

Creating a Patient-led NHS

Delivering the NHS Improvement Plan



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Introduction

The NHS has made huge steps in providing faster, more convenient access to care through increases in capacity and changes in ways of working. There is much more to do but a good foundation has been established.

Since 2000, we have built up capacity, delivered some early reforms and made the step-change in performance necessary to improve services, reduce waiting times and make big improvements in mortality rates.

At the same time we have introduced clinical governance, standards and new arrangements for securing patient safety. In other words we are making sure we can improve the quality as well as the quantity of the services we offer.

But the ambition for the next few years is to deliver a change which is even more profound – to change the whole system so that there is more choice, more personalised care, real empowerment of people to improve their health – a fundamental change in our relationships with patients and the public. In other words, to move from a service that does things *to* and *for* its patients to one which is patient-led, where the service works *with* patients to support them with their health needs.

Capability as well as capacity

The NHS has a proud tradition and at its best has always been very patient-centred and delivered excellent care. Now, we are beginning to have the capability as well as the capacity to become truly patient-led and deliver high-quality services everywhere and at all times.

New practices and systems have been identified and rolled out across the NHS: See and Treat in A&E; the Patient Targeting List (PTL) system in waiting list management; advanced access in primary care; assertive outreach teams in mental health; emergency practitioners in ambulances, primary care and A&E; joint assessment and response teams with social services; closer working links with the independent and voluntary sectors; and much more.

Much of this is led by the 100,000 and more people who have participated in the Modernisation Agency and National Primary Care Development Team programmes who have learned the new techniques for improving quality and services. The NHS now has hard evidence based on thousands of hours of experience in hundreds of organisations of how to improve quality and value for money. And staff throughout the NHS know how to apply this knowledge in improving the services they provide.

Perhaps most striking is the growth in local innovation in the way services are delivered. This is now visible in every part of the NHS – clear, practical evidence of local innovation and creativity. The NHS Live programme is supporting 300 such projects, helping develop a ‘bottom up’ approach to improvement to complement other national programmes.

The NHS Improvement Plan

The *NHS Improvement Plan*, published in June 2004, set out the way in which the NHS needs to change in order to become truly patient-led. These changes are profound. They affect the whole system and the way individuals and organisations behave.

Ministers and I have spent a great deal of time in the last few months listening to patients and staff talking about the NHS, about its successes and shortcomings and about their hopes for the future.

There is clearly a great deal of support for the direction of travel but some uncertainty about aspects of it and many suggestions about how to carry it forward most effectively.

This document is designed to address these issues, offering a description of the major changes underway and – while it cannot deal with every point – describing how some of the biggest changes will be carried forward. It has been written primarily for the leaders of the NHS, the clinicians and managers, the Boards and everyone who is helping lead the transformation of the NHS. But it is vital that these leaders communicate its key messages – about the vision, the values and the major changes – in their own words for their patients and staff.

Learning and leadership

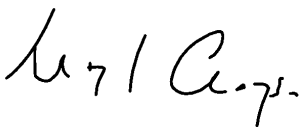
These are complex changes in a complex system. Moving from a centrally directed system to a patient-led system inevitably increases uncertainty. We therefore need to develop even better systems for ‘feeding back’, learning lessons and adapting our approach while maintaining the overall direction.

This feedback and learning needs to be service wide. It needs to involve patients, staff and partner organisations. It needs to be done locally while brought together nationally. We have therefore established the National Leadership Network for Health and Social Care to play a key role in taking forward the work, collecting feedback and shaping the way we implement change.

Although this document is about the NHS, the overall direction of travel is closely allied with social care, where we will be publishing a Green Paper shortly. It is intimately linked to the *Choosing Health* White Paper and requires very good joint working with local authorities, other parts of government, the voluntary sector and private agencies.

I know that this vision and these changes are very ambitious, rightly so. I know too that it is very difficult to deliver improvement for tomorrow at the same time as managing today’s services with all their pressures and demands. But as extra resources are available we have the opportunity to make a profound difference to people’s lives.

The past five years have been about building capacity and capability. The next will be about improving quality, making sure that we give the very best value for money and use the new capacity and capability to build a truly patient-led service.



Sir Nigel Crisp
NHS Chief Executive
17 March 2005

Summary – the major themes

The NHS now has the capacity and the capability to move on from being an organisation which simply delivers services to people to being one which is totally patient-led – responding to their needs and wishes.

Chapter 1 – A patient-led NHS

Every aspect of the new system is designed to create a service which is patient-led, where:

- people have a far greater range of choices and of information and help to make choices
- there are stronger standards and safeguards for patients
- NHS organisations are better at understanding patients and their needs, use new and different methodologies to do so and have better and more regular sources of information about preferences and satisfaction.

Chapter 2 – What services will look like

In order to be patient-led the NHS will develop new service models which build on current experience and innovation to:

- give patients more choice and control wherever possible
- offer integrated networks for emergency, urgent and specialist care to ensure that everyone throughout the country has access to safe, high quality care
- make sure that all services and all parts of the NHS contribute to health promotion, protection and improvement.

Chapter 3 – Securing services

The NHS will also develop the way it secures services for its patients. It will:

- promote more choice in acute care:
 - Primary Care Trusts (PCTs) will be responsible for making sure that from 2006 they offer choices to patients
 - PCTs will not need to direct patients to particular providers but will offer a choice of four or five local NHS providers, together with all NHS Foundation Trusts and nationally procured Independent Sector Treatment Centres
 - all other independent sector providers may apply to be on the list of choices for patients, if they are able to operate to NHS standards and at the NHS tariff
- encourage primary and community services to develop new services and new practices
- strengthen existing networks for emergency, urgent and specialist services, with PCTs and Strategic Health Authorities (SHAs) having explicit responsibility to review and develop them
- build on current practice in shared commissioning with the aim of creating a far simpler contract management and administration system which can be professionally managed and provide better analysis while leaving practices and PCTs in control of decision making
- concentrate more on health improvement and developing local patient pathways and services.

Chapter 4 – Changing the way the NHS works

The NHS needs a change of culture as well as of systems to become truly patient-led, where:

- everything is measured by its impact on patients
- the NHS is as concerned with health promotion and prevention – looking after the whole person – as with sickness and injury
- the staff directly looking after patients have more authority and autonomy, supporting the patient better.

This will require:

- action to tackle the barriers which create rigidity and inflexibility in the system
- shared values and codes of conduct, enshrining the desired changes in culture
- greater support of frontline staff and clinical leadership
- continuous learning, supported by the new NHS Institute for Learning, Skills and Innovation
- a new model for managing change suitable for the new environment
- clearer leadership at all levels, integrated nationally through the new National Leadership Network for Health and Social Care.

Chapter 5 – Making the changes

A patient-led NHS needs effective organisations and incentives, with:

- a new development programme to help NHS Trusts become NHS Foundation Trusts
- a similar structured programme to support PCTs in their development
- further development of payment by results to provide appropriate financial incentives for all services
- greater integration of all the financial and quality incentives
- full utilisation of the new human resources and IT programmes.

Change on this scale involves uncertainty and all organisations need to plan to manage the risks with some national support to:

- strengthen the role of the NHS Bank
- improve the way the NHS handles service and organisational failures
- improve the way that service change and reconfiguration is managed.

Chapter 6 – Next steps

This document outlines action for local and national leaders. There will be a programme of work for the national issues, delivered mainly through the National Leadership Network for Health and Social Care and steered by the Department of Health.

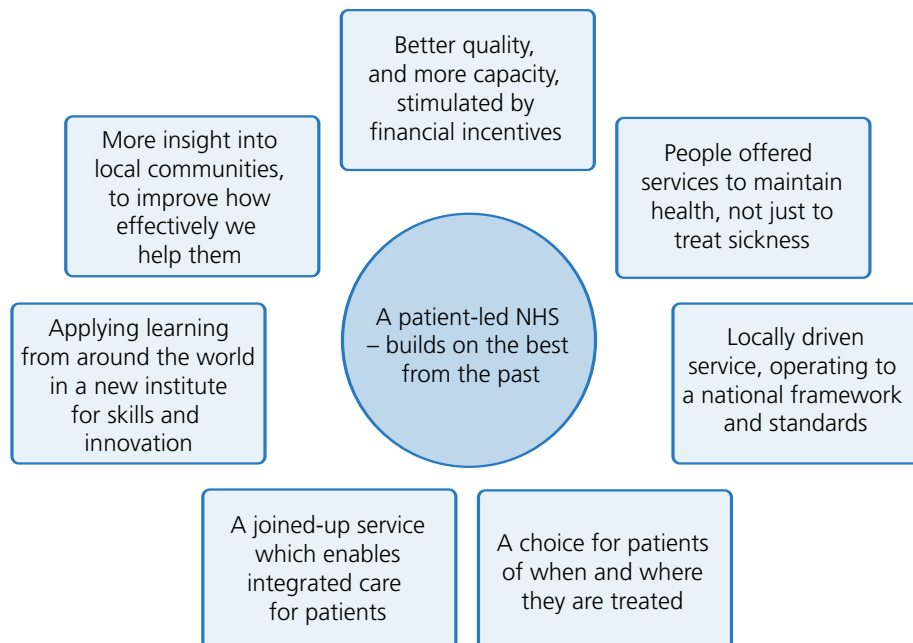
1 A patient-led NHS

Every aspect of the new system is designed to create a service which is patient-led, where:

- people have a far greater range of choices and of information and help to make choices
- there are stronger standards and safeguards for patients
- NHS organisations are better at understanding patients and their needs, use new and different methodologies to do so and have better and more regular sources of information about preferences and satisfaction.

- 1.1 A patient-led NHS is easy to say but hard to do. Individual staff members – be they nurses, doctors, therapists, scientists, support staff or Board members – always want to do their very best for patients. Very often they are successful. The NHS at its best delivers a very high standard of safe, quality, personalised care. This is a tremendous foundation to build on.
- 1.2 But the system itself, and the way people work in the system, can often get in the way. There can be barriers and blockages, professional and organisational boundaries, vested interests and perverse incentives. This is why the service needs to change so that it is truly patient-led with a new framework of standards, skills, organisations, systems and incentives.

A patient-led NHS



What it means to be really patient-led

Sure Start ‘Spa Spiders’ family planning service

Working with a task group of parents and local health professionals, Sure Start and Doncaster West PCT remodelled a local family planning service to better fit the lives of parents with young children.

They listened to concerns about opening times; the location of the service inside the local health centre, which affected confidentiality; all GPs being male; parents with no family support having to take children with them, so children were present when personal discussions and examinations were taking place; and people not having enough time to discuss concerns in depth.

In response, Sure Start provided drop-in family planning sessions with creche facilities separate from the main surgery, supported by a female GP. These sessions were held at more convenient times, with more time allowed for exploring and listening to parents’ concerns.

- 1.3 There are plenty of examples around the NHS of services which are truly patient-led. Where this happens everyone involved makes sure they:
 - respect people for their knowledge and understanding of their own experience, their own clinical condition, their experience of the illness and how it impacts on their life
 - provide people with the information and choices that allow them to feel in control
 - ensure everyone receives not just high quality clinical care but care with consideration for their needs at all times
 - treat people as human beings and as individuals, not just people to be processed
 - ensure people always feel valued by the health service and are treated with respect, dignity and compassion
 - understand that the best judge of their experience is the individual
 - ensure that the way clinical care is booked, communicated and delivered is as trouble free as possible for the patient and minimises the disruption to their life
 - explain what happened if things go wrong and why, and agree the way forward.
- 1.4 This is clearly a better way to treat people but it can also improve outcomes and offer better value for money.
- 1.5 Patients who are treated considerately, who are not left to endure anxiety and worry, who are treated attentively, who are given full and prompt information, who understand what they are being told and who are given the opportunity to ask questions, are more likely to have better clinical outcomes. A good patient experience goes with good clinical care – and patients need both.
- 1.6 Derek Wanless in his 2002 report *Securing Our Future Health: Taking A Long-Term View* shows that giving patients choices, putting them more in control and helping them to be fully engaged in their healthcare is likely to be more cost effective and offer better value for money than if people are simply the passive recipient of services.

Choice and information

- 1.7 The new system will, wherever possible, offer choices of service and of treatment. To make this work, the public generally, and patients specifically, need high quality information. This needs to be available in a wide variety of ways:
- NHS Direct, NHS Direct Online and NHS Direct Interactive – to get immediate advice and help
 - Health Direct – a new service including a telephone line offering general advice on health
 - ‘best treatment’ guides – evidence-based guidance for patients
 - information available in a range of languages
 - magazines aimed at particular groups in society
 - nhs.uk linking with local hospital websites, supported by the NHS Information Centre.
- 1.8 These information services need to be supported by well-trained staff who can help people make sense of the information, make choices and access the system. Health advocates, patient care advisers and the Expert Patient Programme already successfully support people in making decisions about their health and healthcare. The *Choosing Health* White Paper sets out new proposals for community-based health trainers to support healthy lifestyle choices.
- 1.9 Some groups of people, including some from black and minority ethnic backgrounds, are difficult to reach, less well-served and less satisfied with services. The NHS needs to make sure it is sensitive to the needs of all groups.
- 1.10 As part of this the NHS Chief Executive has set all NHS organisations a leadership challenge on race equality to make sure they both address the health needs of all parts of their community and develop staff from all backgrounds. These principles apply to all groups who may have particular needs or find it difficult to obtain services.

Race Equality Action Plan

Health services and outcomes	Developing people
Strategic direction	Mentoring
Align incentives	Leadership action
Development	Expand training, development and career opportunities
Communications	Systematic tracking
Partnerships	Celebrate achievements

The commitment to patients

1.11 As well as offering information, the NHS must also offer safeguards and commit itself to meeting standards. *National Standards, Local Action* sets out seven domains of care which touch all aspects of patients' needs:

- safety
- clinical and cost effectiveness
- governance
- patient focus
- accessible and responsive care
- care environment and amenities
- public health.

1.12 NHS organisations must work to these standards and will be inspected against them by the Healthcare Commission.

1.13 Similarly all other organisations providing NHS services – be they private, voluntary or statutory – will need to work to these standards. Over time, they will be expected to display the NHS logo as a sign of this commitment to the NHS patients they treat. The NHS logo should be the equivalent of a quality 'kitemark' – reassuring patients about the standards and safeguards.



1.14 Patients also need to know about the quality of their care and that their personal information is secure. As the NHS electronic care record is developed, patients must be reassured that their personal details are being kept confidential and well looked after. A 'patient guarantee' is being developed and will be published shortly.

Listening, understanding and responding

1.15 The NHS can be much better at listening to, understanding and responding to people. It can take advantage of the rich mix of information that exists about the people we serve. Patients are not just the sum of their ailments. They have lifestyles and interests which impact on their health. What they buy, watch, read and do all contributes to their health prospects. This is information that can be used to help understand better how to shape services to respond to individuals and their lifestyles.

Understanding local needs

Action Diabetes, run by Slough Primary Care Trust, used marketing data and analytical techniques to target people at risk. The pilot identified a largely Asian community, often without English, who shop locally and have a high preference to watch the local cable TV shopping channel. The pilot is working with local retailers and cable TV to raise awareness of diabetes and use high-level targeting of messages through a celebrity magazine, as well as personalised direct marketing using leaflet distribution door to door.

Volunteers target high-risk post code areas. An Action Diabetes bus takes testing and health promotion services out to schools, temples, mosques, businesses and community centres in the locality.

The local rate for diagnosing Type 2 Diabetes has gone up by 33 per cent. This means that many patients are now receiving treatment much earlier.

- 1.16 Data sets and research techniques which help commercial organisations understand and target their customers can help.
- 1.17 A new Health Insight Unit is being developed by the Department of Health to support this type of approach. It will be operational by summer 2005 and will hold a database of the key data sources that help describe public health needs, demographics and health related behaviours. It will support NHS organisations to develop their own methods of understanding the diverse needs of their populations.

Patient preferences and experiences

- 1.18 There are many sources of information about patient preferences and experiences which can be used to inform local action. Increasingly local surveys will sit alongside the national patient survey programme to inform local action. The national programme provides useful information about patient preferences and experiences. However, a faster turnaround of information is needed, together with better tools for local organisations to use.
- 1.19 The Healthcare Commission is looking at survey frequency, increasing sample sizes and response rates, boosting the responses of some patient groups that are important – given the local population profile of some NHS Trusts – and providing help for NHS Trusts in survey methods and using results.

Patient and public involvement

- 1.20 Patient and public involvement should be part of everyday practice in the NHS and must lead to action for improvement. Only then will patients and the public have a greater say in the way the NHS is planned and developed, how it operates and how it can better respond to their needs and expectations. This is now reflected in the core national standards which the Healthcare Commission will take into account when they assess all NHS healthcare providers.
- 1.21 This involvement begins with patients exercising choice but it needs to go further. The NHS also needs to engage with patients and the public in other ways. Existing mechanisms will need to evolve to reflect this maturing relationship. Current arrangements include:
 - Patient Advice and Liaison Service (PALS) – NHS provision of accessible support, advice and information to patients and carers

- Overview and Scrutiny Committees (OSCs) – local authority councillors have the powers to review and scrutinise the planning, provision and operation of the health service and to make recommendations for improvement
- Section 11 of the Health and Social Care Act 2001, which places a duty on the NHS to consult and involve patients and the public in the planning and development of health services and in making decisions affecting the way those services operate
- patient forums – independent bodies made up of volunteers and set up to monitor the quality of the NHS from the patient perspective
- complaints investigations by the NHS, with the Healthcare Commission managing the independent review stage of the complaints procedure
- Independent Complaints Advocacy Service (ICAS) – the provision of independent support to patients wishing to complain about the NHS
- NHS Foundation Trust Boards.

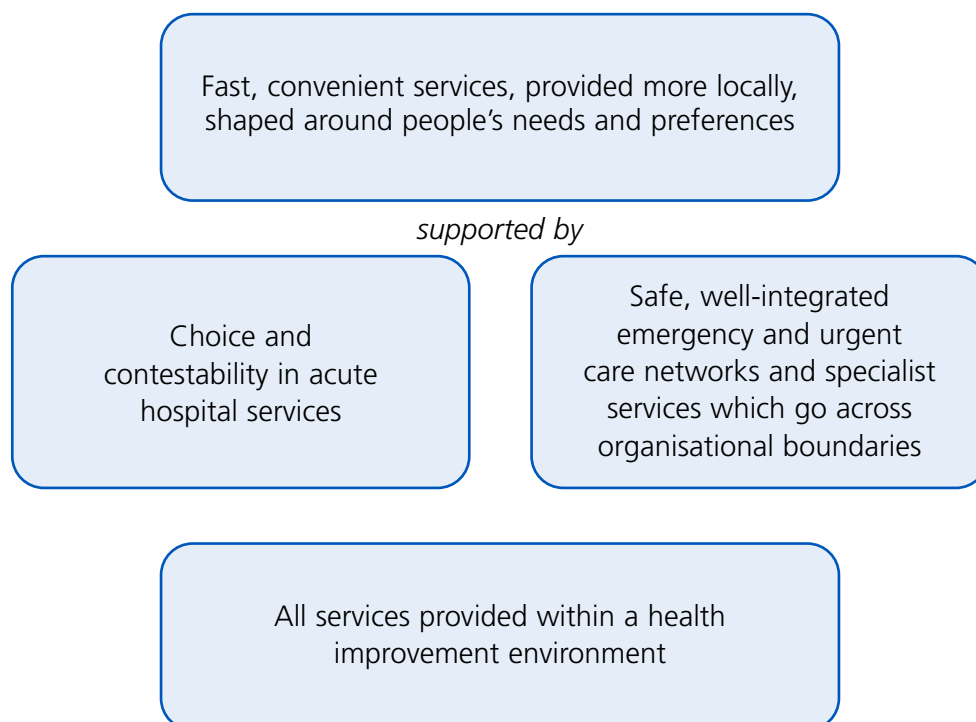
2 What services will look like

In order to be patient-led the NHS will develop new service models which build on current experience and innovation to:

- give patients more choice and control wherever possible
- offer integrated networks for emergency, urgent and specialist care to ensure that everyone throughout the country has access to safe, high quality care
- make sure that all services and all parts of the NHS contribute to health promotion, protection and improvement.

2.1 A patient-led service will require new ways of delivering services that are responsive to patients:

- fast, convenient services, often delivered very locally and shaped around people's needs and preferences
- high quality, integrated emergency, urgent and specialist services for patients wherever they are in the country.



2.2 Already there are many examples around the country of new services being developed. Over the next few months and years the NHS will learn from these examples and introduce new service models everywhere.

Health improvement and self-care

2.3 The NHS and local government will take the lead together in promoting health – helping individuals and communities make informed, healthy lifestyle choices and giving them the practical support and motivation to achieve this in a way that reflects the reality of their lives.

This commitment is spelled out in the *Choosing Health* White Paper and means that patients will increasingly:

- get advice on improving their health as part of routine care, eg advice on giving up smoking before an operation (to improve wound healing) or when receiving mental healthcare
- be able to develop their understanding and skills to improve their own health, eg through Health Direct, health trainer services and the Expert Patient Programme
- have access to high quality health improvement services for smoking cessation, healthy eating and physical activity, obesity and sexual health.

2.4 The NHS also needs to do more to help people care for themselves if they become ill. In recent years, primary care practices, NHS Direct and pharmacists have been successful in giving people the confidence to deal with minor conditions at home.

Support for people with long term conditions

2.5 Improving the management of long term conditions is one of the key priorities for 2008 and is set out in *Supporting People with Long Term Conditions*. The aim is to improve the rate of early diagnosis, empower patients to manage their own condition as far as possible, support them with personalised care, such as access to a community matron and ensure access to specialist advice when needed.

2.6 Experience indicates that improving management of long term conditions can transform health and quality of life for patients. Good self-care, supported by proactive primary care, can achieve excellent results, as the example in the box below shows.

Diabetes self-care in Burnley, Pendle and Rossendale

Burnley, Pendle and Rossendale PCT has developed a six-week group education programme for patients with diabetes – known as ‘X-PERT’. The programme aims to increase knowledge, skills and confidence so that individuals are able to make informed decisions about self-management of their diabetes. It has been tailored for use in 10 communities across the PCT, including three versions for Urdu speakers.

Programme participants have benefited from significant medical improvements, improved diabetes self-management, healthier lifestyles, a better quality of life and greater satisfaction with their treatment.

Practice nurses, learning disability nurses and dietitians are being trained to deliver the programme throughout East Lancashire, allowing all people with diabetes and their carers to attend. The curriculum and learning materials are also being made available for use nationally.

Primary care

- 2.7 Primary care has traditionally been the part of the NHS offering the most personalised service, and GPs remain one of the most highly regarded groups within the NHS.
- 2.8 There is already a huge amount of innovation across the country. The challenge will be to extend this to a new vision for primary care where as much care as possible is delivered as close as possible to patients' homes, ensuring that everyone has access to a range of excellent services. While it is important to be clear that 'one size does not fit all', the NHS needs to learn quickly from examples of best practice.
- 2.9 The NHS system for primary care has many strengths. In particular, the 'registration model' (where everyone registers with a primary care practice), has many benefits. These include continuity – which many patients value – as well as delivering good health outcomes and better public health and managing care pathways and resources across the system.
- 2.10 While these benefits are important and must not be lost, primary care will adapt as the system evolves. Choice and diversity are as important in primary care as in hospital services. The NHS needs to have enough capacity so that a patient's existing choice – which practice to join – is not constrained by lists being closed locally. And the NHS needs to develop new choices for patients who want an alternative to traditional models.
- 2.11 To deliver these new models the NHS will need to innovate. This might mean a new type of professional within a more traditional practice – community matrons and other specialist primary care workers are examples – but with the blurring of professional boundaries, there is scope for more creativity. It will also mean some radically different types of provision – building on the successful introduction of new services such as NHS Direct and Walk-in Centres – and it will involve freeing up the entrepreneurialism within primary care and developing new types of provider organisations.
- 2.12 Some services which were traditionally provided in secondary care will be delivered in primary care. For example, up to 15 million outpatient attendances could be safely and effectively offered in community settings for specialties such as trauma and orthopaedics; ophthalmology; general surgery; ear, nose and throat; dermatology and gynaecology. Currently fewer than a million specialist consultations are delivered in primary care. New facilities will be needed to enable this, while collaborative working between secondary and primary care needs to be incentivised.
- 2.13 Most importantly, primary care can do more than just substitute for existing hospital services. The right early intervention and support from primary care can change the course of a patient's illness. Particularly for those with long term conditions, primary care plays a vital part in supporting self-care and providing timely advice and help when needed.

Service model in 2005

Recently Great Yarmouth and Waveney introduced 'Linkworkers' who are qualified mental health specialists working as part of a broader primary mental health service.

Linkworkers support people with a range of health problems including depression, anxiety, bereavement and phobias. They promote the delivery of care in ways that both feel comfortable and are more convenient for the patient. They support the delivery of effective care pathways, minimising the gaps within services.

In the first year of the scheme, referrals to specialist mental health services have fallen by approximately 40 per cent and feedback from patients is very positive.

Service model in 2008

Patients now have access to health information through NHS Direct and NHS Direct Online, and are able to obtain information to support self-care.

Where referral to more specialised services is necessary, choices of treatment now include care in the patient's home or care provided by independent providers. Admissions to traditional psychiatric hospital beds have continued to fall.

Patients have more access to psychological therapies and counselling services. Staff numbers and training opportunities have increased.

Specialist services, whether provided within the NHS or in partnership with those outside it, are operating as an integrated whole.

Hospital care

- 2.14 The NHS provides many different types of care: from low-tech support to help people stay well, to high-tech interventions; from planned, routine care to the most urgent emergencies. Care is provided in people's homes, in primary care practices, in clinics, walk-in centres, community hospitals, district general hospitals and specialist hospitals.
- 2.15 For some types of care, there is flexibility over where, when and how it is provided, so it is feasible to build a system which continuously adapts to what patients choose. For other types of care a more planned approach is needed.
- 2.16 For both mental as well as physical healthcare, hospitals are critical to the system and beds in hospitals and other settings will always be needed. Hospitals resolve healthcare crises and provide high-tech interventions which require economies of scale to be safe and efficient.
- 2.17 Hospitals – whether they provide mental or physical healthcare, general or specialist services – will change in the future. A more diverse range of providers will deliver planned care, with patients having free choice of provider. But at the same time these organisations will work together to deliver safe networks of care for emergency and specialist services.

Emergency and urgent care

- 2.18 Emergency and urgent care have to be provided through a safe, joined-up network of care. Wherever patients enter the system, they need to be urgently routed to the right place to have the right treatment. Care should be convenient and provided as close to home as safely as possible. Patients will have options as to how they access and use the system.

2.19 SHAs and PCTs must ensure that each system has:

- in-hours and out-of-hours primary care which can respond urgently and route patients to the right place, supported by NHS Direct as a first port of call for some patients
- an ambulance service which treats the patients it can and transports others to the right care provider
- a network of hospitals which provide emergency medical services with access to surgical and specialist trauma services either on site or in the network.

2.20 The time is right for the NHS to take a fresh look at how an emergency and urgent care network should be organised, building on the principles of *Keeping the NHS Local*, to decide the model for essential services in the future.

2.21 This model is needed to guide the development of services, but also to ensure that incentive systems are aligned with goals, and that rules for accreditation, entry and exit of providers are consistent with ensuring everyone is covered by a secure, 24/7 emergency service.

Service model in 2005

The emergency and urgent care network in the south of West Kent co-ordinates emergency services across two local PCTs. It includes the local hospital, ambulance service, mental health trust and social services.

The network is helping the local hospital to achieve and sustain the 98 per cent A&E target and to improve urgent care.

In April 2005, the out of hours (OOH) service will be integrated with the emergency care centre (ECC) at the hospital, the Walk-in Centre and emergency services. Patients will call the OOH service and, together with a triage nurse, decide the appropriate care option.

Patients who phone 999 in an emergency get an ambulance. Less urgent calls will be transferred to an urgent care desk. For patients walking into the ECC, a care co-ordinator will guide them to the right services from the most appropriate team.

Service model in 2008

The emergency and urgent care network has further examined the needs of the local population and improved community and home care. It includes pharmacies, patients, the public and the voluntary sector.

Demands on A&E have reduced, as patients are fast-tracked to the appropriate service.

The hospital's ECC – with a Walk-in Centre, minor injuries unit and OOH service – houses emergency social services and emergency mental health services. ECCs have also been established in community settings. Thanks to better information, the local community has a good understanding of how they can benefit from the ECC.

The public dials a single telephone number to speak with the triage nurse. If appropriate, ambulance paramedics bring patients to the ECC. Emergency care practitioners and emergency social services staff also visit patients at home.

Specialist networks

- 2.22 The care provided by the NHS ranges along a continuum, from supported self-care through to general care provided by practices and other community services, through to the most specialist care provided on a regional or even a national basis.
- 2.23 While choice is the guiding principle, it is clear that the more specialised the service, the fewer the providers that can safely offer the service. Specialist services need a critical mass to perform effectively – both because clinicians need to maintain their skills and because high-tech medicine needs expensive infrastructure.
- 2.24 Patients should receive safe and effective treatment as close to home as possible. For complex problems such as cancer, some elements of care can and should be provided in the community, some in a local district hospital, while other aspects of care will require access to a specialist cancer centre. Good co-ordination of care across a network of primary, secondary and tertiary care is therefore essential.
- 2.25 The model of the future will have a planned network for specialist services which embraces all of the providers who treat patients over the geographical area – NHS and non-NHS – and which has clear clinical standards for involving the specialist centre. These standards will need to cover both how patients move through the system and how knowledge and expertise radiate from the specialist centre to the network.

Service model in 2005

The Yorkshire cancer network includes thousands of healthcare professionals across PCTs, hospital trusts, breast screening services and charitable organisations. It brings frontline clinicians together to agree clinical and referral guidelines and ensure patients receive co-ordinated care.

Most cancer patients in Yorkshire have their case assessed by a multidisciplinary team appropriate to their type of cancer. They are offered a range of effective treatments, backed up by information and support, and continuity of care is ensured.

Treatment is provided safely and effectively as locally as possible. Complex procedures are only carried out by teams with a high level of expertise and experience. However, basic chemotherapy services are often provided locally.

The network has identified bottlenecks and redesigned services to reduce waiting times. 99 per cent of patients see a specialist within two weeks of an urgent GP referral.

Service model in 2008

Specialist care networks have built on pioneering models such as the Yorkshire cancer network.

Patients are linked into the network from their first contact with a healthcare professional. At every stage in their care pathway the professionals they meet have the knowledge and expertise to offer them the right choices and guidance.

Patients are involved in every decision about their healthcare. Wherever possible, they have the freedom to choose the option that fits best with their lives. At the same time, patients can be confident that, if appropriate, they will be referred to a specialist centre with the expertise and technology to achieve the best outcome.

Patients and staff benefit from the diverse skills in multidisciplinary teams and the services offered by organisations across the network. Staff in the network can tap into the knowledge and expertise of the specialist centre.

- 2.26 The challenge is to develop new models for the hospitals of the future that allow them to maintain their role in the emergency/specialist network, whether or not patients choose to use them for planned care.
- 2.27 Hospital services also need to change to support the strategic shift into primary care, and to take into account other key developments such as changes in practice and the next phase of the EU working time directive.
- 2.28 The National Leadership Network for Health and Social Care will take the lead to develop a vision for hospital services covering:
- strengthening clinical networks
 - defining services for the local hospital
 - the mental health system.

A joined-up system

- 2.29 Regulatory, institutional and cultural barriers limit choice, stifle innovation and deter possible new providers. These barriers also create discontinuity for patients when organisations fail to join up around the patient.
- 2.30 The system of the future needs to deliver better integration, while allowing patients to benefit from greater contestability. PCTs and SHAs will be responsible for ensuring that they secure for their population:
- a well-managed service where good quality clinical governance assures safety and high quality care for every patient wherever they receive their care
 - meaningful choice, appropriate for the service, using the full range of a diverse provider base
 - a strategic shift to improve health and deliver care earlier, closer to home
 - safe, joined-up networks of emergency and specialist care.
- 2.31 These considerations will also guide SHAs in strategic planning and in their role in managing entry and exit from the provider system, which in future will be managed via commissioning. How this will be achieved in practice is included in the next chapter.

3 Securing services

The NHS will also develop the way it secures services for its patients. It will:

- promote more choice in acute care:
 - PCTs will be responsible for making sure that from 2006 they offer choices to patients
 - PCTs will not need to direct patients to particular providers but will offer a choice of four or five local NHS providers, together with all NHS Foundation Trusts and nationally-procured Independent Sector Treatment Centres
 - all other independent sector providers may apply to be on the list of choices for patients, if they are able to operate to NHS standards and at the NHS tariff
- encourage primary and community services to develop new services and new practices
- strengthen existing networks for emergency, urgent and specialist services, with PCTs and SHAs having explicit responsibility to review and develop them
- build on current practice in shared commissioning with the aim of creating a far simpler contract management and administration system which can be professionally managed and provide better analysis while leaving practices and PCTs in control of decision making
- concentrate more on health improvement and developing local patient pathways and services.

Promoting choice for patients

- 3.1 For both the NHS and social care, the system of the future will offer more choice and more control for individuals. Whenever possible in the NHS, patients will have an informed choice of treatment options, treatment providers, location for receiving care, type of ongoing care and choice at the end of life. The drive to increase choice has begun through the introduction of choice of provider in elective surgery. This will need to expand into more areas as capacity grows.
- 3.2 From 2006, PCTs will be responsible for making sure a range of options are available to patients needing hospital outpatients or elective care.
- 3.3 While these choices are very important to patients, they are just the beginning in terms of making choice a reality across the whole system. There is more work to do to develop thinking on how choice should be available within primary care, emergency and specialist networks, how far providers should offer choices in treatment and ongoing care and how choice at the end of life will work.
- 3.4 The programme for modernising mental health services will also focus on giving people greater choice in their care and treatment, alongside improving access to effective treatment and care, reducing unfair variation, raising standards and providing prompt, convenient, high quality services.

Providing greater choice in elective care

- 3.5 The aim of elective care is to offer patients choice from a range of high quality services which are continually evolving and developing, using new practices and treatments as they become available. This builds on the good experience the NHS has of offering choice to patients.

- 3.6 Ultimately patients will be able to choose any provider that can meet NHS standards at the NHS tariff. This will include providers who are currently part of the NHS; established independent suppliers such as GPs and their teams, pharmacies and independent hospitals; other parts of the statutory sector; the voluntary sector; and new entrants from the independent, statutory or voluntary sectors.
- 3.7 To offer this choice, PCTs and practices will need to know which providers are accredited to deliver NHS care. There will be a clear and transparent process for accreditation in the future. By 2008, organisations which can deliver services to NHS standards at the NHS tariff will be able to apply to be included in the list of options offered to patients.
- 3.8 From 2006, as a transitional step towards free choice, PCTs will offer a choice of four or five local NHS providers, together with all NHS Foundation Trusts and nationally procured Independent Sector Treatment Centres. Other independent sector providers will also be able to apply to be on the list of choices, with new national contracts rather than the existing local spot purchasing.
- 3.9 GPs and PCTs will not be expected to direct patients to particular providers – and there will be no target for independent sector usage – but PCTs will need to ensure that patients have all the help they need to make choices.
- 3.10 The introduction of Independent Sector Treatment Centres has helped create greater capacity and drive change in how services are delivered. There will be a further national tender process with a focus on areas needing further capacity, to ensure that there is sufficient challenge in the system to provide continuous improvement and adaptation.
- 3.11 In the future, funding for all providers will be wholly decided by patient choice and tariff payments. In the transition to the new system, there will be some national financial support to new entrants. This will replace the current arrangements in which new entrants have guaranteed volumes of activity.

Service model in 2005

In West Berkshire, primary care practices offer patients who need an orthopaedic referral a choice of four to five providers. This includes four NHS Trusts, one with an NHS Treatment Centre, and an Independent Sector Treatment Centre. From April 2005, a second Independent Sector Treatment Centre will be available.

Practices give the patient information on providers, including current waiting times, performance and location, as well as additional support through a referral facilitation centre.

Patient choice and the additional capacity provided by the Treatment Centre have helped to bring down waiting times for orthopaedics to six months two years ahead of the national target.

Service model in 2008

GPs can now offer patients the choice of any NHS accredited provider. Patients know that wherever they go they can expect safe, high quality care without having to wait.

As well as information from their GP, patients can research options using the internet. The Healthcare Commission provides information to assist them. They can book elective treatment at their GP's surgery or over the telephone.

While many patients choose to be treated locally, some choose to travel further afield, particularly where they have relatives nearby or where the quality of service is particularly high.

Practice based commissioning

- 3.12 Primary care clinicians and trusts need to be able to focus on their top priorities:
- maximising health
 - improving primary care and management of long term conditions
 - local service planning, managing the care pathway, enabling choice, and getting value for money.
- 3.13 The new system offers an opportunity for primary care practitioners to achieve more in all of these priority areas. Practice based commissioning will resource and incentivise practices to invest in maintaining the health of their patients. It will also allow practices to offer more care in the practice, through new services in the community and pharmacies, and through joint arrangements with hospitals and other providers.
- 3.14 Choice and practice based commissioning will also enable primary care staff to make decisions based on local circumstances and individual need. Providers will become more sensitive to feedback from local GP practices – not only will practices hold the resources to fund care, but also they will be advising patients on the choices available.
- 3.15 Practice based commissioning and referral management systems organised by practices and PCTs will be a key lever to manage the risk of ‘supply induced demand’ in the acute sector. Effective referral management is already operating in many places and this will become more widespread in the new system.
- 3.16 Collective arrangements for certain services will evolve, either on a locality basis, or through the emergence of specialist commissioners, but practices individually or collectively will retain the overall responsibility for decisions about how resources are used. PCTs will need to think about how to engage all of their practices to take an active part in commissioning by 2008.

Contract management and administration

- 3.17 In many places, PCTs are putting innovative new arrangements in place to deal with the administrative aspects of contracting. PCTs know that negotiating and administering contracts is not the best use of their specific expertise and that as commissioning develops at practice level, it will be better to organise contracting across a larger area.
- 3.18 As practice based commissioning develops, these arrangements will need to be rolled out across the country. Practice based commissioning means more power for the patient and the practice, but without an efficient infrastructure, it could lead to a significant increase in bureaucracy, not only for PCTs and practices, but also for the providers who deal with them.
- 3.19 The emerging pattern involves PCTs using shared services to set up contracts, effect data flows and payments and issue reports. This is similar to the system for dealing with prescribing costs, which is administered through a successful national shared service (PACT), run by the Prescription Pricing Authority.
- 3.20 The time is right to test the viability of a wider system to support practices and PCTs with contract management and administration. At its most sophisticated, such a system could set up contracts on standard terms with each provider, for practices to use as ‘call-off contracts’. It could receive and validate data about completed treatments, make payments, report back

to practices and PCTs and potentially create a new service offering analysis and benchmarking in the way PACT does.

- 3.21 Further exploration of this approach will be taken forward with the active involvement of PCTs and primary care staff, NHS Foundation Trusts and NHS Trusts to ensure that it commands confidence and delivers benefits. A full option appraisal will need to be developed and any new approach will be piloted to ensure that the system will deliver the intended benefits.

The system in 2005: a new model of contract management

The PCTs in North and East Yorkshire and North Lincolnshire are testing the feasibility of a shared contract management service to cover the performance management, financial liaison and analytical aspects of contracting. This will support the PCTs' ability to ensure best value, understand referral behaviour and provider responsiveness and explore commissioning alternatives.

Providers will deal with a single contract management function and there will be greater consistency in reporting requirements.

The system in 2008: streamlined arrangements

There is an agreed national system which establishes framework contracts with all providers, covering cost and quality but not volume. PCTs and practices still hold the purse strings but they are freed from the potential transactional burden of facilitating choice.

If achievable, a new national clearing system has been established, similar to the PACT system for recharging prescription costs, which streamlines contract administration, payments and reporting back to PCTs and practices what they have spent against the budget.

- 3.22 This reduction in transaction overheads will allow practices and PCTs to concentrate on the local planning of services and patient pathways and, equally importantly, to spend more time on the development of health promotion and health improvement locally. This could potentially result in a very large gain in resource at the front line, and is the best use of expert clinical skills.
- 3.23 Providers will also benefit from a huge reduction in transaction costs and bureaucracy.

4 Changing the way the NHS works

The NHS needs a change of culture as well as of systems to become truly patient-led, where:

- everything is measured by its impact on patients
- the NHS is as concerned with health promotion and prevention – looking after the whole person – as with sickness and injury
- the staff directly looking after patients have more authority and autonomy, supporting the patient better.

This will require:

- action to tackle the barriers which create rigidity and inflexibility in the system
- shared values and codes of conduct, enshrining the desired changes in culture
- greater support of frontline staff and clinical leadership
- continuous learning, supported by the new NHS Institute for Learning, Skills and Innovation
- a new model for managing change suitable for the new environment
- clearer leadership at all levels, integrated nationally through the new National Leadership Network for Health and Social Care.

- 4.1 Becoming truly patient-led will require more than just changes in systems. There need to be changes in how the system works and how people behave and a change in culture where everything is measured by its impact on patients and the benefits to people's health.
- 4.2 Becoming patient-led means thinking about the whole person and being as much concerned with health promotion and prevention as dealing with sickness and injury. It also means giving those working closest with patients – frontline staff – more autonomy and authority to act. They are best placed to be able to understand patients' needs and act accordingly.
- 4.3 The NHS has a rich legacy in the way it operates. On the positive side, and at its best, the NHS works on the basis of strong values with an absolute commitment to quality and patients. This needs to be promoted and strengthened.
- 4.4 At its worst, the NHS has a very hierarchical tradition with professional divides and bureaucratic systems and inflexible processes. These can get in the way of good patient care.
- 4.5 Some of these problems are reducing with the increase in multi-disciplinary working, new staff contracts which promote flexibility, new roles for many staff groups, new technologies, choice and contestability and, in places, much more entrepreneurial behaviour. However, there is more to be done to challenge outmoded practices such as fixed roles, fixed timetables and fixed budgets. Otherwise the risks remain of locking resources into outmoded models of care and the NHS failing to take full advantage of the opportunities the new service presents.
- 4.6 The NHS, with new resources available, new staff contracts and new IT systems, has a remarkable opportunity to change. The introduction of patient choice will be a catalyst. Patients will demand more flexible services with greater use of evenings and weekends and different ways to access services. Staff will quickly need to offer more flexible responses

while remaining within proper professional boundaries. Just as importantly, managers will need to flex service levels and budgets much more quickly to respond to fluctuations in demand.

- 4.7 Changing the way the system operates is essential for quality but it will also be necessary to secure value for money from the new resources.

Shared values and codes of conduct

- 4.8 People who work in health and social care share a strong desire to do their very best for patients and the public they serve. A cross-section of NHS staff have highlighted the risk that giving local organisations such as NHS Foundation Trusts and PCTs more authority could fragment the service. Many would value a clear restatement of the common values that will continue to hold the NHS together. These need to make clear what the NHS stands for, how the service should behave and how the values apply to those in contract with the NHS as well as those who work in it.
- 4.9 The process to confirm values is important. Shared values are not achieved by stating them but by living them. They must be owned, understood and enacted at all levels of the service. Hence the new National Leadership Network for Health and Social Care will build on the survey findings and propose and consult on a values statement in the next few months. At its heart will be trust, integrity and respect.
- 4.10 With an agreed set of values governing the NHS, it is useful to explore the benefits of:
- initiatives for greater clinical engagement
 - behaviours across local health communities (as already operate in some parts of the country)
 - updating professional and managerial codes of conduct
 - codes of conduct to guide the operation of financial systems such as payment by results.

Supporting frontline staff

- 4.11 Staff working directly with patients have the most important role to play in a patient-led service. All staff – whether they are porters or receptionists, doctors or nurses – need to have as much authority as possible to make decisions and respond to the needs of the patients they are caring for. They should expect to take on more responsibility for themselves and their actions. They should not have to keep referring things up the line or ask permission – they need a clear licence to care within agreed accountability frameworks. This approach will be reinforced at every level by:
- strengthened clinical leadership
 - making sure staff involvement policies deliver change
 - an even greater focus on clinical teams and multi-disciplinary working
 - emphasis on generating and developing a sense of pride, determination, momentum and pace in improving clinical services.
- 4.12 Clinical leadership and engagement are fundamental. The NHS can go further in promoting the structures and development programmes in providers which recognise the principles set out, for example, in the British Association of Medical Managers' document *Fit to Lead* –

Setting Standards in Clinical Leadership and Management and other comparable publications by groups like the NHS Alliance.

Promoting learning and research

- 4.13 The NHS benefits hugely from being an integrated healthcare system, being much more joined up than its international counterparts. This provides a valuable asset for building the research and development base, and for fast-tracking learning and innovation through the system.
- 4.14 Much of the work of the Modernisation Agency is being localised in the NHS rather than driven from the centre. National support will continue through the new NHS Institute for Learning, Skills and Innovation, which will provide world class expertise from healthcare and other sectors to all who work in – and with – the NHS. It will focus on those interventions that have most impact on improving patient care and people's health, with products that can be easily used across the NHS.
- 4.15 The NHS Institute for Learning, Skills and Innovation will have responsibility for raising standards of leadership and management and for creating a culture within the NHS which seeks out innovative solutions and consistent improvement. It will champion a new approach to innovation and make a strong contribution to leadership succession.
- 4.16 The National Primary Care Development Team and the National Institute for Mental Health have both had a major impact on the identification and spread of good practice. They will continue to make a significant contribution to improving healthcare and supporting frontline clinicians.

Managing change

- 4.17 Cultural change of the order required will take time. Success will depend on every single member of the NHS demonstrating leadership in promoting the values and vision of the NHS. People in senior positions must set the right tone and accelerate the change by:
- describing the vision clearly and avoiding 'technocratic' explanations of change
 - making sure that all the processes and incentives in this system support the change
 - giving patients and staff early opportunities to experience the change in reality – trying new approaches quickly and learning from them
 - prioritising training and education to equip staff with the new skills they will need
 - supporting the changes with constant listening and feedback.
- 4.18 The next phase of reform will benefit from a much more systematic and connected process for managing change.

Managing change to 2004 – delivering services for patients	Managing change to 2008 – creating a patient-led NHS
<p>Vision</p> <ul style="list-style-type: none"> • focus on improving patient care through expansion, investment and reform – improving the way the NHS delivers for patients 	<p>Vision</p> <ul style="list-style-type: none"> • focus on transforming the relationship between the individual and the system – improving care through giving patients themselves more choice and control
<p>Shared values</p> <ul style="list-style-type: none"> • articulated at the front of the NHS Plan and reflected in management and professional codes 	<p>Shared values</p> <ul style="list-style-type: none"> • restatement of NHS values developed with staff with clear links to professional and management codes of conduct
<p>Management focus</p> <ul style="list-style-type: none"> • hitting high profile targets and increasing capacity 	<p>Management focus</p> <ul style="list-style-type: none"> • sustaining and embedding improvement, securing quality, delivering productivity and controlling cost
<p>Quality and patient safety</p> <ul style="list-style-type: none"> • new framework for assuring and improving quality through national standards, local clinical governance and inspection • specific quality standards in National Service Frameworks • new national patient safety and health protection bodies 	<p>Quality and patient safety</p> <ul style="list-style-type: none"> • building on the new arrangements • explicit core and development standards for seven domains of care covering all aspects of patient needs • new quality ‘kitemark’ covering all providers to the NHS, providing patient safeguards
<p>Leadership coalitions</p> <ul style="list-style-type: none"> • national: <ul style="list-style-type: none"> – Modernisation Board comprising NHS Plan architects providing insight and stakeholder input for Ministers • local: <ul style="list-style-type: none"> – a number of regional Modernisation Boards 	<p>Leadership coalitions</p> <ul style="list-style-type: none"> • national: <ul style="list-style-type: none"> – new National Leadership Network for Health and Social Care with extended membership and more democratic and flexible processes – new ‘Young Network’ planned for 2005 • local: <ul style="list-style-type: none"> – support for local leadership networks to bring together local stakeholder interests
<p>New processes including</p> <ul style="list-style-type: none"> • inspection • performance management with rapid support • franchising 	<p>New processes including</p> <ul style="list-style-type: none"> • inspection, regulation and assessment on areas of highest risk and for issues that matter most • performance improvement • integrated incentives • mainstreaming change
<p>Support</p> <ul style="list-style-type: none"> • development programmes within organisations and local networks supported by peer review • series of national programmes around service priorities (Modernisation Agency/NPDT) • leadership development for staff at all levels (Leadership Centre) • range of organisational development (OD) programmes (national and local) • push on learning and skills (NHSU/WDCs) 	<p>Support</p> <ul style="list-style-type: none"> • integrated approach to innovation, service improvement, learning and leadership development at all levels • sponsorship of development and improvement effort to fit local context (SHAs) • through the NHS Institute for Learning, Skills and Innovation, focus on: <ul style="list-style-type: none"> – quicker improvement and innovation cycle times – strategic framework for leadership and learning linked to service priorities – supporting and tracking high potential leaders • specific OD interventions for NHS Trusts, PCTs and SHAs • NHS Live programme supporting innovation and creativity of local frontline teams throughout the NHS
<p>Communication</p> <ul style="list-style-type: none"> • regular bulletins, conferences and publications 	<p>Communication</p> <ul style="list-style-type: none"> • more listening events, stakeholder forums and continuing discussion with local communities • reinforced by national communications support and exchange

- 4.19 There will be a key role for the new National Leadership Network for Health and Social Care to draw out and connect this learning, and to guide development for the future. The network will stimulate the collective leadership and learning model that will symbolise this phase of reform. It has already started work to look at the future shape of acute services and how to speed innovation through the system. People from across the service will be encouraged to contribute to this work with regular feedback to the service as a whole. A work programme for the next few months is included at the end of this report.

The National Leadership Network for Health and Social Care

This network brings together 150 people who have a major contribution to make in steering the next phase: patients and users of services, clinicians and managers, professional leaders, inspectors and regulators and leaders from partner organisations. It will provide collective leadership for the next phase of transformation, advise Ministers on developing policies, ensure rapid feedback from the front line and promote shared values and behaviours.

- 4.20 It is planned to extend the network model during 2005 to establish a 'Young Network' for rising leaders from all parts of healthcare to build in the next generation's perspectives to the change process. It is also planned to develop local networks where this will help bring local leaders closer together.

5 Making the changes

A patient-led NHS needs effective organisations and incentives, with:

- a new development programme to help NHS Trusts become NHS Foundation Trusts
- a similar structured programme to support PCTs in their development
- further development of payment by results to provide appropriate financial incentives for all services
- greater integration of all the financial and quality incentives
- full utilisation of the new human resources and IT programmes.

Change on this scale involves uncertainty and risk and all organisations need to plan to manage the risks with some national support to:

- strengthen the role of the NHS Bank
- improve the way the NHS handles service and organisational failures
- improve the way that service change and reconfiguration is managed.

- 5.1 The NHS rightly aspires to be world class. No part of the system should settle for merely average performance. The past few years have shown what is needed to raise organisational performance and the NHS can now be very focused and rigorous in equipping organisations to operate successfully in the new system. Organisations will therefore be supported by systematic benchmarking and professional development to ensure fitness for purpose and maximum efficiency in the way services are planned and run.
- 5.2 The existing organisational model of the NHS has the scope to deliver this level of performance. Organisational change, whenever possible, will be evolutionary. Over time and subject to local circumstances, there will be opportunities for some mergers and some bringing together of PCTs to get a better fit with local government. As more NHS Trusts move to NHS Foundation Trust status and the number of PCTs reduce, we can expect a reduction in the number of SHAs.
- 5.3 Some providers will also change shape, as services expand and contract. Many primary care providers will extend services into those traditionally provided in other sectors. Many trusts will develop services in the community as they become more responsive to patients' needs. Some will offer their services through other organisations, not just their own. More joint ventures will emerge.
- 5.4 Nationally the arm's length bodies review is reducing the number of organisations and releasing savings for the front line. This will be kept under active review to ensure real added value to patient-led services.

Primary Care Trusts

- 5.5 PCTs have been at the centre of the successful delivery of many service improvements in the NHS. There are now new and demanding roles for primary care and many PCTs are responding to this through internal development programmes and joint initiatives to build capability, deliver efficiencies and increase leverage over local health systems.

- 5.6 PCTs deserve the same systematic approach to development that NHS Trusts receive in their transition to NHS Foundation Trust status. Benchmarking, diagnostic rigour and professional support are needed. This will involve creating a new national development framework, parallel to that for hospitals, to ensure PCTs are properly equipped for the critical leadership role they have. This will be planned with PCTs and primary care professional leaders, drawing in expertise in social care.

Acute, mental health and specialist providers

- 5.7 Equally a strong network of care providers is required who can respond quickly to what patients want, who can introduce new clinical practices at pace and who can flex their services to fit new pathways of care.
- 5.8 The aim remains to offer all NHS Trusts the opportunity to bid for NHS Foundation Trust status by 2008. Experience shows that this requires a great deal of development of Boards and internal systems. There will therefore be a renewed development programme for all NHS Trusts which will draw on the lessons from the first NHS Foundation Trusts. This is being sponsored by Monitor and SHAs and includes the development needs of SHAs and PCTs to operate successfully in a NHS Foundation Trust environment.
- 5.9 In the meantime, NHS Trusts will be helped to achieve the disciplines of foundation status through progressively introducing elements of the NHS Foundation Trust regime. Most of the financial disciplines will be introduced in 2006.
- 5.10 NHS providers will be working alongside vibrant and sustainable voluntary and independent sectors. There will be opportunities for shared development between provider networks. The new National Strategic Partnership Forum, for example, will be used to help voluntary sector providers play a bigger role in provision.

Developing relationships with local authorities

- 5.11 The relationship with local authorities is crucial to maximising health, and for commissioning and delivery of many services. All PCTs need to play strongly into Local Strategic Partnerships and, where these are applicable, Local Area Agreements. Similarly, wherever possible there should be joint appointments, eg Public Health Directors.
- 5.12 The Department of Health will shortly be issuing a Green Paper explaining the vision for social care. This vision is based on the same principles as the vision for the NHS – user-led services with maximum choice and personalisation.
- 5.13 Success in managing this relationship will involve the future development of Care Trusts and Children's Trusts, with clear governance arrangements to suit local circumstances and local priorities.

Strategic Health Authorities

- 5.14 SHAs currently have responsibility for strategic direction, the development of the NHS locally and performance management. In future the direct performance management role will become less resource intensive, as performance management is focused through PCTs, with a more autonomous provider base.
- 5.15 However, in the short term, the development role will increase. SHAs need to build local capacity, strengthen leadership and set the culture through locally agreed 'rules of

engagement'. SHAs will work collectively with the Healthcare Commission, Monitor and the NHS Institute for Learning, Skills and Innovation to design and deliver the development programmes for NHS Trusts and PCTs described earlier. This combination will ensure not only that the NHS has organisations suitable for the future – able to meet quality standards within an appropriate governance framework – but also the ability to manage failure and, where necessary, provider exit.

Arm's length bodies

- 5.16 The arm's length body review has set out the way forward in reducing the national overheads of the NHS. As part of this the remaining bodies need to be properly structured and well managed so as to be able to deliver for the future.
- 5.17 There is a particular need to pay attention to the role of the regulators and inspectors, including the Healthcare Commission, the Commission for Social Care Inspection and Monitor, to make sure that they are proportionate and relevant to the complexity and scale of the health and social care system, and that they command confidence, avoid duplication and demonstrate the value of independence.

Workforce

- 5.18 A patient-led NHS will depend on the whole workforce having the support, training and opportunity to use their full potential. This means breaking down barriers between professions, and supporting staff to adapt to the individual needs of patients more readily.
- 5.19 The pressing human resources challenge is to seize the opportunities of the new contractual arrangements to incentivise staff to work more flexibly and responsively. Staff will also need to be able to harness the power of the new system.
- 5.20 A properly staffed NHS, with modern, flexible terms and conditions, offers scope for unprecedented innovation, responsiveness and continuous improvement. This is being achieved by the new contracts for different staff groups and by local managers' intelligent use of the new system and, crucially, by capturing the imagination of the experts at the front line.

Information technology

- 5.21 A patient-led NHS will also require a far higher level of information and information technology than exists currently. The current investment through the National Programme for IT in infrastructure and information technology will enable patients to directly access a wider range of NHS services. Critically, all of the new systems will contribute to ensuring safety and quality of care while helping improve efficiency.
- 5.22 'Choose and Book' will enable patients to see information about their choices, discuss them with their GP, make a decision about which provider they want to use, and book their first appointment in the GP surgery or later through a booking service. The NHS electronic care record system will allow healthcare professionals to access a patient's personal details and medical records anywhere in the system, with safeguards to protect patient confidentiality. Electronic prescribing will support clinicians in making decisions on treatments and allow them to order drugs directly from a pharmacist chosen by the patient. This saves time for patients and ensures the right drugs are prescribed. New technology will allow more urgent and emergency care to be provided locally, through sharing of images and expertise.

- 5.23 The transformation in patient care extends much further than procurement. The bigger challenge is to learn how to use new technology well, including designing care processes and services to make the most of the new opportunities, making sure clinicians and patients know how to get the best from the system and ensuring that the system is kept up to date in terms of information and best practice. Having the new systems is just the start of a process of change.

Financial strategy

- 5.24 In the period 2002–2008, the NHS is receiving a major injection of funds, with an average annual increase of 7.5 per cent per annum, compared to the historical rate of 2–4 per cent. From 2008, the last year of the current funding agreement, the NHS should be consolidating a financially healthy and stable position. The challenge is to prepare for sustaining improvements achieved up to and beyond 2008.
- 5.25 This autumn, the Department will set out the financial strategy for 2006–2010 to guide and support local action. The context is a new financial regime with far less central planning and far greater scope for local flexibility in the use of resources.
- 5.26 Progressively, the system will be based on open and transparent rules, which specify how finances should flow (largely based on patient choice), and how financial issues should be handled when they arise. This will have the effect of allowing planning certainty for commissioners and providers, and ensuring prompt action to ensure financial problems are acknowledged and addressed.
- 5.27 Moving all NHS providers to a financial regime which requires trusts to pay for capital invested means that the Department will be explicit about the regular and transitional support available to providers to support capital programmes. The full details of the capital investment strategy will be covered in the autumn document.
- 5.28 A clearer set of responsibilities will encourage organisations to move from a short-term approach – making quick economies to deliver immediate financial imperatives – to a long-term strategy for sustained effectiveness and efficiency.
- 5.29 The new regime is improving management of risk. As the patient is put at the centre of the system, the NHS as a whole needs to learn quickly – and share – how best to manage these risks.

Incentives

- 5.30 The incentive system will need to be reviewed and adjusted to ensure that incentives encourage and do not block the desired outcomes for patients.
- 5.31 There are a number of incentives in the system that support this ambition already. The strong values and professional standards of the NHS are geared towards doing the best for the patient; moreover, frontline staff who get direct feedback from patients are strongly motivated to meet their needs.
- 5.32 But not enough of the systematic incentives support frontline staff in delivering for patients – leading not only to perverse outcomes, but causing frustration and conflict for patients and staff. Rewards for individuals, teams and organisations need to be aligned with service goals, and resources need to flow to where they are needed.

Incentives in the new system	
Individuals	<ul style="list-style-type: none"> • personal and professional altruism • patients' response • publication of outcomes data • professional autonomy within national standards • fee for service • agenda for change • consultant contract
Teams	<ul style="list-style-type: none"> • patient experience data • practice based commissioning • primary care contracts
Organisations	<ul style="list-style-type: none"> • Healthcare Commission, Commission for Social Care Inspection and Monitor ratings • accredited provider status • patient survey results • NHS Foundation Trust status • payment by results

5.33 The incentives should work together to reinforce the behaviours which will be needed for the future. The elements which need to be developed are:

- inspection, assessment, regulation and patient feedback, which need to be aligned to pull together in a holistic and proportionate framework. Incentives for inter-organisational relationships will be an important theme
- new contracts for the workforce and independent contractors, which will need to be used well to incentivise the right behaviours
- payment by results, which will give a financial incentive to make services attractive to patients.

5.34 Payment by results is a very powerful incentive for organisations. The policy for 2005 is clear but new arrangements are needed to implement payment by results for emergency and urgent care, long term conditions and mental health. More guidance will be published on these areas in autumn 2005, so that implementation can continue in 2006.

New challenges in managing risks

5.35 Delivering a patient-led, professionally supported service will involve less certainty.

5.36 The job of the NHS in the future will be to anticipate what patients want, to help them make more healthy choices and to retain enough flexibility to respond to individual needs. This is different from the planned service of the past – where clinicians and managers decided in advance what would be delivered to patients.

5.37 This brings new challenges in terms of working with uncertainty and it will require a disciplined, structured approach to living with and managing risk. Organisations will need to be better at planning for a range of scenarios, not just managing risk.

5.38 At a local level, every organisation will need a clear, systematic approach to risk evaluation and management. NHS Boards have a duty to ensure that their organisation is resilient.

The effectiveness of local risk management will be demonstrated by the ability to anticipate patients' demands, continue delivery of safe services, handle uncertainty and maintain financial discipline.

- 5.39 Local services will need to flex in line with patients' choices and new clinical practices. The greater scope for remodelling services and offering local people much more personalised care pathways will require fresh approaches to the way NHS organisations manage service restructuring. In a much more dynamic healthcare system, a more professional model of engaging local people in debates about service changes will be needed.
- 5.40 Nationally the focus will be on three areas of risk: financial risk, service and capacity risk, and risks around behaviours and relationships. The national role will be dealing with systemic issues, eg incentivising the right behaviours. The approach to risk will be linked to the approach to managing change – engaging with patients and the service more systematically, to get expert policy design and speed up the feedback/learning cycle.
- 5.41 Risk management in the future will also involve a clearer approach to dealing with failure. High performing systems accept that failures will occur, and handle them decisively. In health, this means recognising that some services are indispensable while others can be replaced. The approach to failure will distinguish between contestable services, which can be allowed to exit, and indispensable services, where the response to failure needs to ensure the service remains in place
- 5.42 The role of the NHS Bank will be developed together with strategic capability in SHAs, to handle the inevitable swings and instabilities within the new system. This will include support for services in transition, where exit or recovery is needed.

6 Next steps

This document outlines action for local and national leaders. There will be a programme of work for the national issues, delivered mainly through the National Leadership Network for Health and Social Care and steered by the Department of Health.

- 6.1 This document underlines the importance of all parts of the system working together to:
 - develop new ways of managing the system
 - recognise and handle complexity
 - improve feedback loops
 - learn faster in order to adapt quickly.
- 6.2 At a local level, PCTs and providers will not only lead the changes but will also develop even better ways of engaging patients and staff, listening carefully as changes evolve, and developing a responsive approach. To support this, SHAs will want to establish local leadership networks – ‘guiding coalitions’ – to steer reform.
- 6.3 At a national level, the National Leadership Network for Health and Social Care will take forward some key themes in this document, collecting feedback and shaping the way that change is implemented. The Department of Health will steer this process, ensuring that the programme as a whole is coherent and that it will deliver the overarching goals.
- 6.4 This document outlines a lot of action for local leaders and managers. Some is needed to make change in the short term and some to prepare for emerging policies and implementation plans. The next table describes areas for national action.
- 6.5 Leaders and managers will be supported through a structured communications programme which will explain how the whole system reform process fits together, and which will provide tools to explain the changes. This document marks the beginning of the programme.

Action	Products	Timing
1 Improving health insight	a) national Health Insight Unit b) best practice/embedding in local systems	Summer 2005 Autumn 2005
2 Improve flexibility in the system	a) Scoping of major barriers to flexibility, which could include fixed costs, capital, workforce lead-time and workforce contracts	Summer 2005
3 Agreement of values and codes of conduct	a) statement of values b) codes of conduct	October 2005 April 2006
4 New service models	a) primary care b) local hospitals c) support for networks d) developing consistent models	Summer 2005 Summer 2005 Autumn 2005 Autumn 2005
5 Choice	a) delivery plan for free choice b) choice throughout the patient pathway	Autumn 2005 Autumn 2005
6 Commissioning	a) expanded practice based commissioning b) contracting and procurement c) market management	Autumn 2005 Autumn 2005 Autumn 2005
7 Speeding improvement	a) NHS Institute work programme agreed b) local systems strengthened	July 2005 July 2005
8 Payment by results	a) secure policy for 2005/06 b) expanded policy, covering approach to emergency, ambulance, long term conditions and mental health	April 2005 Autumn 2005
9 Developing leadership	a) National Leadership Network programme agreed b) associated leadership networks	May 2005 May 2005
10 Managing risk	a) local risk assessment and agreed action for managing risk b) national risk management arrangements	April 2005 Spring 2005
11 Financial strategy	a) Strategy 2006–2010	Autumn 2005
12 PCT and NHS Trust development programme	a) agreed development programme for all NHS Trusts to achieve NHS Foundation Trust status b) equivalent agreed programme for PCTs	Summer 2005 Summer 2005



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