practice to try to comply.
18	You have the right to make choices about your NHS care and to information to support these choices. The options available to you will develop over time and depend on your individual needs. Details are set out in the Handbook to the NHS Constitution.
19	You have the right to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this.
20	You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.
21	You have the right to have any complaint you make about NHS services dealt with efficiently and to have it properly investigated.
22	You have the right to know the outcome of any investigation into your complaint.
23	You have the right to take your complaint to the independent Health Service Ombudsman, if you are not satisfied with the way your complaint has been dealt with by the NHS.
24	You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body.
25	You have the right to compensation where you have been harmed by negligent treatment.

2.5 The following are proposed new rights and are currently subject to consultation. This demonstrates that the NHS Constitution is a living document. We intend to incorporate further rights and pledges as the NHS continues to improve, subject to the requirements of the Health Act 2009.

	You have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible. The waiting times are described in the Handbook. (This proposed new right is currently the subject of consultation.)
	You have the right to an NHS Health Check every five years if you are eligible for one. If you are not offered one at the provider you approach, you have the right to see an alternative provider. (This proposed new right is currently the subject of consultation.)

Responsibilities of patients

- 2.6** The NHS Constitution recognised that the NHS belongs to all of us. It explained that there are things that we can all do for ourselves and for one another to help it work effectively, and to ensure that resources are used responsibly.
- 2.7** It sets out responsibilities for individuals to register with a GP practice, treat NHS staff and other patients with respect, provide accurate information about health, condition and status and ensure that wishes on organ donation are known. Keeping appointments, or cancelling within a reasonable time, following agreed courses of treatment, participating in important public health programmes such as vaccination and giving feedback – both positive and negative – about the treatment and care received, are all key aspects.

A preventative, people-centred, productive NHS

- 2.8** The actions set out in this chapter balance the role of the NHS and its partners with the public's own responsibility for their own health and well-being. While the NHS can offer advice and support to help people to stay healthy, there are many things that people can only decide to do for themselves, such as being physically active, eating healthily, and avoiding smoking or excessive drinking. Parents and families also have a vital role to play as children's first carers and promoters of health. Their behaviours and the responsibility that they take for their own and their children's health can significantly affect health

and other outcomes in childhood and for many years, including on into adulthood and older age. People can help the NHS by taking the steps that they know they should to take good care of their own health and that of their families – which will help them to be healthier for longer and prevent unnecessary costs to the NHS from avoidable ill-health.

- 2.9** We need to build an NHS that starts with prevention. For too long, this has been an afterthought. It would be wrong to respond to the challenge the NHS faces by reducing spending on prevention – as has been the case in the past. We need a paradigm shift in health – away from 'diagnose and treat' towards 'predict and prevent'.
- 2.10** Care and support are personal. From the simplest support to the most technically advanced intervention, effective care is always the product of a relationship between a patient and those caring for that patient. For delivery of truly high-quality care, that relationship must be based on an accurate and sensitive understanding of the context in which people live and work. We recognise that equality of outcomes and personalised services will only be delivered by working with communities, recognising difference and tailoring provision, rather than having a 'one size fits all' approach. Different professions, services and organisations will need to work together, across traditional boundaries for the benefit of patients. People's individual needs, their dignity and their rights must be respected at every stage of their care journey.

2.11 As chapter 1 set out, we know that keeping people healthy, treating patients earlier to avoid future complications and reducing waste and errors all result in a more people-centred, preventative, productive NHS. We need to reduce the development of avoidable ill-health via the ‘big four’ lifestyle factors (smoking, alcohol, diet and physical activity), which cause 140,000 preventable deaths a year and are important factors in the development of chronic disease. We also need to spot the risks and signs of illness earlier and make sure that people get symptoms diagnosed quickly.

Supporting people to get and stay healthy

2.12 The case for prevention and early intervention to support people’s health has never been stronger. For example, advances in neuroscience and our understanding of pregnancy show just how important early life is for the physical, emotional and cognitive development of children, laying the foundations for later health.¹³ Investing in prevention and early intervention are important because this will pay dividends over the medium and longer term. It will rely on partnerships between organisations and the skills of those who are ‘at the front door’ of prevention, such as health visitors.

2.13 Acting early is also important in shaping health behaviour because, by the time children are in their teens, they will largely have laid down many health behaviours they will follow through their adult lives. Investment in supporting families early to prevent unhealthy behaviours and manage any conditions or illnesses they may have will produce benefits for both the individual and the NHS.

2.14 It can also have a more immediate impact on the NHS and the individual. For example, promotion of breastfeeding significantly reduces the likelihood of babies requiring costly admission to hospital for gastroenteritis, and also reduces the risk and costs of them becoming overweight or obese later in childhood.

2.15 The NHS and its partners must play a fuller role in providing clear, personalised advice and support to help individuals and families look after their own health, considering an individual as a ‘whole person’ rather than as a patient accessing one particular service at one particular time. Robust evidence-based programmes to support children and their families right from the start of life are helpful. Examples include the NHS’s *The Pregnancy Book* and *Birth to Five*, together with the parallel information for parents on the NHS Choices website, and also the Healthy Child Programme,¹⁴

13 *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*, Center on the Developing Child at Harvard University, 2007, http://.developingchild.harvard.edu/files/7612/5020/4152/Policy_Framework.pdf

14 The Healthy Child Programme incorporates *Healthy Child Programme: Pregnancy and the first five years of life*; *Healthy Child Programme: The two year review*; and *Healthy Child Programme: From 5 to 19 years old*; all Department of Health, October 2009, www.dh.gov.uk/en/Healthcare/Children/Maternity/index.htm

which includes reviews, screening tests, developmental checks and immunisations, as well as information and guidance.

2.16 The NHS also already provides highly personalised support, and this will continue. *Valuing People Now*¹⁵ sets out policies and actions to improve access to healthcare and health outcomes for people with learning disabilities. Many primary care trusts (PCTs) commission interventions to reduce alcohol-related health harm, by screening adults who visit their GP and offering brief advice. The Let's Get Moving¹⁶ physical activity behaviour change programme can be used by GPs to identify adults who do not currently meet recommended activity levels and support them to be more active. Campaigns such as Change4Life¹⁷ have been highly successful, already providing practical advice based on the best available evidence and the experiences of people who have successfully changed their behaviours. Over 20 million young people and senior citizens are now eligible for free swimming as part of the Swim4Life programme. Latest statistics show that those aged 16 and under and 60 and over have had 5.8 million free swims. Finally, NHS Stop Smoking Services, which are celebrating their 10th anniversary year, continue to provide world-leading services.

2.17 Such programmes benefit individuals and can save money. Delivering the alcohol high-impact changes – such as alcohol screening to provide higher-risk individuals with brief advice on alcohol consumption, additional counselling or an alcohol health worker to manage dependent drinkers within an acute setting – can produce annual savings of up to an average of £650,000 for a PCT. Total Place¹⁸ pilots in Leicester and Leicestershire, Birmingham, South Tyneside, Sunderland and Gateshead are working to address alcohol and drug abuse. The Total Place pilots are an important opportunity to learn about and build on how partnerships can deliver more for less through collaboration and by designing services around the needs of individuals and communities, not institutions.

2.18 NHS Stop Smoking Services have saved the equivalent of 70,000 lives¹⁹ since they were established and, together with wider national, regional and local action on tobacco control, already deliver annual savings of £380 million to the NHS.²⁰ We will shortly publish a new tobacco control strategy that will set out how PCTs and their local partners can go further.

15 *Valuing People Now: a new three-year strategy for people with learning disabilities*, Department of Health, January 2009, www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Learningdisabilities/index.htm

16 www.dh.gov.uk/en/PublicHealth/Healthimprovement/PhysicalActivity/DH_099438

17 www.nhs.uk/Change4life

18 Total Place involves 13 pilot areas looking at how a 'whole area' approach to public services can lead to better services at lower cost. www.localleadership.gov.uk/totalplace/

19 DH (2009) Analysis of 10 years of NHS Stop Smoking Service data

20 *Beyond Smoking Kills, Protecting Children, Reducing Inequalities*, Action on Smoking and Health (ASH), 2009, www.ash.org.uk/files/documents/ASH_691.pdf

2.19 Our plans to help people stay healthy are not just about physical health. *New Horizons: A shared vision for mental health*²¹ sets out our plans for improving mental health services and promoting public mental health. It emphasises the role of prevention, early intervention, innovation and enhanced productivity in maximising value for money at the same time as improving experience and outcomes for service users – for example, through the increased use of community teams to avoid admission or reduce length of stay, by reducing the number of out-of-area placements, or by improving the way independent sector services are procured. The full Government response to the Review of Child and Adolescent Mental Health Services will also be published shortly.

2.20 A total of 109 PCTs already offer access to psychological therapies. We will work with the NHS to move towards every PCT delivering at least one IAPT (improving access to psychological therapies) service, offering a range of NICE-approved psychological therapies, during 2010/11. These services help alleviate the pain and suffering caused by mental health conditions, such as depression and anxiety.

2.21 Work is now under way to establish what is needed to achieve full geographical coverage in every PCT. This would mean that, anywhere in England, an individual can refer themselves direct to a therapist and expect to be seen within two weeks. They would be given a choice of

the full range of NICE-approved psychological therapies for depression and anxiety. Each PCT with an IAPT service also offers employment support coordination.

2.22 This programme will help reduce avoidable health-related job loss and help more people who are struggling at work, on long-term sick or unable to seek employment because of depression to recover, so that they are ready to go back to work, thus helping the wider UK economy.

2.23 We now need to go further in preventing ill-health. We are extending Change4Life's current offer of free personalised 'action plans' for families to cover 45–64-year-olds, pregnant women and under-2s. And, looking ahead, we will identify and systematically implement those preventative interventions that make the most significant difference to improving health and reducing healthcare costs. This work will start with a rigorous identification of which interventions to focus on, beginning in 2010.

Delivering through partnerships

2.24 As we set out in *High Quality Care for All*, we expect every PCT to commission comprehensive well-being and prevention services, with the services offered personalised to meet the specific needs of their local populations. To support this commitment the *NHS Operating Framework for 2010/11* will continue to emphasise the importance of delivering improvements to health and well-being. In addition, we will

²¹ *New Horizons: A shared vision for mental health*, Department of Health, December 2009, www.newhorizons.dh.gov.uk/Resources/reports/New-Horizons/index.aspx

work closely with leaders in the NHS to identify a small number of specific actions to support the commissioning and delivery of these services.

2.25 Helping people to stay healthy and reaching out to patients is not just the remit of NHS organisations. Preventing ill-health requires partnerships and our goal will only be met through the NHS working closely at a local level with its wider public, private and third sector partners in Local Strategic Partnerships to look at the needs of local people, to consider priorities and how the resources of each partner can be best used to meet those needs.

2.26 The NHS has already had real success in working with local partners, including local authorities, the police and schools, to put health at the centre of the joint targets they have agreed to achieve for local people through local area agreements (LAAs). LAAs provide an excellent starting point for partnership working to tackle big issues like childhood obesity, teenage pregnancy, smoking, and helping older people to stay healthy and independent.

2.27 On these issues there has been good progress, but we know there is more to do. For example, since the launch of the Government's Teenage Pregnancy Strategy in 1999, under-18 conception rates have fallen steadily by 10.7% since 1998. The national trend masks considerable variation at a local level. Around a fifth of areas have achieved reductions of over 20% (double the national average), but in a

similar proportion of areas rates have remained static or increased. There is good evidence for success in improving access to, and uptake of, effective contraception, and provision of comprehensive Sex and Relationships Education (SRE) as part of Personal, Social, Health and Economic Education (PSHE) which will be compulsory in schools from 2011. Levels of childhood obesity are too high, but the NHS Information Centre has said that there are indications that the rise in childhood obesity may be levelling off.²²

2.28 Pharmacies are a crucial local partner, and are well-positioned to provide personalised health advice within local communities. Guidance on how pharmacy staff can be enabled to become health champions and health trainers will be published. We have asked Portsmouth PCT to develop a framework for healthy living pharmacies, setting out a vision for how pharmacies can play a key role in promoting health and well-being, as well as in supplying and providing advice on the safe use of medicines.

2.29 To support the NHS's efforts locally, at national level we are working closely in partnership with the rest of Government, employers, the private and voluntary sectors to create environments and workplaces that support health. Current actions include the following:

- Working with the Food Standards Agency (FSA) and the food industry to reduce levels of salt and saturated fat in food.

²² NHS Information Centre, *Health Survey for England 2007 Latest Trends* [http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england/health-survey-for-england-2007-latest-trends-\[ns\]](http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england/health-survey-for-england-2007-latest-trends-[ns])

- Some leading companies have made a commitment to display calorie information on their menus so that people can all make more informed choices when they eat out. The FSA is consulting on a voluntary approach that would be practical for the whole industry.
- Taking powers in the Health Act 2009 to end the sale of tobacco from vending machines. We are currently consulting on regulations to make this a reality by October 2011.

Case study – Government working in partnership to help people get and stay healthy

In recognising that activity levels fall dramatically after the age of 16, the Department of Health, in partnership with the Fitness Industry Association (FIA) and local authorities, is piloting an incentive scheme to offer 5,000 16–22-year-olds subsidised gym memberships linked to frequency of use.

The project is modelled on a popular Pruhealth insurance scheme that offered free or subsidised fitness club membership to certain groups of policy-holders who could show regular and sustained gym attendance.

The scheme is targeted at teenagers and younger adults who are at risk of inactive lifestyles and living in areas of deprivation. It draws in part on the spare 'off-peak' capacity of both private and public sector gyms. Such a co-ordinated approach has unlocked significant discounts from fitness providers; alongside the subsidy offered by the scheme, this translates to a monthly membership fee of £5 for regular gym users.

2.30 To help us be as effective as possible in these efforts, we have commissioned work to look at the role the Government should play in supporting health and well-being, the most effective approaches to promoting healthier behaviours, and the steps needed to enable effective delivery of health and well-being services.

Reaching out to people

2.31 Moving beyond advice and support, the NHS is already proactively providing targeted help to those most at risk. Programmes include the Family Nurse Partnership, which offers support to some of the most vulnerable young first-time mothers and their families through a programme of evidence-based home visits, delivered by specially-trained nurses. The expected benefits include improvements in antenatal health, such as reduced smoking during pregnancy (which is linked to increases in infant mortality of about 40%), increased breastfeeding, reductions in children's injuries, neglect and abuse, and wider benefits including increased school readiness and other longer-term gains.²³

²³ Olds, DL. 2006. The Nurse–Family Partnership: an evidence-based preventive intervention. *Infant Mental Health Journal* 27(1): 5–25

NHS Health Checks

NHS Health Checks are being made available across the country for all 40–74-year-olds. These will check an individual's risk of heart disease, stroke, diabetes and kidney disease, and will offer support in reducing or managing that risk, with the necessary lifestyle advice and effective interventions (such as NHS Stop Smoking Services or weight management programmes) or through medication.

This is a world-leading programme to prevent heart disease, stroke, diabetes, and chronic kidney disease. The programme will save thousands of lives by preventing stroke and heart attacks, and at least 4,000 people will not develop diabetes as a result.

Some one million checks will have been performed by the end of this year, with complete roll-out planned by 2012/13. Around three million patients will be checked every year.

2.32 The NHS also offers screening either to prevent disease (in the case of cervical cancer and, to some extent, bowel cancer) or to detect it as early as possible (breast and bowel cancer and heart disease), so that we can treat it as soon as possible. We also target the National Chlamydia Screening Programme at sexually active young people under the age of 25 – the group most at risk.

2.33 And for people aged over 50, we are providing access to the checks and services available to maximise their health, well-being and independence in later life.

Our Prevention Package for Older People includes a public information leaflet (*Keep on the Road for Longer*) on existing entitlements, including flu vaccination, cancer screening and sight tests. We are promoting best practice around falls prevention and effective fracture management – since falls and fractures cause substantial avoidable harm, can be life-changing events, reduce mobility and can cause substantial costs to the NHS. Interim findings from our five-year Partnerships for Older People Projects (POPPs) have demonstrated significant reductions in emergency bed days as a result of health and social care investments in a range of primary to tertiary prevention services in the community.

Diagnosing early

2.34 We have already taken steps to improve access to GP surgeries and to dramatically reduce waiting times that patients face – including for diagnostic tests. We have asked NHS pathology services to transform the way services are organised and delivered, so that modern, high-quality care is supported effectively by a modern laboratory medicine service.

2.35 Where a GP makes an urgent referral for suspected cancer, patients are seen by a specialist within two weeks. The Cancer Reform Strategy second annual report²⁴ highlighted wide variation across the country in the number of people referred and the proportion of cancers diagnosed in this way (the 'conversion rate'). It is important that PCTs look at their

²⁴ *Cancer reform strategy: achieving local implementation – second annual report*, Department of Health, December 2009, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_109338

referral and conversion rates to ensure best use of the urgent referral route for their local populations.

- 2.36** We will take further action to achieve earlier diagnosis of cancer. We have already made very significant improvements in speed of access to cancer specialists and to treatment once a person is referred with suspected cancer. But we must get earlier referral of people with symptoms that could indicate cancer. We know that England has poorer survival rates for many cancers than many other similar countries – we believe that this is largely due to late diagnosis, and we could potentially save up to 10,000 lives a year if patients with cancer were diagnosed earlier.
- 2.37** In September, the Prime Minister announced plans²⁵ for those people who are not referred on the urgent suspected cancer pathway but who have symptoms that need investigating to have their diagnostic tests within one week of referral by their GP. In most cases, cancer will be excluded, but, in the few cases where there is a diagnosis of cancer, this will improve the likelihood of a successful outcome. We are also encouraging people to go to their GP earlier when they have symptoms that could be cancer: this is focused primarily on raising awareness of the symptoms of cancer and urging people to seek help early. And we are looking at how best to support GPs in recognising that even symptoms that may seem

unlikely to be serious could be cancer, and so might require full investigation.

Providing high quality services – treating patients well

- 2.38** When people do need treatment, they want to know that it is of a high standard. Lord Darzi set out a vision for high-quality care, and defined quality in terms of safety, effectiveness and patient experience. The following sections set out what we will do – first for priority areas, and then for the three interdependent aspects of quality above.
- 2.39** Our progress on reducing healthcare-associated infections encapsulates where we are on the journey from good to great. We have made great strides, reducing MRSA by 74% and *C difficile* by 37% nationally. This has not only saved lives but has also saved the NHS at least £141 million.²⁶ But pockets of poor performance remain. That is why all NHS organisations will be set a new objective for reducing MRSA next year, which will push them to match the performance of the best. The objective, developed through close working with the NHS, will challenge every provider to improve; variation will be reduced rapidly and poor performance eliminated.
- 2.40** Similarly, our successful drive to reduce waiting times began with setting targets at national level. Subsequently, we applied these goals to individual organisations and then to individual services. Now we have reached the point where every patient will have

²⁵ *The NHS Constitution: A consultation on new patient rights*, Department of Health, November 2009, www.dh.gov.uk/en/Consultations/Liveconsultations/DH_108012

²⁶ *Reducing Healthcare Associated Infections in Hospitals in England*, National Audit Office, June 2009, www.nao.org.uk/publications/0809/reducing_healthcare_associated.aspx

the right to expect treatment within 18 weeks across the whole NHS.

2.41 This approach must now be applied across our national priorities, so that all NHS services meet the highest standards in key areas including cancer care, cardiac care, stroke services, maternity services and patient experience. The NHS has made huge improvements in all of these areas, but there is still more we need to do to drive out variation and go from good to great everywhere.

2.42 We will continue to improve care for cancer patients by:

- Giving patients who have been urgently referred with suspected cancer a legal entitlement to see a cancer specialist within 2 weeks by April 2010 (subject to consultation);
- Offering all patients access to cancer tests within one week, rolled out over 5 years;
- Working with PCTs to identify GP practice use of the 2 week referral pathway and encourage low users to close the gap with higher performing practices;
- Continuing to reduce inequalities in cancer care through the National Cancer Equality Initiative;
- Improving the experience of people living with and beyond cancer, through the National Cancer Survivorship Initiative.

2.43 We will continue to improve care for stroke patients by:

- Ensuring that more patients, for whom there is potential benefit, have a brain scan within 1 hour of admission;

- Accelerating the investigation and treatment of transient ischaemic attacks, which are like mini strokes but may herald a major impending stroke;
- Ensuring that all patients get the best treatment, we will work with the NHS to further improve access to a dedicated stroke unit for all stroke patients.

2.44 We will continue to improve care for those at risk of heart disease by:

- Ensuring at least 95% of the population live in areas with 24/7 primary angioplasty services for heart attack within two years;
- Reducing the time heart patients have to wait for urgent surgery;
- Improving timely access to good cardiac rehabilitation for those who have suffered a heart attack, undergone heart surgery or who have heart failure.

2.45 We will continue to improve care for pregnant women by:

- Continuing to invest in services, with a 1,000 additional midwives already in post from September 2009 increasing to 4,000 by 2012 subject to the birth rate;
- Giving all women more choice in their pregnancy – over how they access maternity and antenatal care, over place of birth and type of birth by the end of this calendar year;
- Ensuring early access to antenatal care, support for breast feeding and reduced health inequalities;

- Continuing to drive improvement in the 31 least well performing trusts with progress reports by the end of January 2010, putting support into any trusts who have not made sufficient progress in Spring 2010.

2.46 Across all of our priority areas we will expect to see improvements in patient experience, and we have made radical changes to the payment system to drive and reward high quality patient experience. Just as we have done with MRSA we will work with the NHS to build on the significant progress to date and to define and agree goals for improvement for all providers. We will require those PCTs with the greatest variation to bring forward plans in early Spring 2010 to set out how they will reduce variation and drive up improvement.

Safer care

- 2.47** We know that safe care is crucial to patients and their families. It must be the priority for boards of all NHS organisations. To reinforce this, we are clear that a strengthened system of regulation is necessary. Further detail on this is set out in chapter 4.
- 2.48** Although the majority of patients receive effective and safe care, there are a number of incidents that do cause patients serious, long-lasting harm. Reducing the number of such incidents should be at the heart of what we do, and we will continue to work with partners like the National Patient Safety Agency to do this.

2.49 We are also introducing, through the new registration requirement regulations, a statutory duty on NHS organisations to report serious patient safety incidents (until now this reporting has been voluntary). These developments will help to mainstream the identification and management of treatment that causes serious harm.

2.50 We will now ask the NHS to build on the progress it has made and to focus on a wider set of safety challenges over the next five years. This will mean safer care for patients, who can be confident that they will be protected from avoidable harm. The evidence points to the NHS focusing initially on eliminating avoidable cases of *C difficile*, venous thrombo-embolism (VTE) and pressure ulcers.

2.51 Given the early achievement of the *C difficile* target, we will challenge the NHS to deliver continued and sustainable reductions in *C difficile* infections beyond March 2011. As with the MRSA objective, the focus should be to reduce variation in performance, and ensure that organisations with high *C difficile* rates make significant improvements. This reflects the NHS's move towards a culture of zero tolerance of preventable infections.

2.52 Each year 25,000 patients who have been hospitalised in England die from VTE.²⁷ This happens, for example, when blood clots that form in veins are swept into the lungs in the bloodstream. Assessing patients in order to identify those at risk, and then taking appropriate action, is known to be effective in preventing this from happening. We will support all NHS providers to adopt this best practice.

2.53 Pressure ulcers often affect older, obese or malnourished people, or those with certain underlying conditions. Ulcers occur when there is damage to tissue as a result of long-term immobility, a patient's body weight, friction or the shearing of skin or deeper tissues. The majority of pressure ulcers are entirely preventable through a risk assessment and the implementation of pressure-relieving measures, such as moving immobile patients. We have set out an ambition to eliminate all avoidable pressure ulcers in NHS-provided care. This will significantly reduce the amount an average district general hospital spends on treating pressure ulcers, currently estimated at £600,000 to £3 million each year.²⁸

2.54 Where mistakes do occur, the NHS will acknowledge them, apologise, explain what went wrong and put things right quickly and effectively. Where patients are eligible for compensation, the process should be as efficient as possible. We will therefore work with

the NHS Litigation Authority to ensure that the claims-handling process is as efficient as possible. We are already working with the Ministry of Justice to develop measures which could further reduce the legal costs associated with clinical negligence claims against the NHS.

Improving patient satisfaction – increasing choice and control

2.55 The NHS was the first national healthcare system in the world to introduce a nationwide patient survey. Because of this we know that patient satisfaction with the NHS is at an all-time high. But we also know there is more to do to give patients the high quality care they deserve, every time, including by ensuring that data is available in real time. Patients want to be treated with compassion, dignity and respect in a clean, safe and well-managed environment. One powerful sign of this is the 11,000 people who have signed up to our Dignity in Care campaign. Their carers also want to be recognised as expert partners in care. **This aspect of quality has been neglected or seen as less important in the past.** If we are to realise the vision of a people-centred NHS, with quality at its heart, then this has to change. Patients and their carers have a right to be treated equitably, whoever or wherever they may be.

²⁷ The Prevention of Venous Thromboembolism in Hospitalised Patients, House of Commons Health Committee, February 2005, www.parliament.uk/parliamentary_committees/health_committee/hcpnsession0405.cfm

²⁸ *High Impact Actions for Nursing and Midwifery*, SHA Chief Nurses in collaboration with the Royal College of Midwives, the Royal College of Nursing, the Nursing and Midwifery Council, the NHS Institute for Innovation and Improvement, the Department of Health, November 2009, www.institute.nhs.uk/building_capability/general/aims

2.56 Over the coming years we will greatly expand the measurement of patient satisfaction on a service-by-service basis within each hospital.

Without clear measurement, staff cannot improve the service they provide to all patients and their carers. They need to know who they have treated and how. So we need a wider range of clear and simple measures of patient satisfaction, and we need these to cover individual services as well as providers as a whole.

2.57 Additionally, we will make information on patient and carer satisfaction and experience much more widely available, service by service, in real time, within hospitals. Giving patients and the public a clear understanding of the quality of experience offered by their local providers is crucial to improving quality and informing choice. This will mean providers including a wide range of patient satisfaction measures in their Quality Accounts, required by law for NHS trusts, ambulance trusts and mental health trusts from next summer. These Quality Accounts will be assured so that patients and the public can rely on them as a fair and accurate assessment.

2.58 We will also continue to expand the information available on NHS Choices, including exploring the use of international benchmarks. We will continue to expand the range of direct patient and carer feedback available via NHS Choices. For maternity, as well as two national surveys of women's

experiences planned for 2010, this will include piloting arrangements to enable parents to give instant feedback by text message, and working to extend our partnership with Mumsnet to allow its users to supply feedback on the maternity care they have received, building on the scorecard of choices that NHS Choices already provides.

2.59 We will link a significant proportion of provider income to patient experience and satisfaction.

This will give providers real incentives to understand and improve, and will ensure that commissioners have the power to act when patients have a poor experience. This will mean directly linking patient satisfaction with payment to hospitals for the first time next year, and significantly expanding the proportion of payment linked to satisfaction in subsequent years. Over time, up to 10% of trusts' income could be dependent on patient experience and satisfaction. This represents a clear shift from a commoditised, production-line NHS to one that is people-centred, where staff are at all times encouraged to see care through the eyes of their patients and their carers. Over time we will consider extending this approach to other settings.

2.60 We will give patients greater choice and control. The choice of which hospital to be treated in is now guaranteed through the NHS Constitution.²⁹ The plans set out in the next section for better management of long-term conditions, end-of-life care

²⁹ *The NHS Constitution for England*, Department of Health, January 2009, www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm

and urgent and emergency services will give patients more choice and control.

2.61 We will ensure patients have the right information, at the right time with the right support through the Information Standard accreditation scheme, which guarantees the quality of information for patients, and information prescriptions, tailored to the needs of individual patients.

2.62 We have already announced³⁰ that over the next year we will **give patients a far wider choice over which GP practice they register with**. Patients will no longer have choice limited by the current system of practice boundaries. This will allow them to choose a practice that provides the services most responsive to their needs, in a location that is convenient for them, and will reward practices that provide high-quality, people-centred services.

2.63 We have already **launched a pilot programme**³¹ **to explore the potential of personal health budgets, to give patients more control** over their care. We are exploring the potential of individual budgets to give control and power to patients to build the care and support that best suits them. Individual budgets could transform the lives of many people, allowing them much greater choice over the services they can ask for.

2.64 Around 70 areas are developing proposals to pilot these personal health budgets across a wide range of

different NHS services, including long-term conditions, mental health and end-of-life care. We will now offer other parts of the NHS another chance to join the pilot programme.

2.65 The pilots, which will run to 2012, will be used to inform the right way to develop and offer a personal health budget. Our ambition for the longer term is that all people who could benefit from a personal health budget should have the right to be offered one. **Ultimately this could mean that millions of NHS patients will enjoy this right.**

Effective care – transforming the lives of patients with long-term conditions

2.66 Demographic changes and public health successes mean there are increasing numbers of older people with long-term conditions and complex needs. In delivering a quality service to all patients, the NHS must be prepared to meet such challenges within the letter and spirit of strengthened equality legislation.

2.67 Over 15 million people in England currently live with conditions such as diabetes, chronic lung disease, heart disease, cancer and dementia. A significant proportion of these are older people. They will often require support from a number of different professionals and organisations. They represent 55% of GP appointments, 68% of outpatient appointments and accident and emergency (A&E)

³⁰ Speech by the Rt Hon Andy Burnham, Secretary of State for Health, 17 September 2009 to the Kings Fund www.dh.gov.uk/en/News/Speeches/DH_105366

³¹ Piloting Personal Health Budgets www.dh.gov.uk/en/Healthcare/Highqualitycareforall/Personalhealthbudgets/DH_109426

attendances and 77% of inpatient bed days.³² In total, they account for around 70% of NHS spend – and, with the expected increase in the number of people living with these conditions, the problem is likely to increase.

2.68 Care for these groups of people has improved in recent years. Our 2006 White Paper, *Our health, our care, our say: a new direction for community services*, set a clear direction of travel: focusing on better prevention and earlier intervention; more choice and a louder voice for people; more on tackling inequalities and improving access to community services; and more support for people with long-term needs. Various Care Closer to Home projects showed that it is possible to provide care in community settings that is more usually provided in hospital. The publication *Delivering Care Closer to Home: Meeting the Challenge* brought together the insights and resources available to support local organisations to bring care closer to home.

2.69 However, much more remains to be done and the imperative to do it is now greater than ever before. Compared with other countries, for example, we have high rates of emergency admissions to hospital for those with diabetes and asthma.³³ Better management of these conditions and better support for

self-care and family carers could avoid such distressing experiences, leading to care that is more effective, a better experience and more productive.

2.70 We therefore want to see care for these groups transformed, starting with care for those with diabetes, heart failure, respiratory disease (including chronic obstructive pulmonary disease – COPD), cancer as a chronic disease and dementia.

2.71 The response to this challenge will be led locally. However, through engagement with the NHS, we have also heard that key elements of the response should be supported and co-ordinated across the country.

2.72 The NHS has a strong track record of delivering major improvements, for example in waiting times,³⁴ in the quality of care in A&E³⁵ and in access to primary care services.³⁶ In each of these examples, work to improve the quality of care has had strong ownership at a local level but has benefited from a co-ordinated, collaborative approach, implemented systematically across the NHS, to support local improvement.

32 General Household Survey 2005, Office for National Statistics

33 OECD Health Data 2009, www.oecd.org/document/30/0,3343,en_2649_34631_12968734_1_1_1_37407,00.html

34 www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/18WeeksReferraltoTreatmentstatistics/index.htm

35 *Not just a matter of time – A review of urgent and emergency care services in England*, Healthcare Commission, September 2008, www.wehct.nhs.uk/hcc-report.pdf

36 www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/PrimaryCare/DH_089459

2.73 We have heard that the NHS would like support to facilitate the large-scale, rapid delivery of those actions that are likely to have the greatest impact.

2.74 Over the coming months, the NHS will create programmes – led by leading clinicians and working with national partners, including voluntary sector organisations, patient and carer groups and local authorities – to consider what high-impact changes we can make in improved self-care and carer support, care planning, case management and making the best use of assistive technology in order to transform the care of patients with these conditions. We will then support PCTs in commissioning the changes.

Chronic obstructive pulmonary disease and asthma

We will consult on how we can transform care for the 835,000 people in England who have been diagnosed with COPD and the 3.2 million people with asthma. This could include the following:

- Reviewing disease registers of patients diagnosed with asthma or COPD and ensuring accurate diagnosis; reviewing home oxygen registers to ensure that those prescribed home oxygen have hypoxaemia (low oxygen levels in their blood) through clinical assessment and are reviewed at regular intervals.
- Encouraging active case management within a community setting through proactive review and development of schemes to avoid the need for admission.
- Providing education and support for people with COPD and asthma through self-management programmes/ action plans, thus reducing hospital admissions and ensuring adherence to drug therapy.
- Ensuring that people with COPD requiring attendance at hospital have a structured hospital admission and are assessed for early discharge, to ensure that length of stay and subsequent readmission are minimised.

Heart failure

We will consider how we can build on the major improvements that have already been made, and transform care for patients with heart failure. This may include the following:

- Patients having an accurate diagnosis and being put on the correct treatment pathway, though the use of diagnostic tools in primary and secondary care. This will result in reduced referrals to outpatients and unplanned admissions.
- Patients being given optimal medication, rehabilitation and devices to stabilise them. This will result in reduced hospital admissions.
- Patients being seen by multidisciplinary teams so that they are comprehensively and accurately diagnosed and treated in the best way. This will result in a reduction in unnecessary admissions and readmissions.
- Patients with complex needs and their family carers being helped by care co-ordinators to navigate their way through different aspects of care. This will result in better co-ordinated care and management of their condition, and a reduction in unnecessary admissions.
- Patients at the end of life having access to palliative care and appropriate interventions in a choice of settings. This will result in a reduction in inappropriate admissions through the ambulance service.

Diabetes

There are around 2.4 million people in England with diabetes. There have already been major improvements in diabetes care but more needs to be done. We will consider what further progress can be made on high-impact changes which could benefit these patients. These may include the following:

- Improving glucose control and reducing the need for emergency admissions to hospitals.
- Improving footcare services for people with diabetes.
- Improving the identification of hospital inpatients with diabetes to ensure that their stay is no longer than necessary.
- Improving prescribing and monitoring – using the most cost-effective drugs and stopping drug use when appropriate. Diabetes glucose-lowering and monitoring drugs and devices accounted for £541 million in 2007/8 – the highest item of national drug spend.
- Improving the self-management of the high-intensity users and so reducing diabetes emergencies and the use of ambulance services.

Cancer

We will consider what high-impact changes could be made for patients with cancer. This could include the following:

- Managing patients more proactively during active treatment, e.g. during chemotherapy, so that emergency admissions are avoided and, when admissions are necessary, length of stay is kept to a minimum.
- Providing treatment outside hospital if capacity has been reached in hospital, e.g. chemotherapy at home or in GP surgery. Although staff intensive, this is cheaper if it avoids having to develop new acute-sector capacity.
- Supporting survivors (those with active disease and those in remission) to lead a healthy lifestyle, e.g. taking exercise and eating healthily. This is proven to reduce recurrence of disease and to help the overall well-being of survivors – and therefore to reduce the burden on the NHS.
- Providing more tailored follow-up for those in remission. Formulaic care is often more expensive because it means paying for unnecessary treatment and is less responsive to changes in symptoms.
- Supporting better communications skills for staff, so that difficult decisions can be made about stopping expensive treatment that does not benefit patients.

Dementia

We will consider what high-impact changes could help improve the care for the 700,000 people in the UK who have dementia. This could include the following:

- Diagnosing people with dementia earlier, and treating, supporting and caring for them after the diagnosis.
- Improving community personal support for people living at home.
- Improving intermediate care for people with dementia to help them stay at home.
- Reducing the prescribing of anti-psychotic drugs to people with dementia to a third of its current level over the next three years. This will be a clinical governance priority across the NHS.
- Providing information, advice and support for carers.

2.75 Our plans to transform care for patients with long-term conditions will involve people being offered personalised care planning and support for self-care. This will help them to manage their condition and cope with any exacerbation of symptoms. New systems of care and technology will allow them, their carers and their professionals to monitor their care, intervene early to prevent deterioration and avoid hospital admissions.

2.76 There will be a new focus on helping those patients with cancer and complex long-term conditions who can benefit from a more personal approach to nursing. We

would expect all parts of the NHS to continually review the way such conditions are managed and to seek out and adopt best practice. Where appropriate this should include the provision of personalised one-to-one support by a health professional. We will consider and cost the possibility of a patient entitlement in this area and publish the results in early 2010.

2.77 Applying these models of care systematically across the country and creating such major shifts in where care is provided will be hard. It can only be achieved if the NHS works more effectively with local partners. The NHS and adult social care services working together to support people in the community will in turn lead to a reduction in emergency admissions for older people and people with long-term conditions. PCTs will need to work with local authorities and other partners across the public sector to consider how services can be designed around individuals' needs and to build on the opportunity of the joint strategic needs assessment to engage partners in this process.

2.78 We will also ensure that transforming effective care for those with long-term conditions and the other commitments we are making will benefit those who need it the most. All national and local programmes that deliver significant change will be assessed for their effects on the most disadvantaged. And we will give even greater prominence to equality as part of our drive to deliver high-quality care for all. The NHS Constitution

makes clear that NHS services should be equally available to all, taking full account of personal circumstances and diversity, including gender, race, disability, age, sexual orientation, religion or belief. In delivering on this commitment, and in order to meet our duties under current equality legislation and the forthcoming Equality Bill, we have established the NHS Equality and Diversity Council to provide clear leadership on equality and diversity issues.

2.79 Building on the progress already made by NHS organisations, we will create further programmes to ensure that people are cared for in the right place – both convenient for them and more efficient for the NHS. This will particularly focus on enabling more end-of-life care in people's own homes, linked to a potential new right to choose to die at home, as set out in *The NHS Constitution: A consultation on new patient rights*.

2.80 We will also build on existing work enabling people to be treated by GPs and community services, rather than having to be seen in urgent and emergency care. We remain committed to introducing a single, memorable, three-digit number for access to urgent healthcare services. We will begin to introduce this in the NHS from next year.

Social care

2.81 Approximately 1.9 million adults currently receive local authority-funded social care. However, over 1.7 million more adults are expected

to need care and support in 20 years' time. Furthermore, the number of people of working age to support those over 65 is shrinking.³⁷

2.82 Leaving adult social care services as they are today would in time become unsustainable as more and more people require services in the future. One of the consequences of the future demand on care and support would be to create significant unmet need in the community, which would ultimately create more pressure on NHS services. Alongside, and in line with, the changes we are challenging the NHS to make, we need to see similar changes in adult social care services.

2.83 We need to reform adult social care services, improve integration with health and make services more preventative in nature, while delivering a funding model that is fair and affordable for the state and for individuals. That is at the heart of our vision for our new National Care Service – a system that is fair, simple and affordable to everyone, underpinned by national rights and entitlements but personalised to individual needs. We will publish our detailed plans for the National Care Service in 2010.

2.84 As a stepping stone to this new National Care Service, we have announced that those with the highest needs will be offered free personal care in their own homes. The Personal Care at Home Bill, which supports the implementation of this commitment, was announced as part of the Queen's speech.³⁸ Subject to parliamentary approval, this offer will be introduced from October 2010.

2.85 The Bill will also support many thousands of people who need home care for the first time, and will help them regain their independence. We will invest £130 million in services that help people to maintain their dignity and rebuild their confidence so that they can continue to live at home. To do this, PCTs will need to collaborate more closely with social care colleagues, using resources jointly to deliver improvements.

Summary

2.86 Our vision for the NHS 2015 will put patients at the centre of care. By providing support to stay healthy, safer and more effective care and improved social care services, underpinned by clear rights and responsibilities, health and social care services will match the expectations of patients and the public. The next chapter describes how we will support staff to deliver these changes.

³⁷ *Shaping the Future of Care Together*, HM Government, July 2009, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102338

³⁸ www.publications.parliament.uk/pa/cm200910/cmbills/011/10011.i-i.html

chapter 3

the deal for NHS staff



NHS 2015 – the deal for NHS staff

The improvements that the NHS has made over the last decade have been made by its staff. Building on this progress and delivering this vision, however, means change for NHS staff. This may mean working in a different place and in a different organisation. But our commitment is to support staff through these changes. We know that it is important to many staff that they work for the NHS. We will give existing NHS services that are underperforming reasonable opportunities to improve. Where new services or new service models are needed, NHS providers will be engaged at an early stage and have a full and fair opportunity to bid, alongside other potential providers. We will keep national pay bargaining and we will continue to help the lowest paid staff. Through the national Social Partnership Forum we will explore the pros and cons of offering frontline staff an employment guarantee locally or regionally in return for flexibility, mobility and sustained pay restraint. We will also measure staff satisfaction more systematically as a way of driving up standards and we will support work to improve staff health and well-being.

- 3.1** Staff are the NHS's biggest asset. They go to work every day to improve and save lives. Our role is to ensure that they have the funding, the skills, the levers and the reward to care for people as well as possible. Their commitment, professionalism and dedication benefit patients and make the NHS what it is.

NHS staff empowered to drive change

- 3.2** Our approach to working with the NHS has evolved over the last 10 years. At the beginning of this journey, our approach was to use top-down management, targets and reforms, to drive the system to make improvements. At the time, this was the right thing to do: the NHS needed these direct approaches to start the improvement process. But this meant the focus was often on the means and not enough on the ends: staff sometimes found this disempowering. Winning the hearts and minds of the people who work in the NHS is vital.
- 3.3** Lord Darzi's NHS Next Stage Review³⁹ was a hugely important process in reuniting people – doctors and nurses, managers and politicians – around the central goal of improving quality. At its heart was the simple recognition that effective leadership from staff who deliver services is crucial in securing successful improvements and changes in the health service. Achieving a great NHS means supporting clinicians to drive improvements beyond any national targets that could be set.
- 3.4** So, as we respond to the challenges ahead, we will work hard to take people with us. We know we will all achieve more together if we support people through change and if we secure what is important to them. Such is the scale of the quality and productivity challenge, we believe that it is essential to proceed in this way. This attitude will characterise the Government's approach to this new era.

³⁹ *High Quality Care For All: NHS Next Stage Review Final Report*, Department of Health, June 2008, www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825

3.5 The solutions to many of the challenges identified in improving patient care and productivity will require staff to work more collaboratively with other agencies in joint teams or arrangements. Many examples of collaborative working already exist, from fully integrated organisations across health and social care, such as Torbay Care Trust, to virtual integrated teams in Wakefield. To implement such arrangements will require clear leadership as well as flexibility from staff.

Embedding and extending the concept of social partnership

3.6 One of the ways in which we will encourage staff engagement is to embed and extend the concept of social partnership. Over the last two years, we have revitalised partnership working at national level through the creation of the national Social Partnership Forum (SPF). This forum is a partnership between the Department of Health, NHS Employers and trade unions, and was established to discuss, debate and involve partners in the development and implementation of the workforce implications of policy in the NHS. As such, it has provided effective communication between partners and has encouraged a positive and constructive approach to problem-solving.

3.7 The results of the first two years of the social partnership model of working have been impressive. The SPF has helped shape a number of high-profile policies such as the NHS Constitution and Transforming Community Services

and the development of the Staff Passport. The forum has also provided a streamlined structure for early employer and union engagement, leading to improved implementation of policy.

3.8 We believe that, with NHS Employers and trade unions, we have shown, through partnership working, that we have a shared commitment to providing the highest quality care and that together we can tackle even the most difficult challenges more effectively. We are therefore committed to embed and extend this approach and have already announced that we will invest £500,000 to support partnership working throughout the NHS this year and next.

Change led locally and supported nationally

3.9 The scale of the challenges set out in chapter 1 means that action is required from everyone who works in the NHS – and with it, as patients, carers, or in partner organisations. Every organisation or team, large or small, should expect to be involved in making what they do more preventative, people-centred and productive.

3.10 We know that within the NHS there are many examples of teams providing more preventative, people-centred and productive care. However, spreading excellence to the next hospital, social care department, GP practice or community health centre, the next ward, or even the next clinical team takes too long. We can

no longer afford to allow improvement to spread at its own pace.

- 3.11** NHS staff have also told us that they need support to make these changes, based on the best available evidence.
- 3.12** We have therefore worked with leading clinicians and experts over the past two months to assemble an initial evidence base, bringing together details of around 70 initial examples of the best available evidence.⁴⁰ We will work with a number of organisations, including the NHS Institute for Innovation and Improvement, NICE and the Social Care Institute for Excellence, to extend this over the coming months and years, so that, as NHS teams deliver against this challenge, they can readily share their knowledge and learning with colleagues across the country.
- 3.13** Drawing on this evidence and on the ideas and experience of frontline staff, we will back major programmes of work to support commissioners and providers. These programmes will be locally led, but will have national support, and will ensure that innovation is spread rapidly.
- 3.14** Implementing these ideas will be the largest and most complex programme of change the NHS has ever attempted. It has few comparators in any industry anywhere in the world. The change effort required will be substantial, and will require co-ordinated support and input from the range of organisations that have expertise in quality improvement skills.

3.15 The NHS Institute for Innovation and Improvement will align its entire work programme to support NHS organisations to meet the challenge ahead. Other NHS improvement organisations (including Interim Management and Support (IMAS), and the improvement teams established to drive programmes on cancer and infection control) and external organisations (such as the Improvement Foundation) will do the same.

3.16 We will continue to invest to improve leadership at all levels across the system. Organisations must create and nurture the conditions for talent and leadership development. Nationally, we will work with the National Leadership Council to set standards, underpin and champion the talent and leadership system, focusing particularly on five priority areas – Clinical Leadership, Top Leaders, Board Development, Emerging Leadership and Inclusion.

Rights and responsibilities of staff

3.17 We will also support NHS staff through the NHS Constitution, which made four pledges to staff. These pledges represent our commitment for the NHS to go above and beyond the normal legal responsibilities of employers and provide all NHS staff with:

- clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, families, carers and communities;

⁴⁰ www.evidence.nhs.uk/qualityandproductivity

- personal development, access to training for their jobs and line management support to succeed;
- support and opportunities to maintain their health, wellbeing and safety;
- opportunities to engage in decisions that affect them and the services they provide, individually, through representative organisation and through local partnership agreements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

3.18 The NHS Constitution⁴¹ also set out the rights and responsibilities for staff, which are detailed opposite.

3.19 Our vision for the NHS therefore includes a strong partnership with staff to provide a high-quality healthy workplace. We will only achieve this goal if staff have the freedom and confidence to act in the interests of patients. To do this they need to be trusted and actively listened to. They must be treated with respect at work, and have the right tools, training and support to deliver care and opportunities to progress and develop. This is not simply about a good deal for staff, it is essential to meeting the productivity challenge: high-quality workplaces make best use of the talents of their people, ensuring that their skills are up to date and their efforts never wasted. The public rightly expect their taxes to be put to the best use. For those working

in the NHS, there is a need to reduce unnecessary bureaucracy, freeing up their time to care for patients within the resource available. Creating high-quality workplaces requires great leadership and good management.

3.20 In November 2008 the Secretary of State commissioned Dr Steve Boorman to conduct an independent review of the health and well-being of the NHS workforce. This builds on specific aspects of Dame Carol Black's review of the health of Britain's working-age population, *Working for a healthier tomorrow*. The Government has accepted his recommendations and is looking to the NHS to implement them in 2010/11.

3.21 Dr Boorman's final report⁴² makes 20 recommendations, including the following:

- NHS organisations should have a prevention-focused health and well-being strategy in place for all staff.
- Senior management should be made accountable at each organisation for staff health and well-being, which will be measured as part of the annual assessments of NHS performance.
- There should be early interventions for staff with musculo-skeletal and mental health conditions, to help minimise the time staff must spend suffering with these problems and to support early return to work.

⁴¹ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093421

⁴² www.nhshealthandwellbeing.org

NHS staff rights contained in the NHS Constitution	
1	You have the right to fair treatment regarding leave, rights and flexible working and other statutory leave requests relating to work and family, including caring for adults that you live with.
2	You have the right to request other 'reasonable' time off for emergencies (paid and unpaid) and other statutory leave (subject to exceptions).
3	You have the right to expect reasonable steps are taken by the employer to ensure protection from less favourable treatment by fellow employees, patients and others (e.g. bullying or harassment).
4	You have the right to pay; consistent with the National Minimum Wage or alternative contractual agreement.
5	You have the right to fair treatment regarding pay.
6	You have the right to be accompanied by either a Trade Union official or a work colleague at disciplinary or grievance hearings in line with legislation, your employer's policies or your contractual rights.
7	You have the right to consultation and representation either through the Trade Union or other staff representatives (for example where there is no Trade Union in place) in line with legislation and any collective agreements that may be in force.
8	You have the right to work within a healthy and safe workplace and an environment in which the employer has taken all practical steps to ensure the workplace is free from verbal or physical violence from patients, the public or staff, to work your contractual hours, take annual leave and to take regular breaks from work.
9	You have the right to a working environment (including practices on recruitment and promotion) free from unlawful discrimination on the basis of race, gender, sexual orientation, disability, age or religion or belief.
10	You have the right to have disciplinary and grievance procedures conducted appropriately and within internal and legal requirements.
11	You have the right to appeal against wrongful dismissal.
12	If internal processes fail to overturn a dismissal, you have the right to pursue a claim in the employment tribunal, if you meet required criteria.
13	You have the right to protection from detriment in employment and the right not to be unfairly dismissed for 'whistleblowing' or reporting wrongdoing in the workplace.
14	You have a right to employment protection in terms of continuity of service for redundancy purposes if moving between NHS employers.
15	You have rights relating to the ability to join the NHS Pension Scheme.

3.22 The report supports the pledge to NHS staff in the NHS Constitution to 'provide support and opportunities for staff to maintain their health, well-being and safety'. It makes a strong case that NHS organisations should be exemplars in improving the health of their staff. The report shows a positive relationship between staff well-being indicators and patient quality indicators. It also states that the NHS could save up to 3.4 million working days – equivalent to 14,900 extra staff – and direct staffing costs of £555 million each year if the report's recommendations are implemented.

A responsible approach to pay and security of employment

3.23 When we consulted the public about the NHS Plan in 2000, we asked them what they wanted most. Their answer was unambiguous: more staff, paid better. Our response has been equally unambiguous. We have increased the number of staff by almost 300,000, including over 44,000 extra doctors and 89,000 extra nurses.

3.24 We could not have done this without reforming and increasing pay for the NHS. In particular, we have introduced new terms and conditions for medical consultants, for staff grades and associate specialist doctors, and for the million staff covered by Agenda for Change. These terms and conditions provide a robust framework for pay which now applies not only throughout England, but across all four UK nations. As such, it ensures that men and women are paid fairly and equally for the work they perform, wherever they are employed by the NHS.

3.25 We believe that these new contracts, and the national bargaining that underpins them, provide a fair basis for pay. We will therefore continue to support this approach and to work with NHS Employers and trade unions to ensure that these contracts remain fit for purpose and that we maximise their effective use for the benefit of patients.

3.26 However, pay now accounts for nearly half of the NHS's expenditure each year.

3.27 We must therefore ensure that future pay awards strike the right balance between rewarding existing staff for increased quality and productivity and the need to maintain security of employment by retraining and redeploying staff to meet additional demand. This will require sustained pay restraint. It must begin immediately and be led by our most senior managers and clinicians.

3.28 We have advised the NHS Pay Review Body that we do not favour reviewing the final year of our three-year pay deal for staff who are covered by Agenda for Change. Our recommendations for those staff not covered by a multi-year deal are for restraint.

3.29 We have therefore recommended that consultants and very senior managers receive no increase in 2010/11, and that any increase in NHS income for GP practices should be restricted to cover projected increases in practice expenses, while practices should be expected to make at least 1% cash-releasing efficiency savings.

- 3.30** Looking further ahead, we believe the announcement in the 2009 Pre-Budget Report provides the resources to protect frontline services in the NHS. We therefore propose to work with NHS Employers and trade unions through the national Social Partnership Forum and Staff Council to explore the pros and cons of offering frontline staff an employment guarantee locally or regionally in return for flexibility, mobility and sustained pay restraint. This may require tough choices for staff, including working in a different place or in a different organisation. It will also require a joint commitment to ensure tight control of the total pay bill.
- 3.31** We will examine the case for asking the Pay Review Body to consider more demanding efficiency requirements from GP practices. We have also asked NHS Employers and trade unions to explore the scope for linking future pay awards to improvements in quality and productivity.

Securing the NHS Pension Scheme

- 3.32** NHS staff also benefit from access to a good pension scheme. We know that this is an important benefit for staff, not only to those who have already given a lifetime of service to the NHS, but also to those who are at an earlier stage of their career. That is why we supported the fundamental reforms that were introduced in April 2008 to preserve access to final salary pensions for both existing and new staff in the NHS.
- 3.33** These reforms introduced a unique cost-sharing deal which preserved access to a pension based on defined benefits, capped employers' liabilities and introduced fairer tiered personal contributions from staff so that those who earned more also paid more for their pension. Most important, however, these reforms provided a solid foundation for a sustainable, defined benefit pension scheme for the future. We remain committed to this cost-sharing arrangement, which is fair to both staff and employers.
- 3.34** The NSR confirmed access to the NHS pension scheme to those staff who were transferred to Social Enterprises under the Transfer of Undertakings (Protection of Employment) Regulations (TUPE). This reassured many staff who wanted the freedoms of working in a new type of organisation that would release them from the normal constraints of NHS bureaucracy and allow them to promote innovation and efficiency to serve their patients better.
- 3.35** Some third sector and private businesses that would like to provide services for the NHS find it difficult to compete against in-house provision. We are therefore considering how potential barriers such as pensions might be lessened.

Improved support for retraining and redeployment where services change

- 3.36** The proposed redesign of services around patients will have important implications for many staff. Some may be anxious about these changes. However, they can be reassured that we will honour the principles, responsibilities and rights set out in the NHS Constitution. In particular, we will engage staff in the decisions that affect them, such as the design of services. We will also support them to adapt their skills and experience so that they can continue to provide high quality services wherever they are needed.
- 3.37** To facilitate this, we will require strategic health authorities, primary care trusts and employers to review their training plans and align them to support the delivery of local clinical visions and new ways of working. This will include ensuring sufficient investment to support the retraining and redeployment of staff, especially for those moving to new roles and settings. We will also require commissioners and providers to work together across health economies to maximise security of employment and we have asked the NHS Staff Council to consider protecting continuity of service for staff who are transferred from the NHS who subsequently choose to return.

Implementing the Staff Passport

- 3.38** Under the auspices of the SPF, we have also produced the Staff Passport, which builds on the pledges in the NHS Constitution and sets out the common standards that staff transferring between NHS-funded services can expect. The Staff Passport enshrines the Cabinet Office Code 2005, ensuring that staff working for non-NHS organisations on NHS-funded services enjoy terms and conditions that overall are no less favourable than those of staff transferred from the NHS. It also sets out the expectation that all organisations delivering NHS-funded services should adopt common standards.
- 3.39** As such, this is an important document that will provide clarity and reassurance for those facing transfer in the NHS. It will also provide a valuable toolkit for HR advisers, trade union representatives and managers to help them support staff through such changes.

Summary

- 3.40** We all rely on hard-working NHS staff to provide the highest quality care. We know that this will mean significant change over coming years. Our commitment is to support staff through these changes and work in partnership with them as we do so.

chapter 4

how the system will support NHS staff and organisations to deliver



NHS 2015 – how the system will support NHS staff and organisations to deliver

More preventative, people-centred and productive services are also more likely to be much more integrated than they are today. The NHS will need to work more closely with a wide range of partners, collaborating to provide better services for patients and the public. We need organisations and systems to support and enable that vision. We want commissioners to be systematic in driving improved quality and in challenging poor-quality services. We want to free up the best organisations to go further. We need to ensure that payment systems reward improved quality and support integrated services.

- 4.1** To make the changes set out in previous chapters, and to create a people-centred, preventative and productive NHS that benefits patients and is driven by staff, we need to ensure that we have right levers and incentives to support bold, capable commissioners, and high-quality, efficient providers of care.
- 4.2** Over the next few months, we will therefore continue to set a clear direction for the NHS towards our vision and provide support to it by:
- ensuring that payment systems support improved quality and efficiency;
 - helping staff through change;
 - strengthening regulation and dealing with failure;
 - creating leaner, stronger commissioners;

- integrating services and supporting high-performing organisations;
- streamlining the reconfiguration process; and
- driving innovation.

- 4.3** Together, these actions will support the NHS in further improving quality and efficiency, more effectively managing demand on local services, and shaping local services in a way that provides the best care to meet the needs of the population.

Ensuring payment systems support improved quality and efficiency

- 4.4** A high-quality and productive NHS needs payment systems that offer the right incentives. That means incentivising providers to maximise the efficiency of care; to provide the highest quality of care; and to shift care from hospitals to the community, reducing hospital admissions. So over the coming years we will continue to develop the national tariff and other payment systems with the aims set out below.
- 4.5** **The tariff payment system must incentivise providers to maximise efficiency** by limiting or freezing the amount it pays for each procedure carried out in hospitals, by having a maximum uplift of 0% for the next four years. This will drive all providers to become as efficient as the highest performers.

4.6 The tariff payment system must incentivise providers to offer the highest quality care by linking increases in payment to specific quality goals and ensuring that the level of payment reflects best practice rather than average costs. This will bind together quality and financial aims for providers – something that is crucial to realising our vision for a high-quality and productive NHS.

In 2006, United League Commissioning (ULC), a practice-based commissioning consortium of GP practices, set out to tackle unnecessary hospital admissions in Halton and St Helens. The PCT was found to have the second highest non-elective admission rate in the NHS North West region.

GPs and other clinicians designed the Acute Visiting Scheme, which is delivered by the local out-of-hours co-operative and provides patients with rapid access to GP home visits during surgery hours, allowing them to be seen quickly, receive a thorough examination and have adequate time to ask questions.

The scheme has helped avoid 30% of unscheduled hospital admissions. Annual savings of approximately £1million have been estimated across a population of 52,000 patients, which will allow investment in new practice-based commissioning schemes to further improve patient care.

4.7 The tariff payment system must incentivise the shift of care out of hospital settings if this is what patients want. This will mean limiting the payments providers receive

when activity exceeds planned levels. Moving care from hospitals to community settings and patients' own homes will not only improve efficiency, but will also drive increases in quality – for example, by providing patients with renal dialysis and chemotherapy in their own homes and offering more scans and tests in primary care rather than in hospital. This will also mean linking payment systems with whole pathways of patient care, so that providers have incentives to keep patients with long-term conditions, such as diabetes and COPD, healthy and prevent unplanned and unnecessary hospital admissions.

4.8 The tariff payment system must not reward poor quality or unsafe care, which means enabling PCTs to withdraw payments when care does not meet the minimum standards patients can expect. This will be included in contracts with providers from April 2010. The care this covers includes, for example, so-called “never events” – examples of unsafe care such as wrong site surgery. We will consider how this list should evolve over time to cover, for example, cases of VTE or pressure ulcers.

4.9 The payment system for primary care must also deliver improvements in quality and productivity. For 2010/11, we have exceptionally agreed to make no changes to the Quality and Outcomes Framework (QOF)⁴³ in recognition of the pressures arising from pandemic flu. For 2011/12 onwards, there needs to be significant reform to QOF to deliver improvements in quality and

⁴³ www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/QOF/index.htm

efficiency. This is likely to mean raising performance thresholds and retiring indicators that have limited cost-effectiveness to make way for more stretching quality indicators.

- 4.10 The payment system for NHS dental services must also increasingly reflect quality of service.** Following Professor Jimmy Steele's independent review of dental services, we will next year start piloting variations to the NHS dental contract. This will link an increasing part of dental practices' remuneration to the quality of care they provide and the number of patients in continuing care.

Helping staff through change

- 4.11** We have said that the NHS is our preferred provider. As we go forward and transform the system, we need to find more engaging, less polarising ways of making change happen than we have in the past.
- 4.12 We will empower and enable NHS staff to lead change** and service transformation. We are asking the NHS and its staff to go through an unprecedented amount of change. It will be led by the NHS, but it can also include partners from other sectors, including the life science industry.
- 4.13** The essence of this policy is to set out the ground rules on which existing NHS services are challenged. It denotes a fair process, not a permanent status. It should not be used to allow underperformance to continue, nor to freeze out our partners in other parts of the NHS, the third sector and the independent sector. Where there is underperformance and the NHS is an incumbent provider we will give the NHS the first opportunity to improve to the level of the best. This 'NHS first' approach will be set out in more detail in Procurement Guidance in January.
- 4.14 Commissioners have a legal duty to secure the best services, in terms of quality and productivity, for the people they serve.** We expect commissioners to do this through robust contract management and benchmarking, including patient experience information. Where there is potential for significant improvements, commissioners should undertake a service review with the provider and agree a service improvement plan and, if necessary, variations to their contract.
- 4.15** Where a service is demonstrably underperforming, we expect PCTs to use the contractual levers available to them to secure substantial and rapid improvements in performance. For NHS trusts and PCTs, the NHS Performance Framework will offer rapid support. In the case of NHS foundation trusts, Monitor can intervene if a trust is significantly in breach of its terms of authorisation. In cases where there is insufficient improvement, the new statutory unsustainable provider regime⁴⁴ may be used.
- 4.16** In addition to this, Monitor now has the power to de-authorise a foundation trust, making it clear that

44 The Health Act 2009 www.opsi.gov.uk/acts/acts2009/ukpga_20090021_en_1

the foundation trust must maintain the high standards expected. We can formally ask Monitor to consider the case for de-authorising a foundation trust if we feel there are grounds for doing so.

4.17 If the required improvements are not, or cannot, be delivered, the commissioner should engage with other potential providers.

If, as set out in the NHS Performance Framework and Standard NHS Contracts, despite being given two opportunities by the commissioner to address underperformance, substantial improvement is not forthcoming – within months, not years – commissioners should tender for alternative providers on an ‘any willing provider’ basis, from partners in the wider NHS, the third sector or the independent sector. If there are issues or concerns about patient safety, we would expect commissioners to act speedily to intervene and, where appropriate, involve the Care Quality Commission (CQC) at an early stage.

4.18 We will encourage NHS providers to empower frontline clinicians and give them greater autonomy, but also greater responsibility for their own services through service-line management. In plain English, service-line management means putting clinical teams in charge of their own budgets. We will work to ensure that the benefits of this approach are understood throughout the NHS. Clinicians are already responsible for the quality of service they provide.

This further step will give them a new level of financial freedom to improve their service further. This freedom will bring with it a responsibility for clinicians to measure and report the quality of services to trust boards.

4.19 We will continue to work with the independent and third sectors,

particularly where new services or new service models are required to meet future needs or to offer patients more choice. Competition for such services will be transparent and fair, with all providers having an equal opportunity to bid, potentially in new partnerships and joint ventures. We will continue to remove potential barriers to the participation of non-NHS providers, including access to information systems. We will support greater staff mobility by clarifying in the new Staff Passport the rights of staff delivering NHS-funded care. We will also ensure that these rights are protected by referencing the Staff Passport in the guidance for the new standard contracts for clinical services.

Strengthening regulation, dealing with failure

4.20 Patients and their families need to be confident that all NHS organisations are meeting tough basic requirements.

We are bringing in a new registration system for providers of health and adult social care, making them subject to the same regulatory regime. This new system will strike the right balance between regulation that is robust and challenging, serving patient interests, and yet proportionate in its implementation.

- 4.21** From 1 April 2009, NHS providers have been required to register with the CQC, to comply with a single requirement in respect of healthcare-associated infections.
- 4.22** Legislation will be in place from 1 April 2010 requiring NHS providers to be registered for a **full range of 16 registration requirements relating to all aspects of the patient experience in a safe and quality service**. The CQC will have new powers, where NHS providers are found to be not meeting their legal responsibilities, to assure the public of the quality and safety of their local hospitals.
- 4.23** We have agreed with the CQC that it will look at how it could bring forward key aspects of the new regulatory regime from January 2010, in advance of the legislation. This would include looking at the use of real-time data to inform its risk assessments, and implementation of the registration system. CQC will give NHS providers information and advice so that they will be able to focus on making their application and any improvements to patient safety that they need to make in order to be registered by 1 April. In addition, CQC will communicate its provisional registration decisions to trusts early, as soon as practicable in March.
- 4.24** The system will provide independent assurance of the essentials of safety and quality of care. Providers will be required to declare compliance, and the CQC will undertake ongoing monitoring and inspection to ensure that providers meet these requirements. Under the new system, **unannounced inspections could occur at any time**. Failure to comply with the requirements will be an offence, and the **CQC has tough enforcement powers it can use to bring providers back into compliance**. The CQC will use both its inspection powers and enforcement tools proportionally, focusing on the organisations with the greatest risks. In very serious cases it has the power to suspend or cancel a provider's registration.
- 4.25** The registration system will be phased in for other providers to ensure a smooth transition and to allow both the CQC and providers time to prepare. Private and voluntary healthcare and adult social care providers of regulated activities will be brought into the new system from October 2010 (this will bring in the majority of providers currently registered under the Care Standards Act 2000), then primary dental care and private ambulance providers from April 2011, and primary medical care providers from April 2012.
- 4.26** At every stage, CQC will work with regulatory partners to ensure a coherent and co-ordinated approach to ensuring safe and high-quality care for patients.

Creating leaner, stronger commissioners

- 4.27** Good management, and particularly good commissioning, is absolutely critical to realising our vision of a higher-quality and more productive NHS. Commissioners must lead the change from good to great at local level. But achieving our vision

also means maximising the level of resources that go on frontline patient care. That is why we are working across government to minimise spending on overheads and management costs, as we set out in the *Putting the frontline first: smarter government*. It is vital that the NHS follow suit.

4.28 The challenge for the world-class commissioning organisations of the future is to continue to lead local change while themselves becoming more capable, more efficient and better able to work together to realise economies of scale. This will mean accelerating commissioner development while reducing the amount we currently spend each year on management costs, including management consultancy, in the commissioning sector.

4.29 Commissioners will continue to drive local change by working systematically to realise the local visions for changing patient pathways agreed during the Next Stage Review. By understanding local needs, reshaping the provider sector, rigorously challenging providers on a service by service basis and thereby securing the highest quality and most efficient services for their populations, commissioners will be at the forefront of change.

4.30 We will accelerate improvements in commissioner capacity by setting clear goals for reaching high standards against the world-class commissioning framework. All commissioners will be

expected to reach clear performance goals (level 3 on the majority of world class commissioning competencies) by April 2011.

4.31 We will help PCTs focus their resources on the most effective and best-value care. We will do this by:

- ensuring that patients who need operations are helped to decide whether or not they want an operation. Evidence suggests that when the likely outcomes are explained in detail, patients often choose not to have the operation or procedure;⁴⁵
- helping PCTs and practice-based commissioning groups stop commissioning treatment that has little benefit to patients. The NHS wastes significant amounts of money each year giving treatment to patients that does not benefit them or where equal benefit could be delivered at lower cost;
- providing timely benchmarking information to enable the NHS locally – down to practice level – to investigate whether current levels of referrals and admissions are too high, given the underlying health needs of their respective populations. There are still large variations in treatment and referral rates, which cannot be explained by differences in need; and
- supporting continued efforts by PCTs to improve the efficiency of prescribing and medicines use. Despite recent progress, there remain unjustifiable variations⁴⁶ in the use of some higher-cost,

45 www.productivity.nhs.uk

46 Mulley AG. 2009, The need to confront variation in practice. *British Medical Journal* 339: 1007–1009

branded drugs (for example to control cholesterol) where lower-cost generic alternatives are just as effective for most patients.

- 4.32 We will offer freedoms and incentives to high-performing commissioners and ensure that the best commissioners** are at the leading edge of the drive to improve quality and productivity. A programme for high performers will be in place by April 2010.
- 4.33 We will require poor performers to demonstrate clear and rapid improvement** by including commissioners in the NHS Performance Framework from April 2010. PCTs that seriously underperform in their commissioning responsibilities could be subject to change in management or merger of functions. Ultimately, high-performing PCTs could take over the management of other PCTs that do not improve sufficiently.
- 4.34 We will improve our information about spending on management costs** by improving the data available to all NHS organisations. This will allow both commissioner and provider organisations to understand and reduce their spending on management and other overheads.
- 4.35 We will significantly reduce management costs in PCTs and strategic health authorities (SHAs)** by setting a clear goal of reducing costs by 30% over the next four years.
- 4.36 We will permit reconfiguration where it leads to greater coterminosity** between PCTs and local authorities. Any proposals for

changes to PCTs will be locally driven; we will not impose reorganisation from the centre.

- 4.37 We will encourage commissioners to work together** to increase efficiency and effectiveness in procuring particular services. PCTs should expand the use of joint commissioning arrangements between groups of PCTs and between PCTs and local authorities. They should also devolve appropriate commissioning activities to practice-based commissioners. These actions will increase productivity and allow us to reduce management costs without the need for changes to organisational boundaries.
- 4.38** Commissioning by PCTs, and jointly with other local partners, will increasingly be the main lever for ensuring that inequalities in health outcomes are tackled locally. We will help commissioners to deliver the intentions of the Equality Bill, including a focus on ensuring that they (and SHAs) give due regard to the needs of the socio-economically disadvantaged when commissioning and planning services. We will use existing data and learn from the findings of the upcoming post-2010 strategic review of health inequalities (the 'Marmot Review') to work ceaselessly to reduce inequalities in health outcomes between different groups of the population.
- 4.39 We will help the NHS to join up more effectively with local partners** and to integrate services to provide children and families with the best start in life, prevent

ill-health, improve quality of life and support independence – for example, by making best use of integrated community settings such as Sure Start Children’s Centres. We will build on the strong focus of Local Area Agreements on health, the comprehensive area assessments, the work of local partnerships such as Children’s Trusts, and the learning from the Total Place pilots.

Integrating services, supporting high-performing organisations

4.40 During the past decade, we have created new forms of providers, including NHS foundation trusts. We have worked with the independent sector, third sector, social enterprises and the wider public sector to provide more care in different ways.

4.41 NHS foundation trusts have brought about rapid improvements in financial management and a heightened level of rigour and professionalism in board governance and accountability. The Care Quality Commission’s annual healthcheck shows that the foundation trust sector is performing well against national standards and targets. They have a major role to play in responding to the challenge ahead.

4.42 A high-quality and productive NHS will need provider services organised around the needs of people. Now is not the time for NHS organisations to patrol their own boundaries. This means hospitals, community services and GPs must work together with other partners to provide seamless, integrated care across the NHS and with other local partners. It means removing the barriers between

different parts of the system that can make care inefficient and lead to a poor patient experience. It means providing care where it is most convenient for patients, reducing unnecessary hospital visits, and shifting services into the community and people’s homes. To achieve this over the coming years we will take the actions set out below.

4.43 We will work systematically with primary care providers and practice-based commissioners to reduce variations in quality and drive the most efficient use of NHS resources. As an increasing amount of care moves out of hospital, those GP practices that are delivering the highest standards of quality and contributing to efficient use of NHS resources will have growing opportunities to provide enhanced services. Where groups of GP practices, working as part of practice-based commissioning consortia, can demonstrate significant improvements in quality and efficiency, with an increasing focus on prevention and health outcomes, they will also have growing opportunities to commission wider services on behalf of PCTs, for instance through devolved budgets.

4.44 We will greatly increase the integration of services by doing much more to shape them around patients and to ensure that the boundaries between organisations do not fragment care. Community services will be a particular priority, since they have a pivotal role to play in realising our vision for more integrated, efficient and people-centred care. We will accelerate

reform of community services and set a clear timetable for completing the locally led process of reshaping them. Bringing organisations together will create much more joined-up care, which will make it easier to navigate between services, and will bring together local partners to focus on improving health outcomes for all. This will build on learning from the 16 Integrated Care pilots. Different provider models may be appropriate for different local systems and local needs.

4.45 We will therefore support the NHS locally to determine which model will best support integration of services. This may mean integrating community services with existing hospital providers or with mental health trusts and practice-based commissioning consortia. Community foundation trusts may be an option for a few areas, if the proposals meet the demanding criteria we will set out. Only a small number of community foundation trusts, however, are likely to be approved, since we believe that in many places other options will be more appropriate. For most of the NHS we do not believe that creating new organisations is the right solution. Social enterprise 'Right to Request' schemes will provide a further option for community services, building on the 'first wave' of 20 that we announced recently.

4.46 **We will look at what more needs to be done to align incentives, so that organisations work more effectively together in the interests of patients**, for instance to transfer patients as efficiently as possible from an ambulance to an A&E department.

4.47 **Reform of provider services must encourage the shift of high quality care from hospitals to the community** – essential to developing a more productive NHS. Reform of provider services offers a further incentive for integration between different provider sectors and means that we need to explore new contractual forms for integrated providers, setting out clearly the standards and improvements expected of these providers.

4.48 **We will reduce overheads and transaction costs** in the provider sector, maximising the resources available for frontline care. This means that all providers should understand and reduce their management costs and that we will set clear limits on the number of new organisations created in the community sector.

4.49 **We will offer rewards and freedoms for high performers.** We will expect all remaining NHS trusts boards to come forward by the end of this financial year with a clear trajectory to reach foundation status in the next Spending Review period. In a limited number of cases other organisational forms may be possible if they deliver benefits within the same timeframe, offer equal or greater levels of autonomy and pass a best value test. We will expect strategic health authorities to oversee this process within a national framework.

4.50 **We will encourage high-performing NHS foundation trusts to expand their services. This may mean foundation trusts based in one area providing both acute and community services in other areas,**

if the PCTs in those areas want to commission from them. This is already happening on a small scale, but we will seek to remove the barriers that NHS foundation trusts face in expanding their services. Foundation trusts will be able to be considered to run primary medical services, within appropriate frameworks, where PCTs tender for them.

4.51 We will also expect NHS foundation trusts to take full advantage of their membership arrangements, particularly where they have not already done so. There are now over one million members of NHS foundation trusts around the country. As the number of foundation trusts continues to increase we expect this figure to grow steadily over time. We expect these members to play an important role in advocating for change and improvement.

4.52 We will deal quickly and decisively with poor performers by supporting integration between organisations in different sectors and by making it easier for high-performing trusts to take over poorly performing organisations.

Streamlining the reconfiguration process

4.53 Implementing our vision will require change to services and organisations across the NHS where these are necessary to deliver the quality improvement we seek. We remain

clear that change should only happen when it will deliver quality improvements for patients. We are clear that the process of change should be led by local clinicians and local commissioners and include consultation with local people and a continuing role for local government (through Overview and Scrutiny Committees (OSCs)).

4.54 These changes have not always happened smoothly. At times they have been fractious and divisive. The NHS must continue to work to improve the way such changes are developed and led, including by involving patients and the public.

4.55 Over the last few years this process has improved, through the introduction of independent clinical and management assessments, overseen by the strategic health authority, and through the application of best practice in the NHS.⁴⁷ We have also stated⁴⁸ that we will always seek the advice of the Independent Reconfiguration Panel (IRP) whenever a dispute is referred to us.

4.56 In light of the likely need for further change, we will look again at the reconfiguration process to see whether it can be further simplified. We will also consider how the NHS could better engage with local people and OSCs to ensure that change which benefits patients and taxpayers is delivered as smoothly as possible.

⁴⁷ *Our NHS Our Future: NHS Next Stage Review – Leading Local Change*, Department of Health, May 2008;

Changing for the better: Guidance when undertaking major changes to NHS services, Department of Health, May 2008

⁴⁸ Next Stage Review – House of Commons Debate 4 July 2007 Hansard ref (column 961)

Driving innovation

- 4.57 Innovation in healthcare can transform the quality of care provided to patients and increase productivity**, whether through high-end technologies or service-led system improvements. Cost-effective innovation in the health and social care sector will not only help to provide quality services, but will also stimulate the private sector and invigorate the economy.
- 4.58 Our commitment to encourage and foster innovation in the NHS, and particularly the diffusion of innovation, is clear.** We have created a £220 million Regional Innovation Fund to support quicker innovation and more universal diffusion of best practice across the NHS. We have developed NHS Evidence, a pioneering system to improve access to information, providing clarity on what good looks like. This will lead to better clinical and commissioning decisions and increase diffusion of best practice. We have supported academic health science centres (AHSCs) to foster world-class partnerships between research, teaching and patient care organisations so that developments in research can be more rapidly translated into benefits in patient care in the NHS and across the world.
- 4.59 The NHS Constitution confirms that research remains a pillar of the NHS.** The NHS will do all it can to ensure that patients, from every part of England, are made aware of research that is of particular relevance

to them. We are therefore putting in place procedures to ensure patients are notified of opportunities to join in relevant, ethically approved research and will be free to choose whether they wish to do so. The National Institute for Health Research clinical research network is building on the extraordinary success of the cancer research network to maximise the potential of the NHS to support clinical trials and involve more patients in them.

- 4.60** The interaction between the NHS and the life sciences industries is developing into a business-to-business, rather than simply a customer/supplier, relationship. The **new NHS Life Sciences Innovation Delivery Board will support the early and systematic adoption of clinically and cost-effective innovations** in beneficial medical technologies, through effective engagement with industry. We will review incentives to consider how we can recognise and reward good practice in partnership working, with the aim of improving productivity and prevention.

Summary

- 4.61** The changes set out in this chapter will better support NHS staff and NHS organisations to accelerate quality improvement and provide high-quality and productive services. We will work with the NHS to develop and implement these proposals.

chapter 5

conclusion – meeting the challenge



- 5.1** This document has set out our vision for the future of the NHS, how we can support the NHS to implement and meet the unprecedented challenge of accelerating quality improvement and drive at efficiencies. Although this will be the most difficult challenge it has ever faced, we believe that the NHS can approach it with confidence, building on the major improvements of the past decade.
- 5.2** Improving quality will continue to be at the heart of everything the NHS does. Improvements will be led by NHS clinicians at the local level, based on what is best for the public and patients in their area. There will be no 'blueprint' imposed by the Department of Health and no top-down reorganisations of the NHS.
- 5.3** We will also ensure that, as the changes are made, those with the greatest need get the greatest help. The NHS will continue to work together with its key local partners to banish discrimination and to narrow health outcomes, ensuring that all receive the care they need, and that nobody is left behind.
- 5.4** Our success in delivering on this challenge will depend on mobilising the whole NHS workforce. It will be a central role for every NHS leader – from the nurse or doctor on the ward to the GP in the surgery, from district nurses and health visitors to community pharmacists, from the manager in a trust or practice to their counterpart in a commissioning body, from the NHS Chief Executive to the Secretary of State for Health.
- 5.5** This will be a challenging time; but it will also be a time when we have the opportunity to deliver great benefits for patients and secure the NHS for the next 60 years.



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