HM Government

The NHS Improvement Plan

Putting People at the Heart of Public Services

Department of Health

NHS

The NHS Improvement Plan

Putting People at the Heart of Public Services

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Contents

Foreword
Tony Blair, Prime Minister

1 The National Health Service (NHS) is one of our country's proudest achievements and an essential strand in the fabric of our nation. Despite past frustrations, the NHS and its values – healthcare for all according to need, not ability to pay – retain overwhelming public support. So, too, do its dedicated, skilled and compassionate staff.

2 The Government has recognised the crucial role of the NHS in our national life and has also faced up to its problems. *The NHS Plan,* launched in July 2000, drawn up with the help of staff, patients and other stakeholders, set out a programme of sustained investment and reform to turn the NHS around, make it more responsive to patients and more in tune with the times. *The NHS Plan* has delivered real progress in healthcare across the country.

3 There are thousands more doctors and nurses. Dozens of new hospitals have opened or are under way. Waiting times have been reduced. Death rates from cancer and heart disease are sharply down. A series of authoritative reports has found the NHS is firmly on the road to a full recovery.

4 We have made a good start. But, as the NHS has improved, so rightly have people's expectations of it increased. With the journey to a world-class health service in all, not just some parts, of the NHS still to be completed, now is not the time to falter.

5 There will be voices, we know, urging us to slow down or perhaps stop altogether. In many cases they are the same voices which have warned against the pace of change over the last seven years. They are right that investment alone would have delivered some improvements in the NHS. But it would not by itself, for example, have halved maximum waiting times or delivered many of the other improvements the public can see in their own local health services.

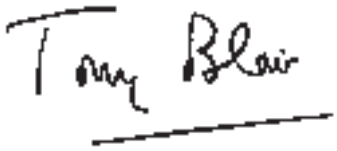
6 These improvements have happened because we realised that while the values of the NHS remain as relevant today as half a century ago, the system for delivering them was badly out of date. A system devised for a time of rationing and shortages cannot be right for a century when the public expect high-quality products, better services, choice and convenience. So over the last seven years, with the help of NHS staff, we have overhauled and modernised the system, focusing on expanding and improving services and access to care and treatment.

7 We make no apology for driving many of these reforms from the centre. Now we can move to the next stage envisaged in *The NHS Plan* to reshape the health service around the needs and aspirations of its patients, not least because the speed of progress means waiting for treatment will soon no longer be the major problem. And this requires us to put power in the hands of patients rather than Whitehall.

8 We are investing to continue increasing capacity throughout the NHS. And because of this increased capacity, we can continue to extend choice. So there will be more choice given to patients over how they are treated and where. They will have the power to choose between hospitals, including the new treatment centres. We will continue to reduce dramatically waiting times from referral by a

GP to the start of hospital treatment. More care for long-term conditions will be provided closer to home or in the home itself. Easier access and more choice over medicines will be provided to patients. Local communities are to be given more power over the priorities of local health services. A greater emphasis will be given in the NHS to public health, to prevent illnesses and not just to treat them – whether it is old challenges like smoking or new ones such as obesity.

9 Our aim is to reshape the NHS, building on *The NHS Plan*, so it is not just a national health service but also a personal health service for every patient. We want to provide more choice for every patient, irrespective of the money in their pocket, funded through the collective finance of the nation and organised by the collective nature and standards of the NHS. It is an ambitious goal. This plan shows how we intend to support NHS staff to achieve it.



Tony Blair
Prime Minister

Preface

The Rt Hon John Reid MP
Secretary of State for Health

1 The NHS was founded on two fundamental principles. The first is that there should be equal access to treatment for all, based on clinical need and regardless of the patient's ability to pay. The second is that collective funding of the NHS, through national taxation, is the most effective way to ensure that quality care is available to all, since paying for all healthcare possibilities is beyond personal financial means. These two principles remain central to our vision for the future of the NHS. To enable us to implement them we need to make sure that the NHS is fit for purpose today, and to do that we need to invest and reform.

2 Sustained investment is already transforming the NHS. Investment has increased from £33 billion in 1996/97 to £67.4 billion in 2004/05. Spending on buildings and equipment has increased from £1.1 billion to £3.4 billion. This investment has enabled the NHS to expand its capacity to care for patients. The NHS today has more doctors, more nurses, more healthcare staff, more and better buildings, state-of-the-art equipment and more life-saving drugs. But investment without reform is not enough.

3 NHS front-line staff are being incentivised to become increasingly innovative and creative. The new pay contracts for nearly all NHS staff provide a powerful package of incentives to reward the health professions for their commitment to improving both patient care and the health of the population.

4 This combination of investment and reform is now beginning to make a real difference, with patients having faster access to the care they need. Since 1997:

- The maximum waiting time for an operation has fallen from 18 months to less than nine months
- The maximum waiting time for an outpatient appointment has fallen from 26 weeks to 17 weeks
- 97% of patients are now able to see a GP within two days
- Growing numbers of patients are taking advantage of new services such as NHS Direct and NHS Walk-in Centres
- 94% of patients are seen, diagnosed and treated within four hours of arrival at accident and emergency.

5 There have also been improvements in the quality of care, achieved through the development and delivery of National Service Frameworks and the work of the Healthcare Commission in inspecting NHS services and working to improve clinical governance. More treatment and care are now available closer to home. Patient choice has begun to have an impact on the way in which the NHS works. There has been clear progress in tackling the country's biggest killer diseases, with premature deaths from cancers and heart disease falling at the fastest rate of any European country.

6 Increases in staff numbers since 1997 are also improving services for patients. They include a 22% increase in doctors, a 21%

rise in the total number of nurses and a 27% expansion in scientific, therapeutic and technical staff. These staff are increasingly working in modern environments which support patient safety, good medical practice and an approach that is centred on improving the experience of the patient. Sixty eight major new hospitals have been commissioned, with twenty four fully operational since 2000, and there have been increases in the number of hospital beds, growth in critical care facilities and expansion in intermediate care facilities to support people who are leaving hospital after treatment. Over 2,200 GP surgeries and primary care premises have been modernised.

7 In national surveys patients are increasingly positive about the quality of their care. Beyond the clinical arena, there has been progress on issues where patients have asked for more focus, with cleaner hospitals, better food and better provision of bedside phones and televisions.

8 This reflects the hard work and commitment of NHS staff combined with increased investment from the public. But everyone – patients, public and professionals – recognises that the job of modernising the NHS is not yet done and that there is further to go before we can fully realise our vision.

The vision

Our vision is one where the founding principles underlying the NHS are given modern meaning and relevance in the context of people's increasing ambitions and expectations of their public services.

An NHS which is fair to all of us and personal to each of us by offering *everyone* the same access to, and the power to choose from, a wide range of services of high quality, based on clinical need, not ability to pay.

9 To deliver this vision, investment in the NHS will rise to £90 billion by the year 2007/8. In return for this investment the NHS will offer the following:

- Patients will be admitted for treatment within a maximum of 18 weeks from referral by their GP, and those with urgent conditions will be treated much faster
- Patients will be able to choose between a range of providers, including NHS Foundation Trusts and treatment centres
- Patients will be able to be treated at any facility that meets NHS standards, within the national maximum price that the NHS pays for the treatment they need
- Patients will have access to a wider range of services in primary care, including access to services nearer their workplace
- Electronic prescribing will improve the efficiency and quality of prescribing
- Users of social care will be empowered through the expansion of direct payments
- In every care setting the quality of care will continue to improve, with the Healthcare Commission providing an independent assurance of standards, and patient safety being a top priority
- People with complex long-term conditions will be supported locally by a new type of clinical specialist, to be known as community matrons
- Major investment in services closer to home will ensure much better support for patients who have long-term conditions, enabling them to minimise the impact of these on their lives

- There will have been further progress in tackling the biggest killer diseases, with the country on track to secure by 2010 a 40% fall from 1997 in death rates from heart disease and stroke, and a 20% fall in death rates from cancer

- The NHS will develop into a health service rather than one that focuses primarily on sickness and will, in partnership, make further in-roads into levels of smoking, obesity and the other major causes of disease. There will be a sustained drive to reduce inequalities in health

- Local communities will have greater influence and say over how their local services are run, with local services meeting local priorities

- Primary Care Trusts will control over 80% of the NHS budget

- All NHS Trusts will be in a position to apply for NHS Foundation Trust status

- More staff will work in the NHS and will be encouraged to work more flexibly in a way that best responds to patients' needs

- There will be incentives for healthcare providers to offer care that is efficient, responsive, of a high standard and respects people's dignity.

10 Our objective is fairer, faster, better care to more people than ever before. This will be achieved by giving patients more information and more choice whilst also giving the public better value than ever before.

The Rt Hon John Reid MP
Secretary of State for Health

Executive summary

This document sets out the priorities for the NHS between now and 2008. It supports our ongoing commitment to a 10-year process of reform first set out in *The NHS Plan*.

Introduction

1 Over the past seven years the NHS in England has been on a journey of major improvement. After decades of under-investment, the NHS has begun to turn itself around, with unprecedented increases in the money it can spend. As its budget has grown from £33 billion to £67.4 billion, the average spending per head of population has gone up from £680 to £1,345.

2 That money has increased the capacity of the NHS to serve patients. It has helped give faster and more convenient access to care. Access to GPs, accident & emergency care (A&E), operations and treatment is improving with every passing year. Quality is also improving, as is the range of services available to the public.

3 These improvements have been made possible by steady increases in the number of NHS staff, who are even more focused on the personal care of individual patients and better enabled to do so. The growth in money and staff numbers has been matched by an unprecedented period of growth, expansion and modernisation in the buildings, equipment and facilities available to care for patients. That in turn has enabled the NHS to provide better quality care to patients, with safer and more effective treatment, better surroundings and services that better suit their lives. The NHS today is fairer as a result. The NHS is now ready to ensure that care is much more personal and tailored to the individual.

4 The next stage in the NHS's journey is to ensure that a drive for responsive, convenient and personalised services takes root across the whole of the NHS and for all patients. For hospital services, this means that there will be a lot more choice for patients about how, when and where they are treated and much better information to support that. For the millions of people who have illnesses that they will live with for the rest of their lives, such as diabetes, heart disease, or asthma, it will mean much closer personal attention and support in the community and at home.

5 Complementing that drive for a high-quality personal service for individual patients when they are ill, there will be a much stronger emphasis on prevention. Death rates from cancers, heart disease and stroke are already falling quickly. The NHS will take a greater and more effective lead in the fight against these big killer diseases. It will lead a coalition to stop people getting sick in the first place and to make in-roads into inequalities in health.

6 In taking forward these reforms, the NHS will continue to learn from other healthcare systems. This will enable the NHS to continue to improve its performance as it aspires to world class standards, where it is not already achieving these. In the next stage, there will be a stronger emphasis on quality and safety alongside a continuing focus on delivering services efficiently, fairly and in a way that is personal to each of us. By 2008, the NHS in England will be seen increasingly as a model that other countries can learn from.

Section 1 – Laying the foundations

7 The investment and reform initiated in July 2000 by *The NHS Plan* has delivered for patients. It is a track record of success, which gives the confidence to support further investment and further reform. The money and the changes promised in *The NHS Plan* just four years ago have been made a reality for patients, the public and the taxpayer. Those who argued that the NHS was beyond reform, were profoundly mistaken. The NHS has demonstrated that its enduring principles can prosper in the new century.

8 At the core of this plan lies a continuing commitment to the founding principles of the NHS: the provision of quality care based on clinical need, irrespective of the patient's ability to pay, meeting the needs of people from all walks of life. The programme is instilled with a resolve to ensure that the NHS meets the expectations of all people in England: enabling and supporting people in improving their own health; Meeting the challenge of making a real difference to inequalities in health; staying the course and supporting those with conditions that they will live with all their lives; and quickly treating people with curable problems so that they can get on with their lives and live them to the full.

Section 2 – Offering a better service

9 Chapter 2 sets out the key commitments that the NHS will deliver to transform the patient's experience of the health service over the next four years. It explains how this will dramatically change the experience of waiting for hospital treatment.

10 In 1997 patients waited up to 18 months for treatment – after seeing a GP, after seeing a consultant, and after diagnostic tests. Those times have fallen and now the maximum wait for an operation is nine months and the maximum wait for an outpatient appointment is 17 weeks. When this programme has been delivered in four years time, the 1997 maximum wait of 18 months for only part of the patient journey will have been reduced to 18 weeks for the whole journey. The previous long waits for GP referral, outpatient consultations and tests are included in that pledge. In four years' time, waiting times for treatment will have ceased to be the main concern for patients and the public.

11 With much shorter waiting times for treatment, "how soon?" will cease to be a major issue. "How?", "where?" and "how good?" will become increasingly important to patients. Patients' desire for high-quality personalised care will drive the new system. Giving people greater personal choice will give them control over these issues, allowing patients to call the shots about the time and place of their care, and empowering them to personalise their care to ensure the quality and convenience that they want.

12 From the end of 2005, patients will have the right to choose from at least four to five different healthcare providers. The NHS will pay for this treatment. In 2008, patients will have the right to choose from any provider, as long as they meet clear NHS standards and are able to do so within the national maximum price that the NHS will pay for the treatment that patients need. Each patient will have access to their own personal *HealthSpace* on the internet, where they can see their care records and note their individual preferences about their care.

13 With waiting times no longer the main issue, the NHS will be able to concentrate more of its energies on providing better support to people with illnesses or medical conditions that they will have for the rest of their lives. Chapter 3 sets out our commitment to a radical, far-reaching and ambitious approach to making a real difference to the quality of life of people who live with illnesses every day. While the way we think about the NHS is often dominated by the easy to understand model of people with diseases being treated and cured, a very significant number of people are living their lives with conditions that can't yet be cured. Diabetes, heart disease, asthma, some mental illnesses and many other conditions are medical problems that most people live with from the time they are diagnosed.

14 The NHS will minimise the impact of these conditions on people's lives and provide people with high-quality personal care. It will enable and support people in managing their conditions in a way that suits them, avoiding complications, maximising their health and helping them to live longer lives. It will also improve people's care closer to home – through specialist nurses and GPs with a special expertise in their condition – which will lead to fewer emergency admissions to hospitals which cause anxiety for patients and their families and are a poor use of hospital resources. The Expert Patient Programme – designed to empower patients to manage their own healthcare – will be rolled out nationally, enabling more people to take greater control of their own care and to listen to themselves and their own symptoms, supported by their clinical team. The new GP contract provides cash incentives to GPs who work with their teams of nurses, social workers, the voluntary sector and other professionals to ensure that people are given the high-quality personal care they need to minimise the impact of their illness or health problem.

15 Having reduced waiting to the point where it is no longer the major issue for patients and the public, the NHS will be able to concentrate on transforming itself from a sickness service to a health service. Prevention of disease and tackling inequalities in health will assume a much greater priority in the NHS. With the NHS working in partnership with others and with individuals to support people in choosing healthier approaches to their lives, real progress will be made on preventing ill health and reducing inequalities in health. Death rates for the under 75s from heart diseases and stroke will be reduced by at least 40% by 2010 and death rates from cancers will be reduced by at least 20%. Suicide rates will be reduced by 20% (from a 1997 baseline). The forthcoming public health White Paper will set out a comprehensive programme to tackle the major causes of ill health, including obesity, smoking and sexually-transmitted infections.

Section 3 – Making it happen

16 Chapters 5 to 9 set out how the NHS will deliver these key commitments. A much wider choice of different types of health services will become available to NHS patients, to enable personalised care, faster treatment, personal support for people with long-term conditions and better social care.

17 For hospital care, NHS Foundation Trusts will, by 2008, be treating many more patients. NHS patients will also be able to choose from a growing range of independent providers, with their diagnosis and treatment paid for by the NHS. To support capacity and choice, by 2008, independent sector providers will provide up to 15% of procedures on behalf of the NHS. The Healthcare Commission will inspect all providers, whether in the NHS or in the independent sector, to ensure high-quality care for patients wherever it is delivered.

18 In primary care, the NHS will be developing new ways of meeting patients' needs closer to home and work. New flexibilities will enable PCTs to commission care from a wider range of providers, inlcuding independent sector organisations, to enhance the range and quality of services available to patients. The Departments of Health will also work with other government departments and local authorities to develop better ways of meeting people's broader health needs.

19 Greater flexibility and growth in the way services are provided will be matched by increases in NHS staff and new ways of working to meet patients' needs. By 2008 the number of staff working for the NHS will have increased significantly. In primary care GPs will increasingly be working with more diverse teams, including GPs with a special interests and community matrons, to enable patients' needs to be met in new ways in the community rather than in hospital. Staff will be given more help to train and learn new skills, with their career progression supported by the NHS University (NHSU). This flexible working to deliver more personalised and user-friendly care for patients will be rewarded by better pay for NHS staff.

20 Information systems will be put in place to enable patients to choose more convenient and higher-quality personalised care. By 2005 an electronic booking service will make it easier for patients to arrange appointments that suit them, and electronic prescribing will make it easier for patients to obtain repeat prescriptions for their medicines. NHS Direct, NHS Direct Online and NHS Digital Television will enable people to communicate with health professionals and these services will also support people in making changes that will improve their own health. An individual personal care record will enable health professionals to have easy, rapid access to patients' medical histories at any time of the day, supporting better diagnosis and treatment and reducing errors. The technology will also enable patients to have more influence over how they are treated, with a new personal facility called *HealthSpace* enabling them to record for health professionals what their preferences are about the way they are cared for.

21 Financial incentives and performance management will drive delivery of the new commitments. The new system of payment by results will support the exercise of choice by patients, improve waiting times for patients and provide strong incentives for efficient use of resources. This system will be fully operational and delivering for patients in 2008. At the same time, Primary Care Trusts will be developing further incentives to enable GPs and their teams to deliver ever higher quality care to patients in a way that is most responsive to their needs.

22 As money, control and responsibility are handed over to local health services, the communities that they serve will be given greater influence over the way that local resources are spent and the way that local services are run. Within a framework of clear national standards, power will continue to move swiftly to Primary Care Trusts and to NHS Foundation Trusts. There will be far fewer national targets for the NHS. Local services will set their own stretching targets, reflecting the local circumstances, ethnicity and inequalities of the communities that they serve and the local priorities of the people who use them. Performance management arrangements will be aligned with this new system, giving the incentive of greater freedom from central regulation and inspection to NHS organisations that serve patients and their communities well.

Conclusion

23 *The NHS Plan* reforms and investment are transforming the NHS, with dramatic improvements in key areas. Tackling the two biggest killers, cancer and coronary heart disease, has been a priority over the past four years and mortality rates are already falling rapidly.

24 Less than four years into the period covered by the 10-year *NHS Plan*, the new delivery systems and providers are expanding capacity and choice. As these new ways of working really take hold across the whole system, the dividend will be a higher-quality service with even faster access to care. A new spirit of innovation has emerged, centred on improving the personal experience of patients as individuals, and this is now taking root in the NHS.

25 The foundations for success are now in place and it is time to move on. Improving care for people with long-term conditions and helping people live healthier lives are essential next steps in our drive to improve the quality of care for everyone. Over the next four years the culture of waiting which has long been a feature of the NHS will be replaced by a personalised approach to care. Appointments will be booked with the GP and the maximum time from GP referral to the start of treatment will be down to just 18 weeks, with many people being seen much quicker than this.

26 NHS Foundation Trusts will be free from Whitehall control, enabling new ways of involving local people, local staff and local patients in the running of their hospitals. New treatment centres run by the NHS and the independent sector will offer fast and convenient treatment that will provide patients with real choices. Primary Care Trusts will control over 80% of the NHS budget and they will use this financial muscle to secure the best

possible deal for each and every patient that they serve. Patient choice will be a key driver of the system and resources will flow to those hospitals and healthcare providers that are able to provide patients with the high-quality and responsive services they expect. Independent inspectors will provide patients with assurance of the quality of care wherever it is delivered. There will be a much stronger emphasis on prevention, keeping people healthy and avoiding the need for medical care in the first place.

27 In 2008, England will have a very different health service from the one it has today. It will retain all those qualities that sustain such commitment from the people of England. It will be an NHS which is fair to all of us and personal to each of us by offering everyone the same access to and the power to choose from a wide possible range of services of high quality, based on clinical need not ability to pay. The changes set out in this document will mean, for the first time, that the system will work with and support those professional instincts of the NHS's dedicated staff and ensure high-quality personal care for patients. It will reward the NHS for these efforts, take away the barriers to doing the right thing and make it easier for dedicated doctors, nurses and thousands of other NHS staff to follow their calling to cure and to care. A modern NHS, equipped and enabled to respond quickly to people's needs, will mean that the obstacles to what people want from the NHS are torn down and that excellence becomes the norm for clinical staff and managers alike. The NHS is set to thrive again by properly meeting the needs of patients and the public.

Section 1:
Laying the foundations

Chapter 1
Progress so far

Rapid progress has been made since *The NHS Plan* in improving the NHS, including:

- Falls in death rates from the major killer diseases
- Faster access to hospital, primary and emergency care
- Improvements to the way services are run
- Increases in hospital activity
- More frontline NHS staff
- Better buildings
- Better healthcare
- Better experiences of the NHS for patients.

Introduction

1.1 The programme of investment and reform initiated by *The NHS Plan* has enabled the NHS to put in place real improvements, giving the public and the NHS the confidence to support further investment and further reform. This chapter describes the achievements of recent years. It shows how the investment and reform promised in *The NHS Plan* just four years ago have rapidly been made a reality for patients, the public, the taxpayer and NHS staff. It shows clearly that those who argued that The NHS was beyond reform, were profoundly mistaken. It demonstrates that the enduring principles of the NHS can prosper in the new century.

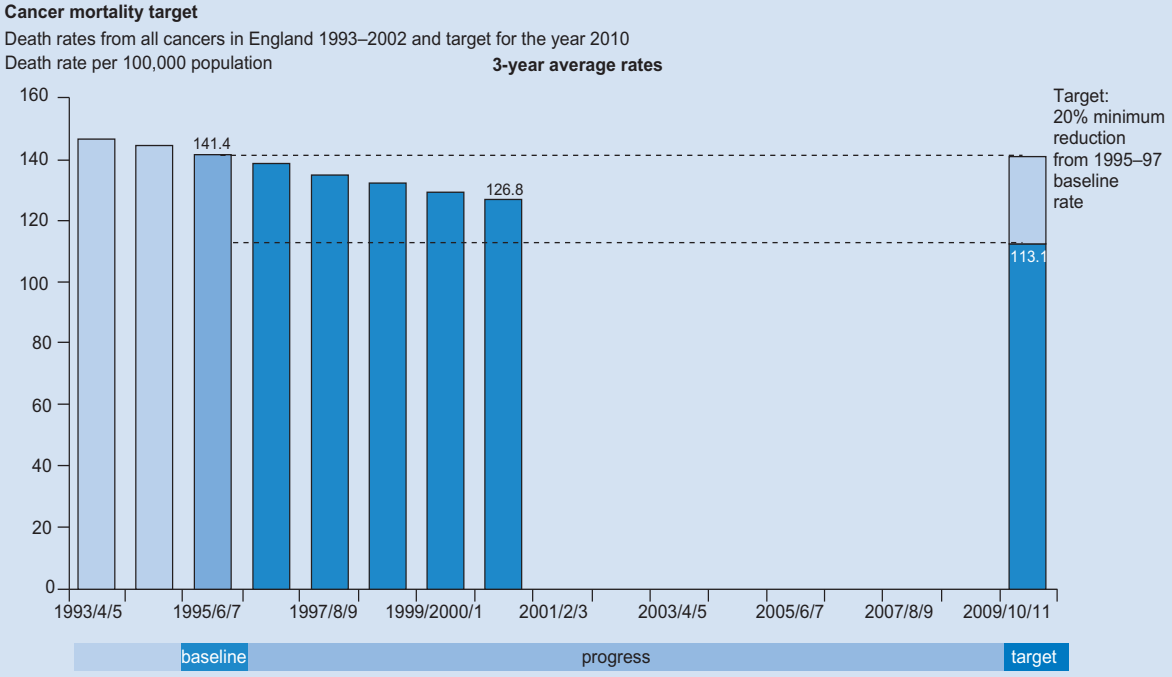
Reducing deaths from cancer

1.2 *The NHS Cancer Plan*, published four years ago, set out the nation's first ever comprehensive strategy for using prevention, treatment, care and research to tackle one of the nation's biggest killers and provide fast and effective treatment for a group of diseases that one in three people will experience during their lives.

1.3 Death rates are falling steadily and patients are benefiting from real improvements in all aspects of cancer care. Survival rates from all the major cancers are improving. *The NHS Cancer Plan* has enabled sustained improvements:

- Since April 2001 an additional 200,000 women have been invited to be screened as a result of the expansion of the breast screening service to include women aged 65–70 years

Figure 1.1: Death rates from all cancers in England 1993–2002: people under 75



Rates are calculated using population estimates based on 2001 census. Rates are calculated using the European Standard Population to take account of differences in age structure.
ICD9 data for 1993 to 1998 and 2000 have been adjusted to be comparable with ICD10 data for 1999 and 2001 onwards.
Source: ONS (ICD9 140–209; ICD10 C00–C97)

- Nearly 99% of patients with suspected cancer are now seen by a specialist within two weeks of being referred urgently by their GP. This compares to 63% in 1997
- Cancer patients can now benefit from 15 of the newest cancer drugs appraised by the National Institute for Clinical Excellence
- There are now over 1,000 more cancer consultants than there were in 1997
- Over 1,000 state-of-the-art pieces of high-tech equipment used to diagnose and treat cancer have been delivered to hospitals, including Magnetic Resonance Imaging (MRI), computer tomography (CT) scanners and breast screening equipment. This means that 44% of MRI scanners, 64% of CT scanners, and 48% of linear accelerators now in use are new since January 2000.

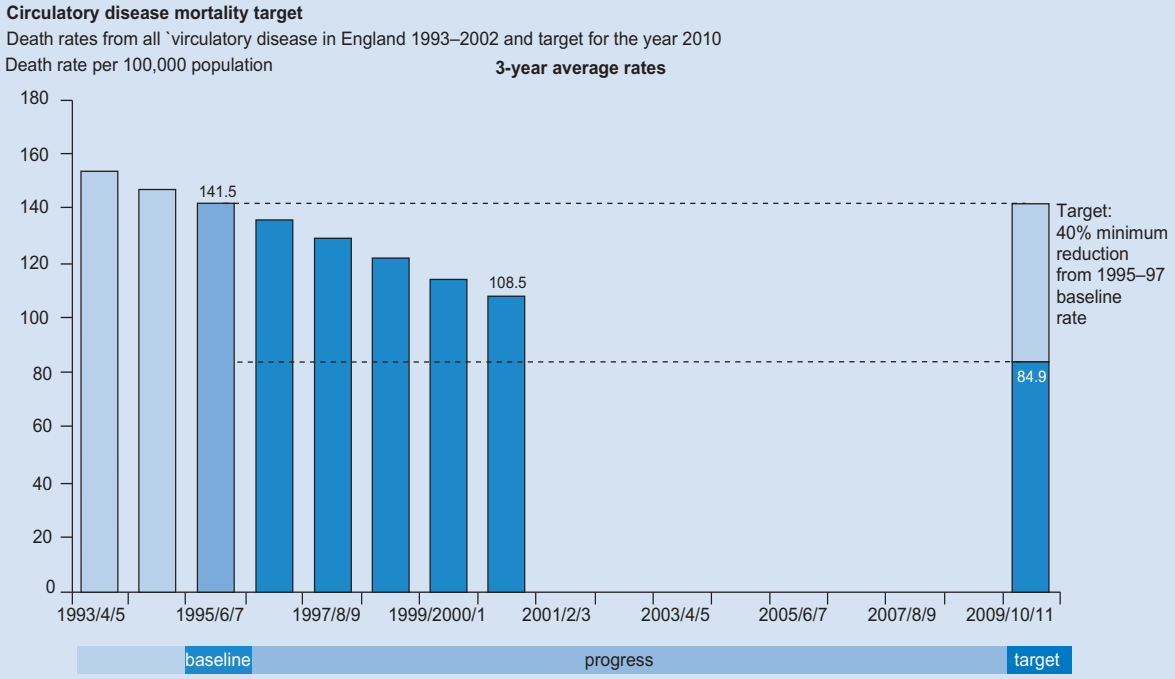
Reducing deaths from heart disease

1.4 In 1997 about 140 people out of 100,000 died of heart disease or strokes. By the end of 2001 that had fallen to about 108 out of every 100,000.

1.5 The *National Service Framework for Coronary Heart Disease*, published in 2000, has enabled NHS staff to make dramatic improvements to the prevention and treatment of heart disease:

- The number of NHS heart operations performed a year has increased from 46,000 in 1999/2000 to over 60,000 in 2002/03, a 31% increase. As a result, maximum waiting times for heart operations have fallen from 18 months to six months in four years and are set to fall to three months by March 2005. From that time all patients will be eligible to choose to be treated in a different hospital at the time they are told they need surgery

Figure 1.2: Death rates from circulatory diseases in England: 1993–2002: people under 75



Rates are calculated using population estimates based on 2001 census. Rates are calculated using the European Standard Population to take account of differences in age structure. ICD9 data for 1993 to 1998 and 2000 have been adjusted to be comparable with ICD10 data for 1999 and 2001 onwards.
Source: ONS (ICD9 390–459; ICD10 C100–199)

- 1.8 million people are receiving cholesterol-lowering drugs, which reduce their risk of a heart attack
- 81% of patients who have just had a heart attack now receive life-saving clot-busting drugs within half an hour of arrival at hospital, compared to only 38% in 2000
- Over a million children in more than 7,500 schools are receiving a piece of fruit a day and this year all 4–6 year olds will be entitled to a free piece of fruit each day.

Shorter waiting times

1.6 People are able to access NHS services much faster since the publication of *The NHS Plan*.

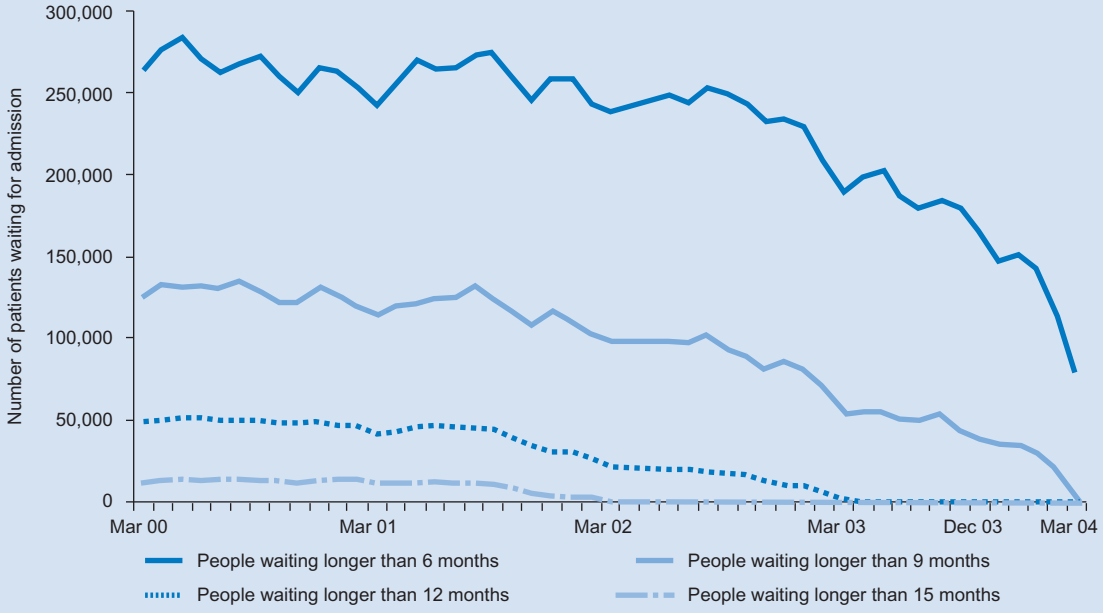
1.7 These trends are now well established:

- As of March this year there were only 48 people who had been waiting more than nine months for inpatient treatment
- These reductions in waits are accelerating – over the last year there has been a 60% reduction in the number of people waiting more than six months
- The maximum wait for a first outpatient appointment is now 17 weeks, down from 21 weeks a year ago
- The number of patients waiting more than 13 weeks for their first outpatient appointment has fallen by nearly two thirds in the last year.

1.8 The number of patients waiting for hospital admissions fell to 906,000 in March 2004, the lowest for more than fifteen years and the tenth successive month that the waiting list has been below a million. Fewer people are waiting and they are being seen more quickly.

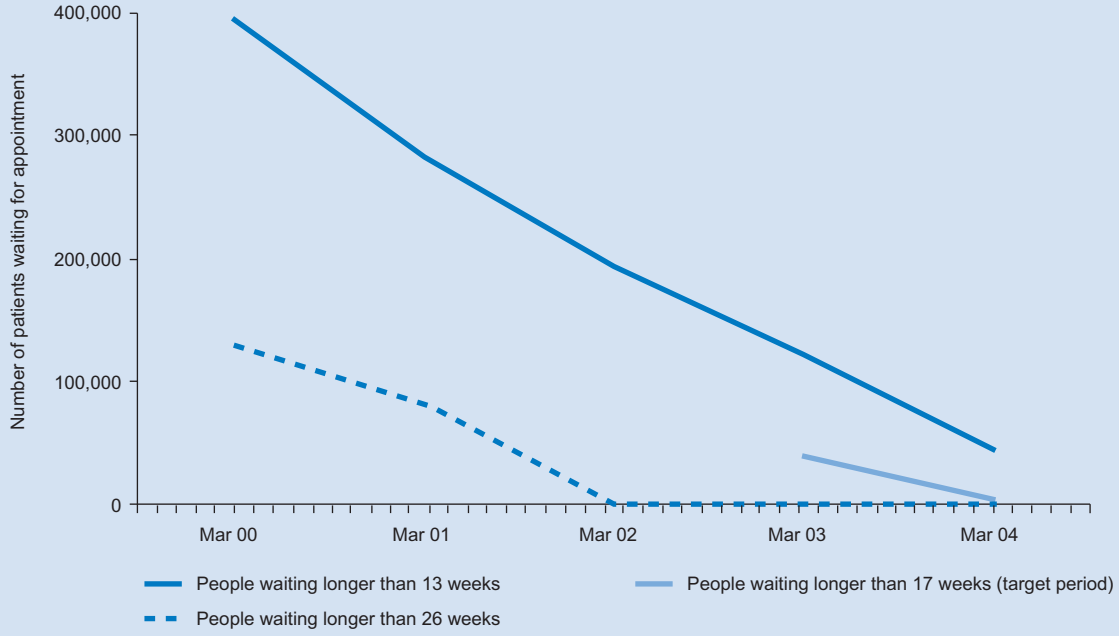
1.9 Hospital activity levels are are also increasing in order to reduce waits. Between 1996/97 and last year the total number of hospital admissions rose by 22% at the same

Figure 1.3: Inpatient waiting times, England, 2000–04 (months waited)



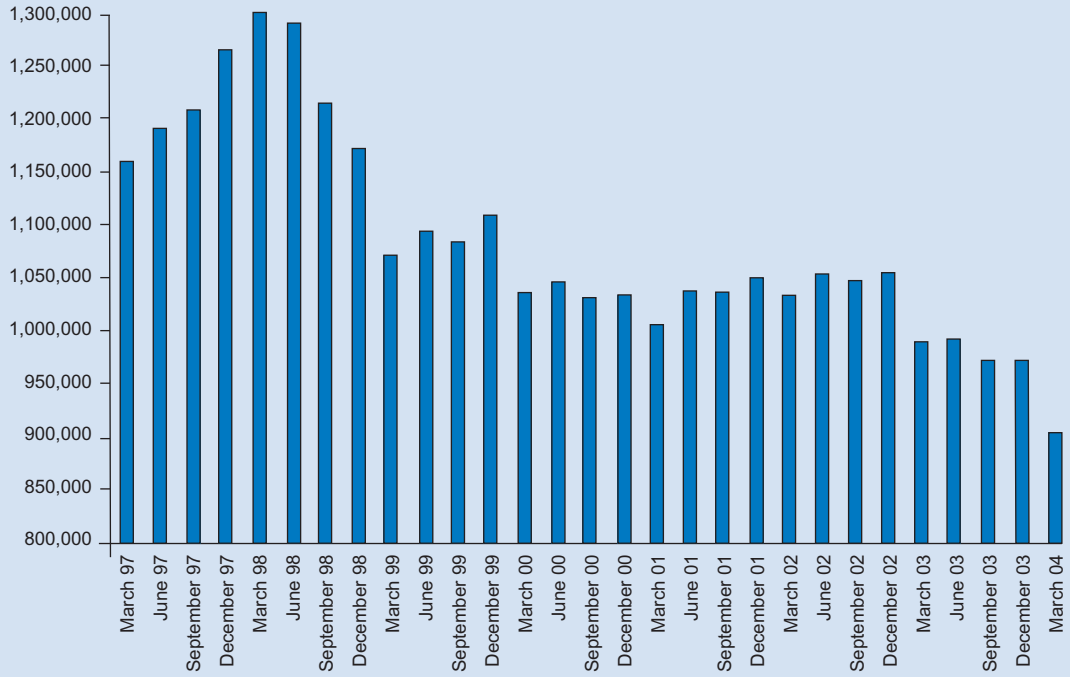
Source: Chief Executive's Report to the NHS (May 2004)

Figure 1.4: Outpatient waiting times, England, 2000–04 (weeks waited)



Source: Chief Executive's Report to the NHS (May 2004)

Figure 1.5: Total inpatient waiting list size



Source: Chief Executive's Report to the NHS (May 2004)

time as maximum waiting times were reduced from 18 months to nine.

1.10 Similar excellent progress has been made for patients who need to see their GP or a primary health care professional.

1.11 New services offered to people by telephone, the internet or through NHS Walk-in Centres have transformed the way in which people can quickly access the health service:

- NHS Direct – the telephone information and advice service – is now a well-established part of the health service, with steady growth in the number of patients who use it. There has been a large increase in calls to NHS Direct since *The NHS Plan* was published, rising from 1.7 million to 6.4 million a year
- NHS Direct Online, a new internet service, has now supplemented NHS Direct and has seen particularly rapid growth in use. Last year there were 6.5 million hits on the website *www.nhsdirect.co.uk*

Table 1.1: GP and primary health care professional appointment availability

Appointment type	March 2002	March 2004	Increase last two years
Percentage of patients able to see a GP within two days	74.6%	97.4%	22.8%
Percentage of patients able to see a primary healthcare professional within one day	71.7%	97.5%	25.8%

Table 1.2: New primary care centres

	March 2000	March 2004	Increase since *The NHS Plan* (July 2000)
Number of NHS Walk-in Centres	4	43	39
Average visits per centre per day	30	103	73

- NHS Walk-in Centres – where patients can be seen without an appointment – are experiencing rapid expansion as new sites open and others grow in popularity. These centres offer patients faster and more convenient access to healthcare. Since opening in 2000, staff in the centres have seen over 4.5 million people. Twenty-two new NHS Walk-in Centres came on stream in spring this year.

1.12 There has been similar progress in securing faster emergency care for patients:

- There has been good progress towards improving ambulance response times so that 75% of 999 calls to life-threatening emergencies are responded to within eight minutes

- *The NHS Plan* set a target that the maximum waiting time in A&E, from arrival to admission or discharge, should be four hours. By September 2002, 77% of patients were treated within four hours. As of March 2004, 93.7% of patients were treated within four hours. (The September 2002 figure is for major A&Es while the March 2004 figure is for all A&Es).

Changes in the way services are delivered

1.13 To make healthcare more convenient for patients, the NHS is increasingly offering services in primary care or in outpatient departments, without the need for a hospital admission. With more staff, more facilities and new ways of working, more patients are being treated in primary care. As a result last year there was almost no growth in the number of patients referred to hospital by their GP. This, combined with increases in the number of operations in hospitals, is helping to bring down waiting lists and ensure that patients are treated more quickly and more conveniently. There has been impressive growth in services effectively provided in the community:

- The number of prescriptions issued in the community has risen from 550 million in 2000/01 to 615 million in 2002/03. Since *The NHS Plan* the number of prescriptions has risen by over 11%. Spending on drugs has increased from £6.7 billion in 2000/01 to £8.4 billion in 2002/03. Since *The NHS Plan* there has been a increase in spending of almost 25%

- In mental health, there has been a significant increase in the number of Assertive Outreach Teams since *The NHS Plan*, rising from 121 to 251 in 2003. There has also been an increase in the number of Crisis Resolution Teams, rising from 85 to 137 since *The NHS Plan*. The number of Early Intervention Teams has increased by 125% over the same period. These initiatives are all supporting more effective care in mental health

- In social care there has been a rise of 16% in the number of hours of home care provided to vulnerable citizens, rising to over 3 million last year. The number of households receiving intensive home care has increased from 68,700 to 87,000 since the publication of *The NHS Plan*, a 27% increase

- Last year the number of procedures carried out in primary care had risen to an all time high of an estimated 725,000

- As growing numbers of primary and community clinics are able to offer more services to patients, people can increasingly avoid a hospital visit. Last year the growth in referrals by GPs to hospitals was only 0.1%. Over 70% of patients' contact with the NHS is now at home or in primary and community care facilities and this is set to increase significantly.

Productivity

1.14 With this growing shift of services from the hospital to the community, the old measures of productivity do not properly reflect the work of the NHS, measuring only the work of hospitals, and ignoring the length of wait for patients, improvements in the quality of care provided, improvements in the outcomes of treatment, work to prevent the development of diseases and efforts to support people with life-long illnesses. New services such as NHS Direct and NHS Walk-in Centres do not feature. So in all the areas in which the NHS has forged ahead in recent years, productivity measures have failed to keep up. The independent Atkinson Review is working with the Office of National Statistics to develop new measures of productivity that are appropriate to the realities of the NHS today and the new ways in which it is meeting the needs of patients.

More staff

1.15 Big increases in the money available to the NHS have enabled the service to secure rapid growth in its key resource, its staff. Between September 1997 and September 2003 the number of doctors increased by 19,400 (22%) and the number of nurses increased by 67,500 (21%). Over the same period the number of scientific, therapeutic and technical staff increased by 25,800 (27%). This growth has been underpinned by unprecedented investment in staff for the future. By autumn 2003 extra investment in training had increased the annual intake of medical school students to over 6,000, a rise of 61% since autumn 1997. There has been a 53% increase in the number of nurses entering training since 1997. Investment today will ensure that the NHS of tomorrow has the nurses, doctors, therapists, scientists and technicians and managers that it needs to deliver a world-class service.

Better buildings for patients and staff

1.16 The NHS has continued to invest in buildings, equipment and infrastructure to provide the additional facilities and beds that enable NHS staff to deliver modern, safe, convenient and high-quality care. Since 1997, 68 major hospital developments worth over £11 billion have been approved and 24 of these are already open and serving NHS patients. By 2004, up to £1 billion will have been invested to modernise buildings and facilities in primary care. Over 2,200 GP practice premises have already been modernised through substantial refurbishment or replacement with new buildings. Two hundred and eighty six one-stop primary care centres have been created, bringing primary care and community services onto one site. Twenty six NHS-run treatment centres have already opened and a further 20 are in development. They are complemented by independent-sector treatment centres, with a further 32 currently in development. By the end of 2005, there will be at least 80 treatment centres, providing a further quarter of a million operations a year for NHS patients.

Better healthcare

1.17 Patient safety is a top priority for clinical staff and over recent years the NHS has put in place further improvements to support them in that critical aspect of their work. The NHS is leading the world by introducing the first truly national patient safety agenda, focusing on improved patient care through the promotion of a culture of reporting and learning from mistakes and errors. The National Patient Safety Agency has developed a new reporting system that has now gone live in the NHS.

1.18 Patients have the right to expect assurances about the quality of care that they receive wherever they receive it in the NHS. The Health Act 1999 set out a statutory duty of quality to be implemented through a framework of clinical governance, the systems and practices of which ensure the highest possible standards of care for patients. Clinical governance support teams have been set up to help organisations focus on high-quality clinical services, and the Healthcare Commission will regularly be assessing NHS organisations' progress towards implementation.

1.19 The Department of Health recently published a set of new draft standards for the NHS for consultation. The standards are wide-ranging and cover the full spectrum of NHS services, including primary care and public health. They apply to all organisations providing services to or for the NHS including NHS Foundation Trusts and NHS treatment centres. These standards will be used by the Healthcare Commission to assess the quality of NHS healthcare and to support improvements in care.

1.20 A Patient Advice and Liaison Service has been established in every NHS Trust and PCT in England to provide information and support to patients, their families and carers in using the NHS. This service works with Patient and Public Involvement Forums to monitor and review health services from the patient's perspective.

Improvements in patient experience

1.21 Since *The NHS Plan*, the NHS has increasingly listened to the patient voice in designing services. NHS Trusts are now required to collect feedback from service users on a regular and ongoing basis. There is also a rolling programme of national patient surveys to ensure that key issues for patients are picked up quickly and addressed by the NHS. Overall these surveys show that a very large proportion of patients say the services they receive are excellent or very good, a sign that the changes set out in this chapter are driving real improvements in the way the NHS meets the needs of the people that it serves.

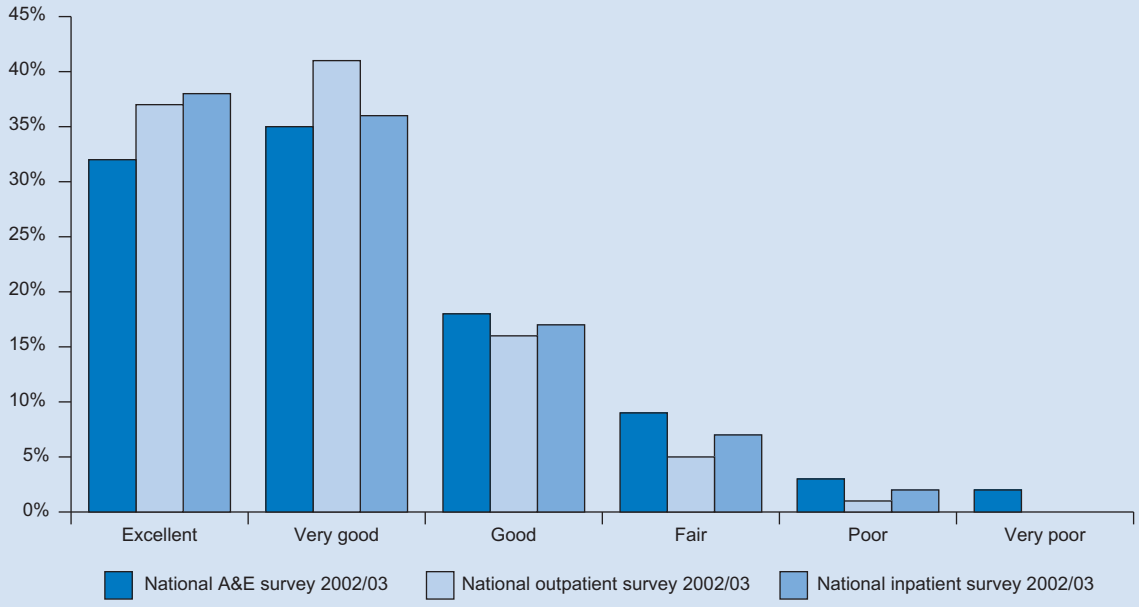
1.22 However, these surveys also show that patients expect more from the NHS on getting the basics right – cleaner hospitals, better food, a pleasant environment, and services provided by staff who are even more attentive to patients' needs and eager to improve the service. The NHS has responded to this feedback:

- The Better Hospital Food Programme, launched in 2001, has improved the choice, quality and availability of food in hospitals, having a real impact on the 300 million meals the NHS provides each year at a cost of £500 million. Patients now receive menus with nutritional information, 24-hour catering services, snack options and hot evening meals. This has resulted in better services for patients and less waste in the NHS

- 98% of wards are now single-sex and the remaining mixed-sex wards will soon be a thing of the past. Widespread work is underway to convert large dormitory-style wards into modern accommodation, providing greater privacy, dignity and comfort for patients

- Through partnership with the private sector, the NHS has secured £100m of investment in bedside televisions and telephones. At the end of last year 109 hospitals had integrated television and telephone bedside services, giving 51,000 patients access to the service. Another 95 hospitals are currently installing the system

Figure 1.6: Overall, how would you rate the care you received?



Source: Chief Executive's Report to the NHS (May 2004)

- Hospital cleanliness is improving. In 2000 over 200 hospitals were rated as unacceptable. By 2001 all hospitals in England met or exceeded minimum standards. Hospital cleanliness continues to be targeted for further improvement.

Section 2
Offering a better service

Chapter 2
High-quality and personalised care

Waiting for treatment will reduce to the point where it is no longer the major issue for patients and the public:

- By 2008, no one will have to wait longer than 18 weeks from GP referral to hospital treatment, and most people will experience much shorter waits, with even quicker access in priority areas such as cancer
- Patients will be able to choose from four to five providers for planned hospital care from December 2005
- By 2008, patients will have the right to choose from any health care provider which meets the Healthcare Commission's standards and which can provide the care within the price that the NHS will pay
- Patients will be given more access to a wider range of services in primary care
- Patient choice will be supported by the provision of information about waiting times at different providers, and about the quality of care available
- Every care setting will encourage the culture, systems and working practices to assure the quality of care provided and enable improved quality and more personal care
- Patient safety will be a central focus of health care delivery: care givers will act to further reduce risks and learn from things that go wrong.

Introduction

2.1 By 2008 the NHS will provide patients in England with services that compare well with world-class standards. Choice and responsiveness to individual needs will be a reality for all, not just the more affluent or the better informed. Waiting for treatment will have been reduced to the point where it is no longer the major issue for patients and the public.

2.2 Our priorities in this area are based on the public's views captured by the consultation process carried out in 2003 and published in *Building on the Best: Choice, Responsiveness and Equity in the NHS*. The aim is a health service which responds to 21st century public expectations by offering:

- flexible access to services shaped around individuals' needs and preferences, rather than an expectation that people will fit the system
- greater choice and shared decision-making between patient and clinical team over treatment and care
- better access to the information and support that people need to exercise choice.

Improving access

2.3 *The NHS Plan* set out an aspiration of a maximum three months wait for any stage of treatment by 2008. The NHS has made good progress. Compared to an 18-month inpatient wait, the maximum wait for inpatient treatment is now nine months and the maximum outpatient wait is 17 weeks. By next year the maximum wait for inpatient treatment will be six months.

2.4 This is still too long to wait for essential care. By 2008 no one will wait longer than 18 weeks from GP referral to hospital treatment. Waits from GP to initial outpatient consultation will not normally exceed six weeks. There will be even shorter waits for patients whose conditions require faster treatment. In the case of patients with suspected cancer, maximum waits by 2005 will not exceed eight weeks from referral to treatment and four weeks from diagnosis to treatment.

2.5 While 18 weeks will be the maximum, most waiting times will be much shorter than this. On the basis that average waiting times are currently under half the maximum, if this relationship is maintained, average waits in 2008 will be around nine weeks from GP referal to treatment. PCTs and providers will be encouraged to set and achieve even more ambitious goals. Some are already achieving these.

2.6 Because it is not acceptable to patients to have short waits for inpatient and outpatient treatment but no maximum wait for all the stages beforehand, waits for consultations, diagnostic procedures and tests are included in the pledge for the first time ever. In four years' time, waiting times for elective care will have ceased to be the main concern to patients and the public.

2.7 In the longer term the NHS will also aim to bring waiting times to see other professionals, such as physiotherapists and speech and language therapists, into this target. In the meantime, the NHS will make particular improvements in reducing waiting times for speech and language therapy and child and adolescent mental health services. There will be further improvements in access to NHS dental services. From April 2005, PCTs will be able to contract directly with dental practices to improve access for their local populations.

2.8 Access to primary care is also an important focus for the next phase of reform. Ongoing training and recruitment of new GPs together with the opening up of a wider range of primary care services, including NHS Walk-in Centres, minor injuries units and the expansion of the NHS Direct service are all contributing to improved access. PCTs are also now being encouraged to be much more proactive in their management of local supply to ensure access for all. Incentives to attract new providers will be developed to ensure that everyone has fair access to primary care near their home and/or workplace (see Chapter 5).

Empowering patients

2.9 Rapid access is not enough. To meet today's expectations, patients need to be able to choose from a range of services that best meet their needs and preferences. Between now and 2008, the NHS will be making the changes which enable patients to personalise their care and for those choices to shape the system and the way that it is run.

2.10 People will be able to book their hospital appointments for a time that suits them, from a choice of hospitals:

- From this August, people waiting more than six months for surgery will be offered faster treatment at an alternative hospital
- From April 2005, patients who need a heart operation will be offered a choice of provider from the time they are referred for treatment
- By December 2005 all patients who need surgery will be offered a choice of four to five alternatives at the time they are referred for treatment by their GP.

2.11 By 2008, all patients will have a right to be seen and treated within a maximum waiting

time of 18 weeks. A patient who is referred for planned hospital care will also have the right to choose any healthcare provider which meets the Healthcare Commission's standards, which can provide the care within the price that the NHS will pay, and which can meet the 18 weeks waiting time target. If a patient chooses to be treated by a provider which cannot offer a waiting time of 18 weeks or less the patient will be able to choose another provider or choose to wait longer for their first choice. Patients making such choices will be fully informed of the total time they may have to wait for treatment. Patients are guaranteed that all care provided through the NHS will still be based on need and not on the patient's ability to pay.

2.12 In order to ensure that low-income groups are also empowered to exercise choice, eligible patients will be able to have their transport costs covered by the Hospital Travel Costs Scheme, as at present. Guidance will be issued shortly to PCTs on the implementation of choice at the point of referral. This guidance will include policy on wider support for patients exercising choice from 2005. Patient support services will need to be provided by PCTs appropriate to their local populations. These may include, for example, assistance with language, literacy, or other communications and mobility issues. It is expected that these support mechanisms will continue to be available as choice in planned hospital care is expanded.

2.13 Patients will also have more choice from a wider range of services in primary care, helping people to get access to more personalised healthcare. In addition to developing traditional primary care services, such as GP practices and pharmacies, the NHS will be increasingly working with innovative new providers. These will be particularly important in deprived areas where primary care is most needed and has traditionally been weak, and for commuters, for whom the NHS will provide more convenient services which will minimise disruption to their working lives.

2.14 The NHS will also make it easier and more convenient for patients to get the medicines they need safely. The Department of Health will:

- continue to ease the bureaucracy surrounding repeat prescriptions
- free up restrictions on the location of new pharmacies
- expand the range of medicines that pharmacies can provide without a prescription
- promote minor ailments schemes where pharmacies can help patients manage conditions like coughs, hayfever and stomach upsets without involving their GP
- increase the range of healthcare professionals who can prescribe drugs to patients.

2.15 The NHS will widen choice further, starting with greater choice in maternity services and greater choice over care for people who are terminally ill:

- Local services will promote direct access to midwives, giving women quicker access to specialist advice and support. Expectant mothers will have access to local guides to maternity services
- Building on the strong tradition of end-of-life care in cancer and HIV/AIDS services, the NHS will promote a training programme for staff working in primary care, residential care, nursing homes and hospital wards to ensure that in time all people at the end of life, regardless of their diagnosis, will be given a choice of where they wish to die and how they wish to be treated.

2.16 In addition, the Expert Patients Programme, described in the next chapter, will be expanded nationally, to enable many more people who have long-term conditions to take greater control of their own treatment, supported by NHS professionals in the community when they need it.

Supporting personalised services – *HealthSpace*

2.17 A critical component of a personalised service will be giving people a bigger say in how they are treated. As part of that work, an important building block will be to enable patients to record how they wish to be treated and give them the opportunity to record their own information in their personal care records.

2.18 Everyone will have their own *HealthSpace*, linked to their electronic health record, allowing people to make their preferences known to the clinical team treating them. These might include, for example, how they wish to be helped at a time of mental health crisis; next of kin contacts; or simply how they prefer to be addressed by staff.

2.19 Patients will be able to record their own information securely on the internet. As facilities build up over time, *HealthSpace* will enable patients to access their own electronic health records and doctors to access information that the patient wants them to see.

2.20 The Department of Health and the NHS will also be working to ensure that patients have the right information at the right time to ensure that the services they receive are prompt, personal and convenient. Working with a range of partners, the NHS will harness new and existing technology, such as digital TV and the internet, to meet the needs of patients. As part of this work the Department of Health will develop a programme to "kitemark" information from a variety of sources so that patients know what sources of information are reliable and trustworthy. The Department of Health will continue to extend the range of local guides to services.

2.21 The Department of Health is currently considering the development of an NHS Card, which could support smart access to personal data and speed confirmation of access to appropriate care.

Listening to patients

2.22 Expanding choice and developing a personalised service for patients depends on giving patients a stronger voice. Where patients choose to go will be important, as it will affect where resources go and which providers thrive. But there will also be a greater readiness, nationally and locally, to seek and listen to the views of patients, and to act on them.

2.23 Patient surveys and other systems will be developed further to provide faster and clearer feedback about their experiences of the NHS. Patient surveys are managed by the independent Healthcare Commission and cover a wide range of care settings. All the surveys focus on the issues that patients say are important to them and they are used to provide information on how the NHS can improve the quality of care it provides.The assessment of the patient experience is based on the five areas that patients and the public have identified as being of greatest importance:

- access and waiting
- safe, high-quality and well co-ordinated care
- better information and more choice
- even better relationships between patients and staff based on respect and dignity
- clean, friendly and comfortable environments.

2.24 The Department of Health will also strengthen arrangements for monitoring the impact of improving choice and responsiveness on equity, and for tracking the experience of different patient groups and communities. There will be a particular focus on the needs of groups which have traditionally suffered from relatively poor access to some elements of care including black and minority ethnic groups.

A choice of high-quality services

2.25 For patients to be confident in exercising choice, they need the assurance that all of the services that they are choosing from meet high standards of clinical care. That confidence is the bedrock of modern medical practice. Patients have a right to take it as a given that every effort is made to ensure that their care and treatment is both safe and effective. While every NHS professional has that aim ingrained in their professional practice, they need support in ensuring that their individual contributions add up to a system that is safe and effective.

2.26 A great deal of progress has been made to ensure that this is the case. The development of clinical governance in NHS organisations is supporting the development of a system to ensure that improving safety and clinical care is central to every NHS professional's working life. The development of national standards, including National Service Frameworks, is helping to set a clear framework against which organisations can measure their clinical performance. The continuing work of the National Institute for Clinical Excellence (NICE) in the development of clinical guidelines is also contributing to improving clinical care. The establishment of the independent Healthcare Commission puts in place the inspection system needed to ensure that those standards are maintained and improved upon.

2.27 All NHS bodies will continue this drive for safer and higher-quality care. This objective reflects public concerns both about safety in hospitals and about risks in the environment. The main approaches we will take are:

- continuing the drive to create a culture of greater patient safety so that it becomes an even greater priority for all those working in the NHS, and for the organisations they work in
- ensuring that learning from incidents that endanger patient safety is the norm for all NHS staff and organisations
- building on clinical governance so that, like broader quality issues, safety is of higher priority throughout all organisations caring for NHS patients
- supporting the work programme of the National Patient Safety Agency (NPSA) to run a new national system for reporting, analysing and learning from adverse errors or mistakes in caring for patients
- ensuring that the work and learning of the NPSA becomes part of everyday clinical practice
- ensuring the newly-established Health Protection Agency effectively supports the development of frameworks to protect the patient
- using the investment in IT and information systems to contribute to improved safety of care for NHS patients through better communication, use of knowledge about best practice, and specific issues on drugs, such as interactions and monitoring.

2.28 An example of the new drive to better safety and quality is in our approach to Methicillin Resistant *Staphylococcus Aureus* (MRSA). National mandatory surveillance for MRSA blood stream infections was introduced in April 2001. The availability of reliable data is enabling NHS Trusts to benchmark their performance and to take action to prevent avoidable cases. The implementation of the actions set out in *Winning Ways* will lead to a reduction in rates of MRSA and other healthcare-acquired infections in England.

2.29 New ways of working for health professionals will be supported by systems of regulation to ensure the highest quality of patient care, complemented by effective processes for reporting, auditing and inspecting care and by facilitating continuing professional development. In the context of a wider review of regulation there will be:

- reform of the General Medical Council and other statutory professional regulatory bodies overseen by the Council for the Regulation of Healthcare Professionals
- reform of post-graduate medical training overseen by the Postgraduate Medical Education and Training Board
- re-accreditation procedures linked to annual appraisals for staff
- the development of the NHS University (NHSU) to provide ongoing training and learning opportunities for all NHS staff
- support to employers dealing with poorly-performing doctors
- following consultation, proposals to take steps to introduce regulation of other health care professionals, such as acupuncturists and herbalists
- continued work with the General Social Care Council to better develop the effective regulation of social care professionals.

THE NHS IN 2000	THE NHS IN 2008
Patient has to make an appointment with a registered GP for advice, diagnosis and referral.	Patient chooses whether to make an appointment with a GP or practice nurse, visit an NHS Walk-in Centre or Pharmacy Service Centre, or contact NHS Direct for advice and diagnosis.
Patient may wait several days for an appointment with their GP.	Patients see a primary care practitioner within 24 hours when they need to or within 48 hours for a GP.
GP makes decision about *how, when* and *where* patient is treated.	Patient chooses *how, when* and *where* they are treated – from a range of providers funded by the NHS and accredited by the Healthcare Commission.
GP sends referral letter to NHS Trust requesting outpatient appointment. NHS Trust then sends appointment time to patient.	Patient books hospital appointment electronically for their own convenience.
Patient waits up to 12 months for an outpatient appointment. Patient waits up to 18 months for inpatient appointment.	Patient waits for specialist care are reduced to no more than 18 weeks from GP referral to treatment.
Patient waits several hours in A&E.	Patient contacts NHS Direct or visits Minor Injuries Unit. If patient needs to go to A&E, he/she is seen rapidly (maximum four hours).
Patient records owned by hospital, split between the specialties, often go missing or are not available at the right time.	Patient records owned by the patient; with secure access for appropriate health professionals.
Patient in (mixed sex) Nightingale wards.	Mixed sex wards abolished for older people and for all but a small number of patients e.g. intensive care.
Patient has to keep repeating any personal information about communication, language, dietary or mobility needs at every contact with the NHS.	Patients record their preferences in their personal *HealthSpace* on the internet, linked to their patient care record.

Chapter 3
Supporting people with long-term conditions to live healthy lives

People with long-term conditions will receive higher-quality care:

- The Expert Patients Programme will be rolled out throughout the NHS by 2008 to enable thousands more people with long-term conditions to take more control of their health
- The new contract for GPs introduced in April 2004 will reward family doctors who deliver higher standards of care to patients
- Patients with complex long-term conditions will be supported by community matrons, and by 2008 every PCT will be offering these services
- People with long-term conditions will benefit from the rapid implementation of NICE guidance on cost-effective drugs.

Introduction

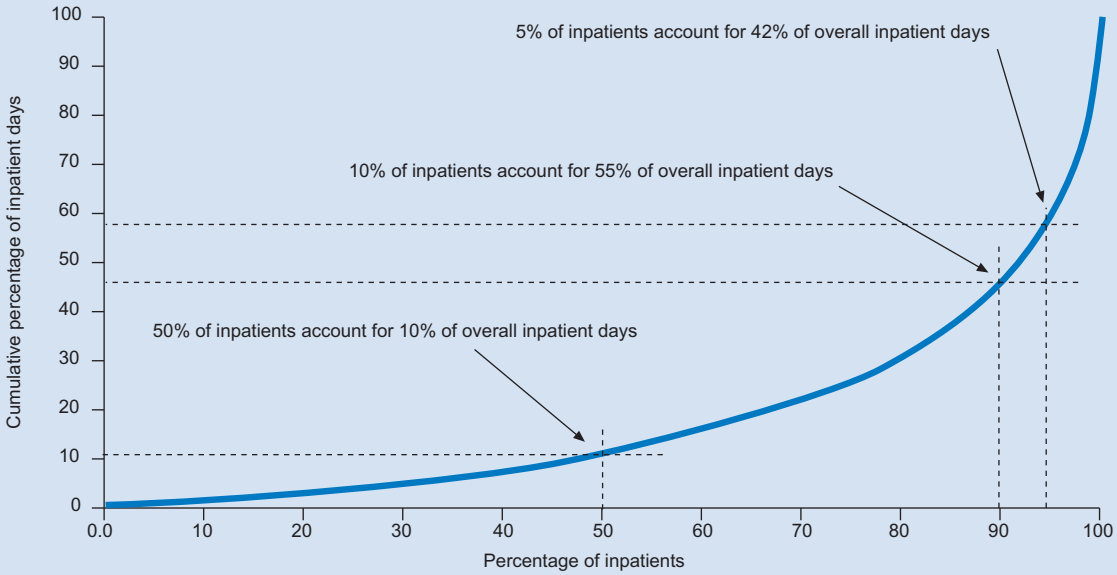
3.1 With medical technology improving, the provision of universal healthcare, and improved prevention, the NHS continues to make inroads into curable and preventable medical conditions in England. As people live longer, growing numbers of people have medical conditions that they will live with for the rest of their lives. These long-term illnesses are increasingly common and the ability to respond well to the needs of patients with them has become an important part of modern healthcare.

3.2 Long-term conditions affect older people more than younger people and people in lower socio-economic groups are also more likely to be diagnosed with one or more condition. Long-term conditions include diabetes, asthma, arthritis, heart disease, depression, psoriasis and other skin diseases that can be controlled but not cured. They vary in their degree and severity but living with such a condition usually has a major impact on a person's life and on their family.

3.3 The impact on individual patients and the NHS is enormous:

- About 60% of adults report some form of long-term or chronic health problem
- People with long-term health problems are significantly more likely to see their GP (accounting for about 80% of GP consultations), to be admitted as an inpatient (on average about twice as likely, given a particular problem) and stay in hospital for longer
- Use of the NHS increases with the number of problems reported (the 15% of people with three or more problems account for almost 30% of inpatient days)

Figure 3.1: Percentage of those admitted as inpatients by cumulative days spent as inpatients



Source: Analysis of British Household Panel Survey (2001)

- There are some patients with more than one condition whose complex needs mean that they depend very heavily on hospital stays to support them. Ten per cent of patients who stay in hospital for their care account for 55% of hospital stays, compared with 50% of patients who use only 10% of the bed days.

3.4 The NHS needs to provide a much better service for patients with these conditions and provide high-quality personalised care to meet their needs. It needs to enable people to take greater control of their own treatment, and to spend more time at home and in the community with their families and friends. The NHS needs to do much more to support patients in avoiding the fear and anxiety of having to go to a hospital in an emergency, by anticipating problems and working with patients to prevent these worrying episodes. This chapter sets out how the NHS will both respond to these needs and build a responsive service tailored to patients with long-term illnesses.

3.5 The benefits to patients are arguments enough for doing so. But responding in this way will also create a more efficient health service that is better able to meet the needs of all the patients that it serves. There is strong evidence that improved management of these conditions can lead to:

- Fewer emergency admissions into hospitals, where care is more expensive. Many patients with severe conditions experience periods of relatively poorer health when emergency admission to hospital is required to stabilise their conditions. These admissions account for a high proportion of overall emergency admissions and of total bed-days. This occurs across a wide range of conditions, including heart disease, chronic obstructive pulmonary disease (including bronchitis and emphysema), diabetes and mental health problems

- Fewer admissions for inpatient care. Slowing the progression of disease can delay or prevent the need for treatment in hospital. For example, better management of high blood pressure and high cholesterol in patients with heart disease means that fewer of these patients will require heart surgery. Effective physiotherapy for patients with arthritis can delay the need for joint replacements.

Personalised support for patients with long-term conditions

3.6 Over the next four years, the NHS will be offering better, more effective, services to people with long-term conditions.

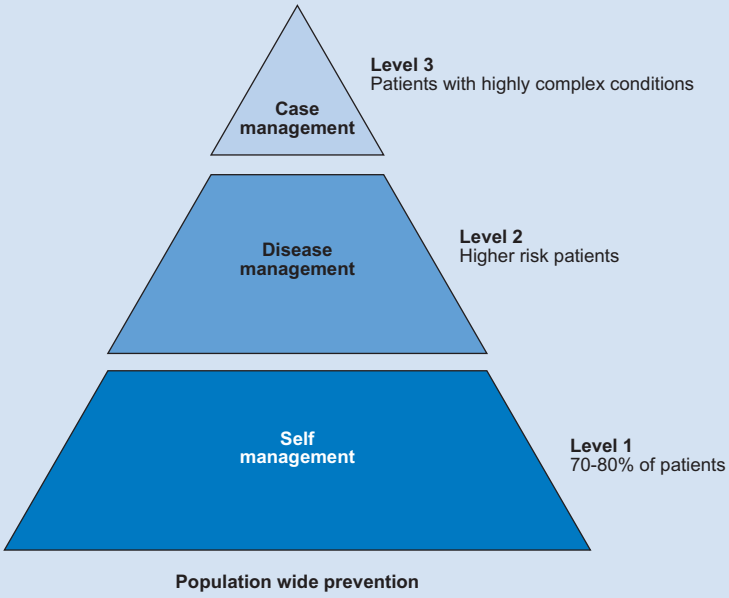
3.7 The NHS will concentrate on giving the right level of support to patients. While patients will need individually-tailored care, patients can be broadly divided into three groups requiring different levels of support. The large majority of patients are usually able to manage their own conditions, given the right advice and support. Another group needs more proactive support in caring for themselves, with particular support on avoiding complications and slowing the progression of their disease. A smaller group of patients with particularly complex needs require an approach known as "case management", with more active and specialist care.

Self-management

3.8 For the first level of care, self-management, people with long-term conditions can often live healthier lives when they are supported to manage their chronic disease. In recent years, drawing on international experience and research evidence, the Expert Patients Programme has been developed in the NHS to find effective ways of giving this option to patients.

3.9 Using trained non-medical leaders as educators, people with arthritis and other long-term conditions have been equipped with the skills to manage their own conditions. Compared with other patients, "expert" patients report that their health is better, and they cope better with fatigue, feel less limited in what they can do and are less dependent on hospital care. The programme has involved many PCTs across the country and to date has supported over 10,000 patients in this way. By 2008, it will have been rolled out throughout the NHS, enabling thousands more patients to take greater control of their own health and their

Figure 3.2: The right service for patients



own lives. The following statements indicate the benefits reported by patients:

- "It gave me new ways of analysing and solving some of my problems… I believe that this is one of the most important initiatives for those with long-term conditions."
- "The Expert Patients Programme has really helped me to take more control of not just my arthritis, but also my life."
- "I have learnt that I need to take responsibility for my health instead of leaving it all to the GP."
- "Coming on the programme has given me real confidence to move on, plan for the future without fear, because I can now plan and pace – really good teaching."

Disease management

3.10 At the second level of care, there is very good evidence about the positive impact of better disease management on specific conditions like heart disease, chronic obstructive pulmonary disease, asthma, diabetes and depression. With proper support in primary care and systematic and tailored programmes for individual patients, better healthcare and social care can make a very real impact on slowing the progression of these diseases and delaying or avoiding severe phases of illness.

3.11 For example, for coronary heart disease, GPs now have registers of all their patients who suffer from this condition. They can use these registers to invite patients in once or twice a year to check that their blood pressure is under control, that their cholesterol levels are kept in check and that they are provided with support in stopping smoking or taking more exercise. It has been estimated that drugs for cholesterol alone have saved up to 7,000 lives through this approach. Many more heart attacks have been prevented and fewer patients have had to go through the trauma of surgery as a result.

3.12 The new approach to disease management will consolidate this work for all patients who can benefit. The National Service Frameworks provide clear models and frameworks for many of these conditions. The National Institute for Clinical Excellence guidance provides many of the key clinical underpinnings for a number of these conditions. The new contract for GPs provides strong financial incentives to those practices that seek out patients who can benefit from this kind of support and demonstrate that they are making a real difference to their health.

Case management

3.13 At the third level, where patients may often have three or more long-term health problems, the NHS needs to put in much more effort to meet their complex needs and provide a proper personalised service. Evidence for case management has come from a range of sources, both within the NHS and from international experience where it has been successfully implemented. This evidence has shown that high-quality and personalised case management can improve patients' lives dramatically, reduce emergency admissions to hospital and enable patients to return home from hospital more quickly when they do have to be admitted. From the perspective of a more efficient NHS, a range of UK studies have shown reductions in admissions of between 10% and 20% as well as reductions in the lengths of hospital stays of between 20% and 30%. Taking the thought and making the effort to meet the individual needs of patients who need help most is not only good for patients and for their families, but it is good for the NHS.

3.14 The key to meeting the personal needs of these patients will be a new type of specialist clinician, often a nurse, who works with patients and social care providers and who has particular expertise in responding to patients' complex problems. These community matrons will work with patients with complex problems to assess their needs and the support that they need and then work with local GPs and primary care teams to develop tailored personal plans to deliver the best possible care to them. These nurses will act

as a fixed point for the patient, take responsibility for their care, and co-ordinate the contribution of all the different professionals who can help, anticipate and deal with problems before they lead to worsening health or hospitalisation.

3.15 The pilot phase of this approach has shown that patients' health is improved quickly and, following on from that, reductions in admissions and long stays in hospital also reduce pressure on hospital and accident and emergency services. This is because case management avoids many of the admissions in this complex group of patients which are due to relatively minor and easy to prevent conditions such as dehydration and urinary tract infections, which could be avoided if the NHS was better able to quickly respond to patients' needs in the community. The addition of these relatively minor problems to patients' existing poor health and complex chronic disease is often the trigger for admission to hospital, which is upsetting for patients and their families and inefficient for the NHS.

3.16 Nine PCTs are working to adapt and implement case management for vulnerable, older people. Strategic health authorities are now developing case management approaches across their health communities for implementation by April 2005. This model of care will be adopted by every PCT between 2005 and 2008 by which time there will be over 3,000 community matrons using case management techniques to care for around 250,000 patients with complex needs.

Care closer to home

3.17 Patients generally prefer to be at home rather than in hospital, provided that they are properly supported. This programme will ensure that more care will be provided closer to home. Where possible, patients will be able to choose where and when they receive care and will be supported in making these choices. This includes making use of contact through the telephone, digital television and the internet, and applying the benefits of telecare, where there is evidence of cost-effectiveness (see Chapter 7).

3.18 In the case of planned hospital care, we will build on schemes already in place in parts of the NHS that enable patients to be treated more quickly and conveniently without having to attend hospital. For example, in Greater Manchester, many patients are now diagnosed and treated by GPs with a special interest, specialist nurses and other practitioners. Similarly, in Somerset, a referral management centre helps patients make informed choices with their GP about where they should be referred for specialist treatment. The result has been a significant increase in the number of patients choosing to see a specialist GP in the community, and this is often more convenient for them than a hospital appointment.

3.19 In the case of emergency care, the emphasis on supporting people with long-term conditions will help reduce unnecessary emergency admissions and enable hospitals to respond more effectively to the needs of acutely ill patients. This includes making use of emergency care practitioners in the ambulance service where appropriate. For example, the London Ambulance Service has 24 emergency care practitioners. They provide a service in two boroughs between 10am and 10pm, mainly for people whose conditions are not life-threatening but who need assistance or advice. Of these people, 83% are dealt with by a single emergency care practitioner avoiding admission to hospital altogether.

Social care

3.20 Effective social care services are often critical to meeting the needs of people with long-term conditions, enabling people to live more independently and, along with healthcare and other services, improving their health and the impact that it has on their lives. The following principles will be essential to ensuring that the NHS and social care services work together to meet the needs of these patients and provide them with the personalised support that they need:

- Social care, like healthcare, needs to be person-centred and personalised. Services need to cater for the individual's needs, rather than those of the service providers. This is not only about professionals interpreting an individual's needs and tailoring services to those assessed needs, but also involving people themselves, and their families, in the design and delivery of those services

- Social services are often provided at a time of crisis or significant event in a person's life, and sometimes continue long-term from that point. Social care services and the NHS need to reinforce the focus on *proactive* services that stop problems happening and help patients to maintain independence and existing networks of support. Picking up the pieces after the event, if it was avoidable, is a failure for those who require social care and health services

- Social care commissioning and provision will be further integrated with healthcare to deliver a better experience for the individual and ensure the most efficient use of available resources. Patients and their families should not have to take the trouble to communicate between different services. That is the job of local NHS and local authority services

- There will be a greater role for *preventative services* to help people avoid hospitalisation. Social care is critical to that work. Effective home care can help patients avoid going to a residential care home. Creative work to meet people's needs with better transport, housing and leisure services can also support this effort, as can excellent examples of work by local authorities to provide people with social and community networks that sustain them and help them to cope with the right support.

3.21 The single assessment process and better care co-ordination will be central to achieving these aims. It will help everyone involved to ensure the full range of health and social care needs of the individual are met. The Department of Health has already put in place a number of building blocks to support greater integration. The 1999 Health Act removes many of the legal barriers to allow joint commissioning of services by the NHS and local government, enabling combined provision and funding. In some areas, there have been joint appointments of senior managers in key roles in PCTs and local authorities to foster combined planning of care for the people that both organisations exist to serve. The Community Care (Delayed Discharges) Act 2003, also gives social services departments strong financial incentives to work with healthcare partners to ensure a smooth transition for patients from hospital back to the community.

3.22 As part of this drive, people will be given further control over their social care needs and the way that they are met. Direct payments – where people are given the financial resources to pay for the services that they need, rather than the services that the council offers – empower people to make their own choices about the design and delivery of the services and equipment that they need. With the option of support and advocacy functions, direct payments can significantly improve people's satisfaction with the help they secure and minimise the risk of making people dependent. Direct payments can also be co-ordinated with health commissioning so that, where needed, PCTs can commission integrated packages of social care and community-based healthcare in partnership with patients. This will be part of an overall strategy to improve choice in social care services.

Older people and long-term conditions

3.23 Older people have a relatively high likelihood of chronic disease and long-term conditions. They make heavy use of healthcare services and are majority users of social care. Frail older people with poor mobility, poor functioning and confusion are more likely to develop urinary tract infections, suffer dehydration, malnutrition and

hypothermia, and may fail to take medication. Often, the home environment may make it difficult for them to cope without support, particularly if they are alone, under stress, or have lost confidence in their ability to manage on their own. In all these cases, well-targeted and co-ordinated community-based healthcare, community equipment and social care are effective at providing the personalised care that they need and preventing stressful and disruptive admissions to hospital.

Mental health

3.24 The complex medical and social underpinnings of mental health and its treatment make it different from other long-term conditions, but this has often made it a forerunner in delivering combined approaches to delivering more personalised care, using preventative services, self-care, treatment in the community and, overall, more proactive care. *The National Service Framework for Mental Health* sets out a comprehensive agenda for improving services for adults. *The National Service Framework for Children*, to be published later this year, will include a new standard for child and adolescent mental health services.

3.25 A key priority will be to ensure better availability of early intervention and prevention services. In particular, the aim is to ensure a continued emphasis on assertive outreach services that seek to engage those with mental illness who are at risk of falling out of contact with services. Crisis resolution and home treatment services that respond rapidly to people in a crisis and provide support in the community will also be developed. Such teams have already shown that they can help to provide more effective support to patients, and they are well-liked by the people who they serve, helping them to avoid unnecessary time in hospital.

What the future will look like for the patient

Scenario: Sayed
Sayed (15) has had a cough for a week. He knows most coughs get better by themselves but that they sometimes make his asthma worse so he increases his preventative inhaler therapy. He, his GP and his parents have agreed that he can manage things himself. He accesses his personal care record from home, including personalised management plans for asthma and chest infections. Despite having increased his inhaler therapy as planned, his wheeze is worse and his measurement of breathing (peak flow) has fallen. He rings his GP. Sayed has been on the Expert Patients Programme, and has taken the specific module on managing worsening of his asthma. Therefore they decide that Sayed can go directly to the pharmacy to pick up a three-day course of steroids after the GP sends an electronic prescription. Sayed knows what to do if his symptoms change or if he is still concerned. The next morning he is contacted by the practice nurse who finds he is making a recovery. The following week they talk again and amend his care plan to help prevent future exacerbations.

Scenario: Lucy
Lucy (30) has had diabetes since childhood. She has registered a profile of interests on *HealthSpace*, her own secure place on the internet, that holds her personal care record. She regularly receives updated information about managing diabetes from the NHS, Diabetes UK and a diabetes clinic in Boston that her specialist nurse recommended. Recently, she has found that the pharmacy near to work can do full diabetes tests, including blood tests, foot checks and retinal screening. These are put onto her *HealthSpace*. In 2003, she started on a newer, long-acting, insulin (glarine), as recommended by NICE. Recently, she and her partner have decided to start a family. Lucy went to her GP and discussed the implications. To back this up, her GP sends some general information to her *HealthSpace* about preparing for pregnancy and more detailed information about what diabetic mothers should do, and gives her a link to an evidence-based website on diabetes in pregnancy.

Scenario: Esther
Esther (82) has had raised blood pressure, angina, heart disease, diabetes and arthritis affecting her knees, hips and hands. The pain was getting worse last year so, instead of increasing her medication, she went on the Living With Arthritis programme jointly run by her PCT and Help the Aged. It was a great success. Unfortunately, she recently had a small stroke but made a good recovery in the specialist-run, community-based stroke unit. Since then, she has had an emergency admission to the local acute hospital with a urine infection, leading to confusion. This, combined with the fact that she has multiple chronic conditions and is on more than five medications, automatically alerts her GP to the fact that she is now at a high risk of repeated admissions. Her GP therefore refers her to a community matron who, working with Esther's practice, the local occupational therapy and physiotherapy service and social services, manages to help Esther become increasingly independent and less at risk. After two weeks of intense input and then occasional follow-up for a further two months, the matron hands back her care co-ordination to Esther's GP practice.

Scenario: Peter
Peter (36) has had psoriasis since his early twenties. About eight years ago it became so bad he had to be admitted to hospital for two weeks, but in recent years it has been much more stable. For the most part, Peter now manages his own psoriasis, using different creams and regimes according to how bad his symptoms are. He receives most of his prescriptions by post after ordering them over the internet. Recently he went to his local pharmacy and got some useful advice about exposure to the sun, which he knew helped his psoriasis but was also a risk for skin cancer. He is very active in his local psoriasis group, and as a result has become an educational resource for other patients with psoriasis. He has also become part of a group of clinicians, managers, patients and carers who advise the local Primary Care Trusts on how to commission services for patients with skin problems. He was particularly pleased to make sure that a number of different specialist providers are now available. He thinks that as a result, there are now providers who will suit the needs of many groups of people, including children, younger patients like himself and the elderly.

Chapter 4
A healthier and fitter population

The NHS will become more of a health service and not just a sickness service and:

- Inequalities in health will be reduced by targeting people at greatest risk
- Death rates from coronary heart disease and strokes in those under 75 will be reduced from 1997 by at least 40% by 2010
- Death rates from cancer in those under 75 will be reduced by at least 20% by 2010
- Death rates from suicide and undetermined injury will be reduced by at least 20% by 2010
- Building on current initiatives will help us in reducing risks of infection from MRSA with significant reductions between now and 2010
- The Department of Health's 2004 public health consultation, *Choosing Health?,* will lead to comprehensive proposals in a White Paper later in the year for tackling obesity, smoking and sexually-transmitted infections.

Introduction

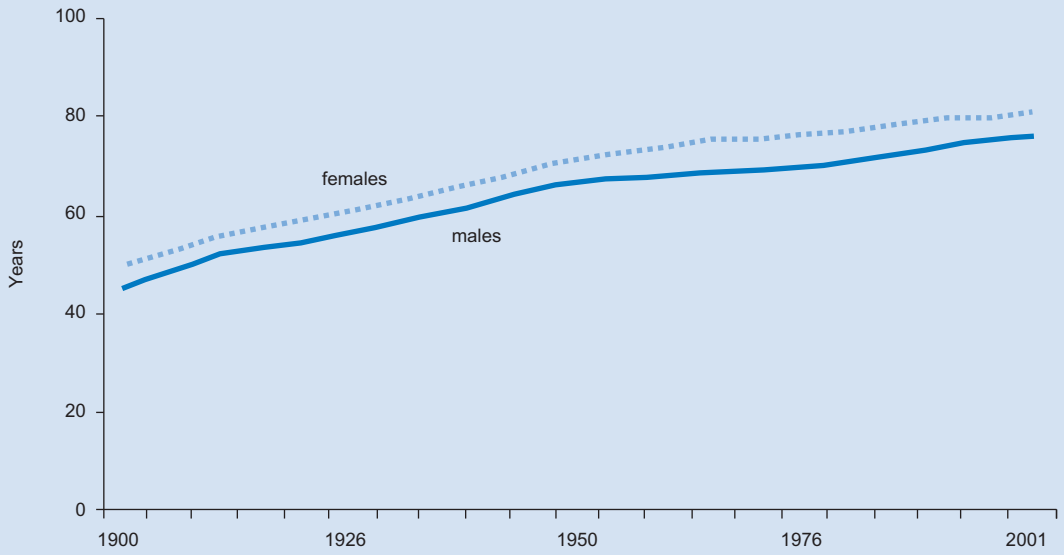
4.1 As the effects of investment and reform gather pace in the NHS, and the health service is better able to provide patients with fast and personalised treatment, the promotion of health and the prevention of ill-health will assume a much more important role in the work of the NHS. This chapter sets out how, following the publication of a White Paper on public health later this year, the NHS will become a health service and not just a sickness service, leading national and local efforts to tackle the causes of ill-health and narrowing the gap between the healthiest and unhealthiest parts of the country.

Health in England

4.2 There have been progressive improvements in the health of the population over the last century. Life expectancy at birth increased by around 30 years between 1901 and 2001 (Figure 4.1), and life expectancy at age 65 increased by around seven years between 1901 and 1991. These improvements have resulted from better nutrition and housing, advances in medicine and technology, and the provision of health services freely available to all.

4.3 The population of England is increasing slowly and is ageing. Changes in the population and new treatments have helped to change the pattern of illness and disease which affects people in England today. There has been a substantial decline in infectious diseases such as measles and an increase in cancers, heart disease and strokes, which now account for 35% of 'life years' lost before the age of 75. Long-term conditions have also increased in importance.

Figure 4.1: Life expectancy at birth, England, 1900–2001

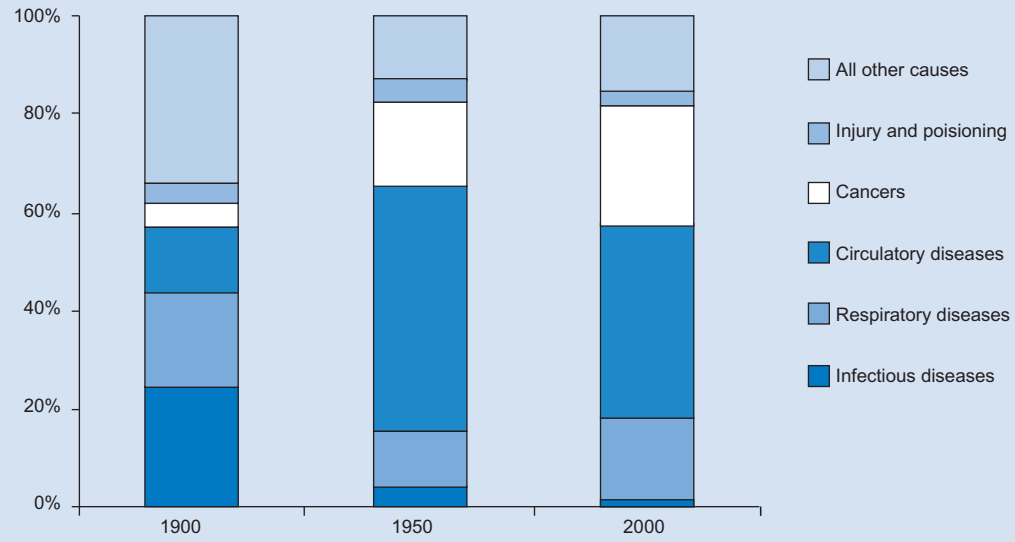


Source: Securing Good Health for the Whole Population: Population Health Trends (2003)

4.4 Analysis undertaken for the second Wanless Report shows that the health of the population of England is not as good as that of other comparable countries. The factors that contribute to poor health include relatively high levels of smoking (27% of the adult population) and overweight/obesity, and low levels of physical activity and consumption of fresh fruit and vegetables.

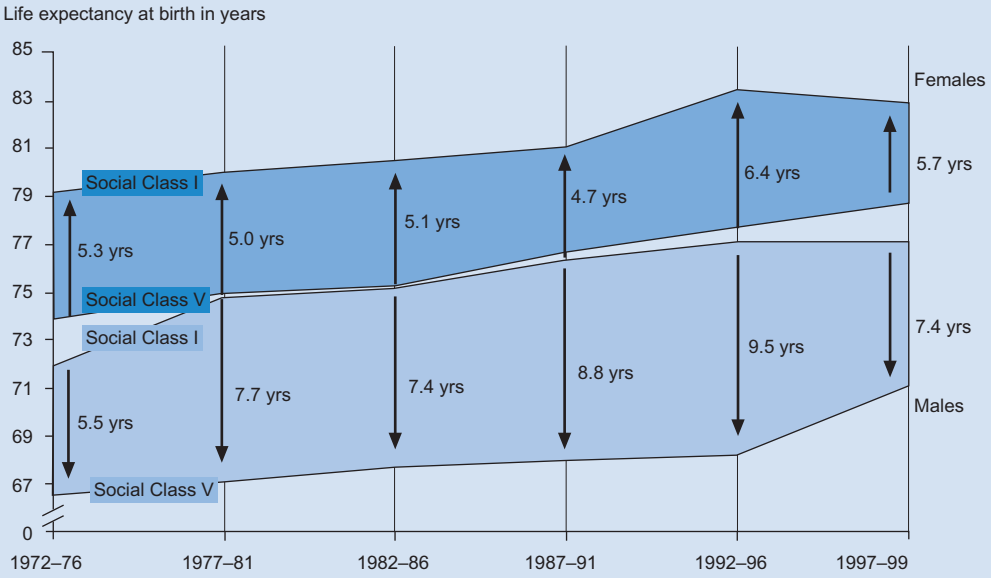
4.5 The social and economic determinants of health remain important factors as well. Poverty, ethnic origin and low educational achievement are all potentially significant issues. These determinants of health give rise to inequalities in health between different socio-economic and ethnic groups. Figure 4.3 shows how the gap in life expectancy between socio-economic goups has changed since the 1970s.

Figure 4.2: Selected causes of death at the beginning, middle and end of the last century



Source: Securing Good Health for the Whole Population: Population Health Trends (2003)

Figure 4.3: Changes in life expectancy at birth, by social class, 1972–99



Source: Tackling Health Inequalities: A Programme for Action (2003)

Cigarette smoking accounts for around half the difference in survival to 70 years of age between socio-economic groups one to five.

4.6 A recent analysis by the World Health Organization considered the impact of disease on countries in Europe, looking at both deaths and ill-health in the population. This information was used to create a measure known as "disability adjusted life years" or 'DALYs'. Table 4.1 shows that heart disease and strokes, mental illness, accidents, injuries and cancers have the greatest impact on the health of the population. The ranking of these

Table 4.1: The burden of disease in Europe

Cause	Disability adjusted life years	Percentage (%)
Cardiovascular diseases	33,381	21.8
Mental illness	31,080	20.3
Injuries	22,707	14.8
Cancers	17,642	11.5
Digestive diseases	7,087	4.6
Infectious and parasitic diseases	6,823	4.4
Respiratory diseases	6,416	4.2
Musculoskeletal diseases	5,304	3.5
Sensory organ disorders	4,150	2.7
Respiratory infections	3,891	2.5
All other causes	14,631	9.5
Total DALYs	153,111	100.0

diseases is expected to remain relatively stable over the period to 2020, so the priorities for improving health in England will focus on these causes. The World Health Organization also identified the key risk factors for these diseases in developed countries. These are tobacco, high blood pressure, alcohol, high cholesterol and obesity.

A health service, not a sickness service

4.7 If England is to secure world-class standards of health, the enormous human, financial and physical resources available to the NHS need to be focused on the prevention of disease and not just its treatment. The NHS will be prioritising preventative public health measures. The current national public health consultation, alongside the recommendations of the second Wanless Report, give a strong steer on how this can be achieved. The Department of Health will publish a White Paper, Improving People's Health, later this year setting out in detail what needs to happen next. This will include proposals for further action in relation to current priorities, such as smoking and its links to cancer and heart disease, and mental health. It will also include recommendations in relation to challenges such as obesity and sexually-transmitted infections.

4.8 In developing these plans, the White Paper will spell out how the country can build on the good progress that has already been made. England is experiencing rapidly declining death rates from its two biggest killers – cancer and heart disease – and policies on screening, smoking and treatment have contributed to this progress. But as these big killers have continued to decline, stark inequalities in health have remained, and for some important diseases the health gap has widened. The challenge now is to extend the improvements in health to all groups in the population and to find ways of reducing inequalities at the same time as improving the health of the population as a whole.

4.9 The NHS has a part to play in this, but also important are the contributions of other public agencies, the voluntary sector and communities. For example, partnerships such as Healthy Living Centres and Sure Start (see box) can have a significant impact. The *Choosing Health?* public health consultation is exploring how this work can be taken forward, looking at how people can be supported to make healthier choices in a way that recognises their social circumstances and the obstacles that these may present to improving their own health. This will include a particular focus on children – tomorrow's adults –

Sure Start – action on diet and nutrition in disadvantaged areas

One of the aims of the Sure Start programme is to improve outcomes for children, parents and communities by helping service development in disadvantaged areas. Improving health and tackling health inequalities are key themes of the programme. Nutrition and diet are important issues.

- In Wear Valley in the north east, the St Helen Auckland Community School operates a breakfast club for children in its nursery classes through a joint Sure Start/Wear Valley PCT initiative. The club is open from eight o'clock and breakfast includes cereals, fruit juice, and fruit when possible. It is supported by volunteers and parents are encouraged to join in. Teachers have found the children more responsive in lessons and more motivated to get to school earlier.
- In east London, the Mapledene Early Years Centre in Hackney has built a flourishing partnership with a national supermarket chain promoting its healthy food range to ensure that children eat healthily. This is important because many of the children at the centre come from disadvantaged backgrounds and attend for breakfast, lunch and tea. The partnership also provides cookery skills workshops for parents, and an organic garden with a vegetable patch for children.

because of the importance of early influences on health later in life.

Health and inequalities

4.10 The two Wanless Reports have highlighted the need for the Government to engage fully with patients and the public in order to deliver better health outcomes for the poorest in our communities and ease pressures and costs for the NHS in the long run. This includes ensuring that all NHS organisations form active partnerships with local government and other local agencies to promote population health and reduce inequalities. As this happens, particular attention should be given to the needs of minority ethnic groups and the health gap between these groups and others should be narrowed.

4.11 The NHS will engage citizens and communities in health improvement and help them to play an increasing part in adopting healthy behaviours and promoting the "fully engaged" scenario outlined in the first Wanless Report. This will include new approaches such as the "collaborative" techniques which have been used to improve health services. In this model, NHS organisations sign up to try out new approaches, share learning about what works and seek to achieve specific measurable improvements in health by working together and supporting each other. One such approach has already reduced accidents among the elderly by 60% in three geographical areas. The White Paper will set out how these approaches might be applied to other areas and topics where preventable risks can be dramatically reduced.

4.12 Making a real impact means that the NHS will need to engage with local communities much more effectively, building on the good progress made and good practice developed in initiatives such as Sure Start, Healthy Living Centres and work to reduce teenage pregnancies. Models of outreach and community engagement will need to be built into mainstream services nationally, once evaluation has demonstrated their real value. And just as the health service will need to engage the communities it serves, it will also need to engage the efforts of wider players in civic society – local government, business, the voluntary sector and the various faiths.

4.13 The contribution of primary care to reducing health inequalities is particularly important. The new General Medical Services (GMS) contract and the forthcoming pharmacy contract will be important drivers, providing financial incentives to practices to improve the quality of care for people with long-term conditions and, over time, extending this approach to "at risk" groups to prevent avoidable deaths and illness.

4.14 In taking forward the public health agenda there is a need to strengthen the public health capacity and delivery system to ensure that the right people, skills and approaches are in place both in the NHS and in partner agencies to make sure improvement, health protection and health inequalities are actively pursued and performance managed. One element of this is to strengthen information and knowledge management systems so that knowledge of what works can be shared and public health problems can be detected at an early stage. Strengthening the evidence base for public health interventions, including evidence on cost-effectiveness, through a systematically commissioned programme of research, will be an early priority.

4.15 Public health priorities include developing and implementing plans for tackling infectious diseases including tuberculosis, Hepatitis C and new diseases such as SARS, as set out in the *Getting Ahead of the Curve* strategy. Our strategy to reduce MRSA and other healthcare-acquired infections is set out in the report *Winning Ways*. The Government will set out the next steps for tackling these infectious diseases later in the summer. A key objective here is improving knowledge of infectious diseases and reducing cases of transmission. There is also a need to make further progress on the development and implementation of immunisation programmes. The Health Protection Agency will lead this work.

Partnership working in practice

4.16 We will work to improve the way we support effective public health interventions in partnerships, both locally and with other government departments and agencies. The *Choosing Health?* public health consultation is exploring ways to strengthen Local Strategic Partnerships. These partnerships facilitate greater co-ordination in delivering health and social care services to local populations. Together with other countries we will also tackle global health problems through appropriate bilateral and multilateral actions. The following are examples of the ways in which we will achieve this objective.

4.17 The Department of Health will in time be more outward-looking and focused on the pursuit of health and healthcare objectives as well as supporting the wider governmental agenda. The Department of Health will play a more strategic role in engaging with the wider international agenda, the World Health Organization and the World Trade Organisation in partnership with other government departments. In so doing, the Department of Health will work to align strategies, priorities, objectives and targets more closely across other government departments, including shared objectives to maximise consistency and ensure effective delivery.

Rehabilitation and occupational health

Building on the work of NHS Plus, the NHS can play an increasingly vital role in ensuring that employees are able to return to work as soon as possible following illness or injury. The Department of Health will work with the Health and Safety Executive and the Department for Work and Pensions to ensure that a wider occupational health approach is supported by the NHS. The Department for Work and Pensions and the Department of Health are working together on the Pathways to Work rehabilitation scheme for those on incapacity benefits, in line with Recommendation 6 on NHS rehabilitation services from the Better Regulation Taskforce Report 2004, *Better Routes to Redress*.

Diet and activity

The Department of Health will work with the Departments for Environment, Food and Rural Affairs, Culture, Media and Sport and Education and Skills (DfES), and the Food Standards Agency, to address the issue of obesity. This will be done in conjunction with work on the Food and Health Action Plan and with the Activity Co-ordination Team. Transport policies and local transport schemes have an important impact on the levels of physical activity. The Department of Health will work with the Department for Transport to encourage healthy local transport schemes to encourage walking and cycling. DfES and the Department of Health are already working to promote physical activity and a healthy diet among children and young people through the National PE and School Sports Strategy, Sure Start, the National Healthy Schools Programme, the Healthy Schools: Healthy Living Action Plan, and the Food in Schools Programme.

Public health in 2000	Public health in 2008
Many aspects of health in England lag behind comparable industrialised countries.	Health in England has improved and the gap with other countries has narrowed.
People expect the NHS to treat them when ill and view health as the responsibility of doctors.	People see the NHS as helping them to live healthy lives and view health as a shared responsibility.
At national level, public health is seen as the responsibility of the Department of Health.	There is an interdepartmental agenda on public health and health inequalities with clear roles and responsibilities identified.
Local approches to public health are not joined up.	Collaboration at local level on public health with local government, PCTs and the community.
Focus of public health policy is on health education and health promotion.	Co-ordinated set of policy levers, community development and individual behavioural change.
Obesity rates are rising but with limited awareness of its implications.	Growth rates of obesity among children and young people have flattened out as a result of co-ordinated action by all stakeholders.
Smoking rates reach a plateau.	Smoking rates are falling in response to concerted action.
Rates of MRSA increasing with incomplete reporting of cases and a limited awareness of implications.	MRSA rates declining with extended surveillance of infections and awareness across the NHS that infection control is everybody's business not just specialists.
GPs have incentives to focus on cervical screening, immunisation targets and new patient health checks.	GPs and other primary care providers have incentives to manage actively the health of their registered population.
GPs send letters to recall enrolled population for screening interventions in order to meet target payments.	Electronic reminders are sent to individuals to alert them to the need for screening and provide information about screening procedures and the meaning of different results.
There is a weak evidence base for informing public health policy or resource allocation decisions of purchasers, and there are low levels of investment in prevention.	PCT commissioning includes prevention, and is informed by a sound evidence base of both the effectiveness and cost-effectiveness of public health interventions and best practice guidelines.

Section 3
Making it happen

Chapter 5
Investment, new capacity and diversity of provision

NHS Foundation Trusts, treatment centres and independent sector providers of NHS services will enable patients to have a greater degree of choice:

- By 2008 all hospital trusts will be in a position to apply for NHS Foundation Trust status
- A wider range of primary care services will facilitate greater access and convenience for all
- NHS capacity will continue to grow. Independent sector providers will also increase their contribution and may provide up to 15% of operations and an increasing number of diagnostic procedures to NHS patients by 2008
- The Healthcare Commission will inspect all providers of care and provide assurance of quality of care wherever it is delivered.

5.1 Increased capacity will be introduced in order to reduce waiting times for elective care and facilitate choice across the system. New and existing providers will become increasingly dynamic, and more open to the demands placed on them by ever more informed and empowered users. The contribution of the independent sector will expand, particularly in relation to planned hospital care and diagnostic services, in the next wave of independent sector procurement. Growth (or otherwise) of alternative providers will be a function of the choices patients make. The new financial incentives being introduced into the NHS (see Chapter 8) will enable resources to flow to those providers offering care that is responsive to patient needs and of a high standard.

New capacity

5.2 We will continue to renew and expand NHS capacity through direct investment and in partnership with the private sector. By 2008 a further 54 new hospital schemes are due to be opened. This will mean that we are on course to exceed *The NHS Plan* goal of 100 new hospitals by 2010. It will also mean that the associated goal of ensuring that 40% of the NHS estate is less than 15 years old by 2010 will have been achieved. We will continue to invest in and promote the Private Finance Initiative to further upgrade physical capacity thereafter.

5.3 Our investment in primary care, through the use of Local Infrastructure Finance Trust projects (the programme to develop public/private partnerships in primary care and community services known as LIFT) and other sources will also accelerate. There are currently 42 NHS LIFT projects and work has begun on 12 of the new LIFT premises. By 2008 we will have delivered at least 54 LIFT projects able to provide new primary care facilities for some 50% of the population, and work will have begun on hundreds of new primary care facilities. Most of these projects will be in the most deprived areas of our communities, thus helping further to reduce health inequalities.

New providers

5.4 By 2008 all NHS acute trusts in England will be in a position to apply to become NHS Foundation Trusts, working as independent public benefit corporations, modelled on co-operative and mutual traditions. NHS Foundation Trusts will be controlled and run locally, with freedoms to retain any operating surpluses and to access a wider range of options for capital funding to invest in delivery of new services. They will be able to use their new capital and management freedoms to respond much more quickly to the needs of patients. They symbolise the Government's commitment to community-based public services whilst remaining firmly within the NHS. We are already seeing the benefits. Examples include:

- Countess of Chester – developing a new emergency centre, which will house the traditional A&E service, medical and surgical assessment facilities, and some diagnostic support services.
- Homerton – accelerated building of a new perinatal centre up to two years ahead of schedule (antenatal, delivery suite, neonatal intensive and special care unit).
- Moorfields – increase of at least £6 million in its capital spend, including a £2 million extension to a community outreach centre and £1 million on new and replacement equipment for clinics and theatres.
- Peterborough – £2 million of extra capital spend on essential equipment upgrades and replacements, as well as installation of automatic doors in patient areas and improvement of ward flooring
- Stockport – investing in new operating theatres and a new cardiology and surgical unit.

5.5 By the end of 2005, the Department of Health expects that there will be a total of 46 NHS-run treatment centres, with 34 run by the independent sector. Treatment centres provide safe, fast, pre-booked surgery and diagnostic tests by separating scheduled treatment from emergencies. They will increasingly provide a wide range of surgical procedures and diagnostic tests whilst concentrating on those services where there are bottlenecks. They will make an essential contribution towards improving access to services and meeting the new 18 weeks access target set out in Chapter 2. We anticipate that, by 2008, the independent sector will carry out up to 15% of procedures per annum for NHS patients, paid for by the NHS.

5.6 Our most recent procurement for additional capacity has been at a significant discount to prices previously negotiated between the NHS and the independent sector. We are clearly beginning to see a fundamental shift in the pricing structure of private providers as we use the corporate buying power of the NHS more effectively. The Independent Sector Treatment Centre (IS-TC) programme will bring additional benefits as they spread new ways of working, spur NHS providers to increase their responsiveness to patients and, as a result of increased contestability, drive down the level of inefficient spot purchasing.

Diversifying and expanding services

Primary care and long-term conditions

5.7 The expansion of provision will also affect the primary and community sectors. Patient choice in primary care has been increased through the development of new services like NHS Walk-in Centres and NHS Direct. There has also been an increase in the number of staff working in primary care. The development of new staff roles such as GPs with a special interest has enabled more care to be provided closer to home, and there has also been an expansion in the role of community pharmacists. In the case of long-term conditions, the introduction of case management through community matrons has started the process of targeting people at greatest risk, and in Chapter 3 we set out our plans for implementing case management throughout the NHS.

5.8 In the next four years, we will extend these initiatives and will focus on the provision of an increasing number of specialist services by community and primary care providers in local settings and an increased choice of providers from all sectors. New forms of service delivery will be supported by both the added commissioning freedoms available to PCTs and the introduction of new contractual arrangements such as Alternative Provider Medical Services (APMS), Personal Medical Services (PMS) and Primary Care Trust Medical Services (PCTMS). The flexibilities available to PCTs will enable the NHS to build on the traditional strengths of primary care, particularly in areas where there may be difficulties in recruiting GPs or where new forms of provision may be needed, for example for commuters. This will include PCTs directly providing care, and contracting with the independent sector where this is the best option. Early initiatives in these areas include the licensing of 1,300 GPs with special interests. We will also develop six instant access GP-led primary care centres, aimed at commuters based in London, Manchester, Leeds and Newcastle. These centres will open during 2005 and will offer a full range of primary care services, plus minor injuries services. Further centres will open in 2006.

5.9 Where possible, the focus will be not only on alternative providers of similar services but also on choices of integrated packages and pathways of care. For example, GP practices may decide to collaborate to offer a wider range of services to the patients they serve, and PCTs may engage in alliances with the providers of acute services to offer integrated provision, for example for people with diabetes. PCTs and GP practices may also choose to commission care from independent sector providers where this offers better value for money. As a result, patients will increasingly be able to select not only the type and location of provider, but also from new models of care.

5.10 To ensure that PCTs are successful in their role as commissioners and in their use and application of existing and alternative providers, the Department of Health is working with a number of agencies to promote a range of initiatives supporting PCT development. This includes managed care organisations from the United States, pharmaceutical companies with expertise in disease management, and independent sector providers in the UK. The Department of Health is also exploring what more needs to be done to expand patient choice in primary care. From the end of the year we will also have made it easier for new pharmacies to locate in areas such as one-stop primary care centres. The Department of Health will facilitate the establishment of pharmacies intending to open more than 100 hours a week or to operate wholly via mail order or the internet.

Diagnostics

5.11 Building on the success of the recent procurements of ground-breaking mobile cataract and MRI scanning services, new market entrants will play an important role not only in providing additional new capacity, but also by acting as catalysts for innovation. The emphasis will be on flexibility and responsiveness to patients' needs, with more resources being invested in forms of service delivery that can respond quickly and effectively to shifting burdens of disease.

5.12 Our aim is to transform diagnostic services by expanding capacity and making the best use of the resources we already have. Increasingly, the NHS will provide diagnostic services closer to the patient's home or work. Efficient diagnostics will enable faster and more appropriate access to acute care where this is needed and should also enable a wider range of care options to be considered without necessarily falling back on the acute sector. Investment in and procurement of improved diagnostic services from both public and private providers will be an increasingly important feature of the new system. Patients will be offered greater choice in where, when and how they access diagnostic services. Where appropriate, GPs will also be able to refer patients direct to a diagnostic facility,

cutting out patient waits associated with going to diagnostic services via a consultant.

5.13 As a result of new technology, x-rays and other images will be securely transmitted within and between hospitals, primary care and other health settings at the touch of a button. This will reduce the need for repeat tests, speed up patient treatment and reduce the pressure on medical and other clinical staff.

5.14 As a first step, 80,000 extra MRI scans a year are being commissioned through a mobile service run by the independent sector. This represents a 10% addition to NHS capacity and this will be followed by a market-testing exercise to assess the capacity of new providers for other diagnostic services, as well as imaging. Reflecting the urgency of developing diagnostic capacity and encouraging innovative solutions, the next wave of independent sector procurement is likely to include diagnostic services. The Department of Health will also be looking to expand diagnostic provision in primary care and "high street" settings, and via the letting of one or more major contracts to new providers to process electronic and routine diagnostic test results remotely.

Emergency/unscheduled care

5.15 Emergency/unscheduled care will be expanded and increasingly provided in a wider range of settings to provide efficient, convenient and effective services for patients. This will include the development of minor injury units, NHS Walk-in Centres, ambulance services, out-of-hours primary care services, NHS Direct/Online and pharmacists. We will promote further integration between primary and secondary care.

New approaches, capacity and diversity in social care

5.16 Social care services have been and will continue to be provided by a wide range of organisations, from small community and voluntary organisations, private providers, private and public companies to direct local authority providers. This diversity allows services to be closely matched with people's needs, and offers a very high degree of contestability. To exploit the potential of integrated care, social care providers will be encouraged to integrate with healthcare providers, e.g. integrated mental health provider trusts.

5.17 The Department of Health will continue to support councils and others to invest in new capacity and diversity in social care. Councils are responding to the preferences of people that use social care services in expanding social care capacity where it is wanted. The provision of care in people's own homes continues to grow rapidly, particularly very intensive home care services. Respite care has a critical role. The Department is also promoting an increase in the provision of newer forms of care such as extra care housing, which provides purposefully designed and safe housing for people combined with an *in situ* care team. This model can cater for a wide range of needs, perhaps even those of the most dependent people and will provide a realistic and attractive option for many.

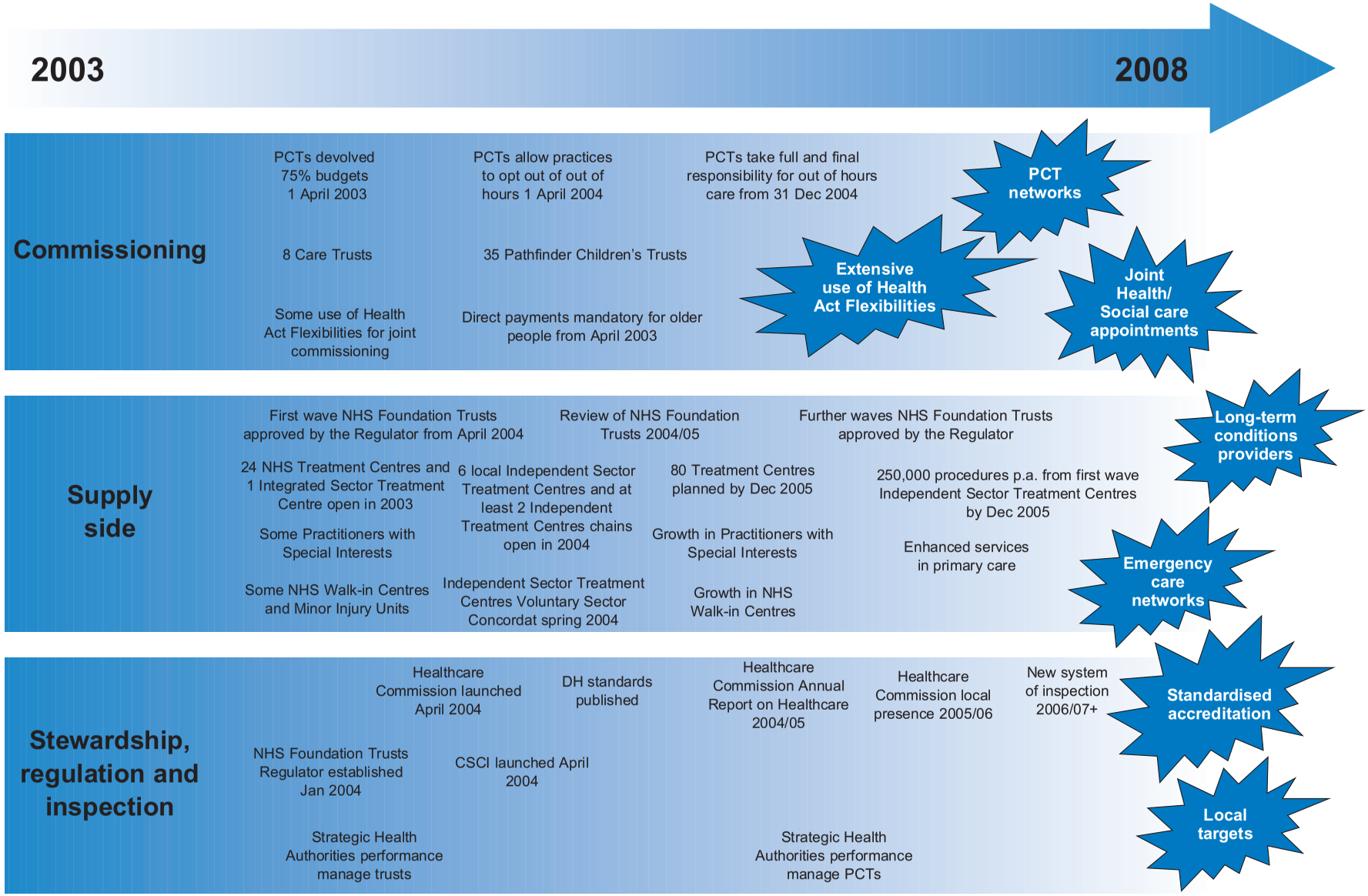
5.18 The Department is also committed to helping people maintain their independence for example using aids and adaptations to their own homes. To this end, councils are making additional aids and adaptations up to a value of £1,000 available without charge. Assistive technology offers great potential to maintain the independence of older or disabled people, with encouraging early evidence about its cost-effectiveness.

5.19 The Department is promoting a significant expansion in the use of direct payments, which will empower more people to arrange care and support that is tailored to their individual needs. The Department has now made direct payments the first choice for most people eligible for assistance from social services. Councils are obliged to offer all those eligible a direct payment before an offer of council arranged services. This is becoming more commonplace.

The Healthcare Commission and the Commission for Social Care Inspection

5.20 As the provision of health services diversifies and localises, it will be increasingly important to ensure that service quality continues to be enhanced. The Department of Health will publish new healthcare standards later this year, following the recent consultation period. The Healthcare Commission will have responsibility for developing the criteria to assess quality which it will use to review the performance of all healthcare providers. It will also take up responsibility for the annual assessment of NHS Trusts via performance ratings.

5.21 People who use social care services can also expect good-quality and consistent care services. The Commission for Social Care Inspection (CSCI) is responsible for promoting continuous improvement and high performance in social care organisations. It supports integrated working focused on user needs, ensuring that service providers deliver services of an appropriate standard whether in the statutory or the independent sector. This includes the registration and regular inspection of the full range of providers from care homes and domiciliary care providers through to fostering agencies. The national minimum standards used by CSCI were drawn up by the Government in consultation with the social care industry and people using health and social care services to promote best practice and identify areas for improvement. It is the first time that there have been national minimum standards for social care in England.


2003
2008
Commissioning
PCTs devolved 75% budgets 1 April 2003
PCTs allow practices to opt out of out of hours 1 April 2004
PCTs take full and final responsibility for out of hours care from 31 Dec 2004
8 Care Trusts
35 Pathfinder Children's Trusts
Some use of Health Act Flexibilities for joint commissioning
Direct payments mandatory for older people from April 2003
PCT networks
Extensive use of Health Act Flexibilities
Joint Health/ Social care appointments
Supply side
First wave NHS Foundation Trusts approved by the Regulator from April 2004
Review of NHS Foundation Trusts 2004/05
Further waves NHS Foundation Trusts approved by the Regulator
24 NHS Treatment Centres and 1 Integrated Sector Treatment Centre open in 2003
6 local Independent Sector Treatment Centres and at least 2 Independent Treatment Centres chains open in 2004
80 Treatment Centres planned by Dec 2005
250,000 procedures p.a. from first wave Independent Sector Treatment Centres by Dec 2005
Some Practitioners with Special Interests
Growth in Practitioners with Special Interests
Enhanced services in primary care
Some NHS Walk-in Centres and Minor Injury Units
Independent Sector Treatment Centres Voluntary Sector Concordat spring 2004
Growth in NHS Walk-in Centres
Long-term conditions providers
Emergency care networks
Stewardship, regulation and inspection
Healthcare Commission launched April 2004
DH standards published
Healthcare Commission Annual Report on Healthcare 2004/05
Healthcare Commission local presence 2005/06
New system of inspection 2006/07+
NHS Foundation Trusts Regulator established Jan 2004
CSCI launched April 2004
Strategic Health Authorities performance manage trusts
Strategic Health Authorities performance manage PCTs
Standardised accreditation
Local targets


2003
2008
Incentives
15 Healthcare Resource Groups in 2003/04
Delayed transfers fully implemented Jan 2004
48 Healthcare Resource Groups in 2004/05
Standard tariff applies to 60% hospital activity in 2005/06
Choice of hospital at referral Dec 2005
Practice level incentives
Resources
Spending Review 2004 agreed with HM Treasury
PFI/LIFT capital projects
Allocations to PCTs
All PCTs have Strategic Service Development Plans
Strategic asset planning
Workforce
Consultant contract transition 04
Fee for service pilots 2004
PMS+
nGMS 1 Apr 2004
Agenda for Change roll-out begins
Fee for service expanded 2005
IT
Contracts for e-booking awarded by Dec 2003
Roll-out of NHS Care Records Service 2004/05
100% e-booking by Dec 2005
50% e-prescriptions by Dec 2005
Roll-out of patient care records July 2005 onwards
Integration of electronic patient record and HealthSpace
Governance
Overview and Scrutiny Committees 1 Jan 2003
New Public Service Agreements agreed 2004
Independent Complaints Advisory Service established by Sept 2004
Priorities and Planning Framework published July 2004
Moving towards locally-agreed targets during 2006
Local ownership
Performance, improvement and development
NHSU established
Mondernisation Agency leading modernisations
Integrated Care Network
NHSU full university status
Modernisation Agency work devolved to local health systems
External improvement

Chapter 6
More staff working differently

More staff and more flexible working will contribute to better quality and more choice

- There will be continuing increases in frontline NHS staff where these are required to meet patients' needs
- Staff will be supported in working differently, making the best use of skills. For example, GPs and other practitioners with special interests will be enabled to deliver care more flexibly
- Staff will be supported to fulfil their potential with the NHSU and Skills Escalator helping staff develop throughout their careers
- Extra pay for staff and pay linked to performance will create stronger incentives to deliver personalised care.

6.1 Delivering world-class services with improvements in quality and responsiveness will require extra capacity. This capacity will be delivered by an expansion in the numbers of staff working in and with the NHS and social care system and by using those staff more effectively.

6.2 Over the past five years, growth in the total NHS workforce has increased by an average of 3.6% every year. The total workforce in the NHS is now at its highest level yet. Current trends will continue over the next four years in order to further increase the size of the workforce, focusing on growth in clinical staff. We will do this through a range of measures including:

- increasing the supply of healthcare workers
- working to retain existing staff
- more flexible retirement and extending the productive life of staff
- planned and ethical international recruitment to supplement key skills – including nurses, doctors, dentists, pharmacists, radiographers, healthcare assistants, allied health professionals and other staff groups
- developing and working with other providers, including new public/private partnerships, independent sector treatment centres, volunteers, the charitable sector and expert patients
- making the NHS a model employer.

6.3 More staff alone will not deliver high-quality and responsive services. We will take steps to ensure that staff work where they are needed. Temporary staff will be better supported and more effectively deployed and sickness and turnover rates will reduce. The NHS will continue to develop and implement policies – such as *Improving Working Lives* – to make it a "model employer". However, staff will need to work differently too.

Improving roles in a more flexible workforce

6.4 In the NHS, rigid demarcations between staff can mean that patients seeing a number of different health professionals often have to repeat the same details at each stage. These unnecessary barriers between professionals lead to frustration for patients, waiting, the inappropriate use of staff and a failure to fulfil the potential of clinicians and support staff.

6.5 There is a significant appetite for developing new roles in the service. Attitudes to workforce flexibility have also changed, with the Royal Colleges and other professional bodies now actively leading these changes. Updated regulatory frameworks allow greater flexibility while ensuring quality and patient safety. For example:

- We now have around 1,300 GPs with a special interest providing 700,000 procedures in the community previously done only in hospital. The accreditation frameworks for these GPs have been developed with the Royal College of GPs. An independent evaluation of GPs with a special interest in ear, nose and throats (ENT) showed that a GP could see 30 to 40% of ENT patients referred to secondary care. GPs with a special interest in ENT lead to significantly shorter waits and high levels of patient satisfaction

- Nurses make up the biggest single group in the NHS and have been at the forefront of developments. The number of nurses and midwives in advanced roles will increase and the NHS will build on the current number of nurse and midwife consultants, going beyond the target for 2004 of 1,000. The NHS will continue to increase the number of nurses who are able to prescribe and the range of medicines they can prescribe. In addition to their extended clinical roles, nurses will be given a lead role in improving the experience of patients in both the hospital and the community. This will build on the success of the modern matron.

6.6 The Changing Workforce programme has sponsored national trials, followed by accelerated development programmes, that have spread many new roles. The following are some examples:

- Over 50% of NHS Trusts have redesigned roles in radiology and radiotherapy services to reduce waiting. Advanced Radiographer Practitioners can now interpret the results of diagnostic tests, with Assistant Practitioners being trained to undertake diagnostic procedures

- One hundred and sixty new roles for medical secretaries have freed up doctors' time for patient care and created a clear skills escalator-based career structure. If most consultants in the country were able to free up two hours a week by the more effective use of administrative staff, they would create at least 1,000 additional whole-time equivalents worth of consultant activity

- Over 300 emergency care practitioners are being trained, working across 118 NHS Trusts in out-of-hours, minor injuries, A&E departments, NHS Walk-in Centres and ambulance services. These posts combine the skills of nurses and paramedics to create a more flexible workforce, with more motivated staff

- Practitioner trials in surgery, anaesthesia, critical care, renal services, medical assessment units and primary care already show great promise for staff taking on work previously covered by doctors

- The hospital-at-night scheme both improves the use of medical skills, creates opportunities for other staff to take on a wider range of healthcare responsibilities and helps the NHS comply with the European Working Time Directive.

6.7 By 2008, the workforce will be much more flexible and adaptable. Educational incentives and regulatory systems will support this. In line with the NHS career scheme, staff will be able

to transfer skills gained in one job to other jobs or in one healthcare organisation to another. Rapid Roll Out programmes will ensure all teams are trained to use new roles, especially Assistant and Advanced Practitioners for clinical services. Changing skill-mix and improving the way the NHS uses the skills of all its staff will deliver care more efficiently and increase capacity. New IT systems will also contribute, in particular through the new personal care records and electronic booking, which will streamline and simplify working processes resulting in staff saving time that can be used for patient care.

Learning, education and training

6.8 Modernising education, training and opportunities for learning are essential. In the future, education, training and learning will be more flexible and based on transferable, competency-based modules. The Department has already funded joint programmes in common learning and inter-professional education between higher education institutions and the NHS. These programmes will achieve national coverage as we ensure that people learn together so they may better work together in the NHS. Such developments are backed nationally by arrangements for joint working between the Department of Health and the Department for Education and Skills through the Strategic Learning and Research Advisory Group for Health and Social Care. Health and Education Strategic Partnerships between strategic health authorities and local learning and research institutions will mirror this partnership. Health and Education Strategic Partnerships will ensure that we deliver the learning needs of staff at a local level in a co-ordinated and tailored fashion.

6.9 There will be a new focus on experience-based learning. Already, accreditation frameworks for practitioners with a special interest, such as nurses, GPs and allied health professionals, are based on competencies and vocational based training. In addition, doctors outside formal training will have their skill levels formally recognised and accredited and will be able to progress their careers towards consultant or GP status if they wish.

6.10 The skills escalator will help the NHS attract people who previously could not access health careers. It brings together different programmes – Lifelong Learning, Recruitment and Retention, Pay Modernisation and the Changing Workforce programme – to deliver the objective of a growing and changing NHS workforce. It will attract a wider range of people to work within the NHS by offering a variety of career and training options.

6.11 Traditional entry points such as pre-registration programmes for the established professions will continue, but they will be complemented by other entry routes such as cadet schemes and role conversion, attracting people in other careers who are seeking new challenges and drawing people back into the labour market. This offers the dual benefit of expanding the NHS workforce whilst also tackling problems of longer-term unemployment and social exclusion, which have such a high correlation with poor health. The Department of Health will work closely with the Department for Work and Pensions and Job Centre Plus in this area.

6.12 Employers will benefit because a structured programme of skills development will help them to recruit and retain staff to fill posts which are traditionally hard to fill. Individuals will benefit in a range of ways: those who are finding it difficult to get into permanent employment, or who have limited formal education, and older people looking for second careers will have access to new employment opportunities. Those already within the NHS will benefit from the opportunity to develop and enhance their skills and take on new and more challenging roles. Communities will benefit from an active approach to employing and developing staff by major local employers. This approach will extend to migrant workers and refugees, ensuring the NHS makes the best use of their skills and helps their integration into local communities.

6.13 Access to education and training materials will change with an increasing focus on electronic access. E-based learning

programmes will develop. For example, under the *Radiology Integrated Training Initiative* the 400 modules that make up the radiology curriculum will be available electronically. Other staff, such as radiographers, nurses and anaesthetists will be able to access these modules to develop competencies in areas that affect their roles, thus providing transferable, competency-based team skills. By 2008 such developments will be much more widespread, with the NHSU leading their development.

6.14 Major changes to postgraduate medical training will arise as a result of the *Modernising Medical Careers Initiative*, launched in April 2004. This will take a radical look at the way we train doctors, the speed and quality with which we do it and the end product of that process. We will take opportunities for streamlining medical training and increasing flexibility in medical careers for the benefit of both doctors and patients. From August 2005, new graduates in medicine will undertake a comprehensive two-year foundation course, which will equip them with all the basic skills needed for clinical practice. In addition, by 2009, all stages of training will be delivered through structured programmes to maximise the available time. Programmes will be robustly managed. Consultants will take less time to train because training time will be fully utilised. There will be no diminution in the quality of training and patient care.

New contracts

6.15 We are embarking on a period of significant change with new contracts for GPs, consultants and staff included in the Agenda for Change programme. New contracts for dentists, opticians and pharmacists are on the way. These contracts cover over 1 million staff and will provide a secure platform for developing, recruiting and retaining the workforce we need. They are backed by significant new investment in pay to 2007/08. The new GP and consultant contracts and Agenda for Change will reward those healthcare professionals who are committed

NHSU

NHSU will contribute to radical change and improvement in health and social care through the transformation of learning.

NHSU will make a key contribution to the fulfilment of *The NHS Plan*. In the short term, it will develop learning programmes to meet the immediate and urgent needs of the NHS in consultation with the Department of Health, the NHS and other key stakeholders. Increasingly, it will design learning services and programmes to support team working and enable all staff to work more effectively across traditional occupational, professional and organisational boundaries.

As a dedicated "corporate university", NHSU will make a critical contribution to health and social care through:

- the **Learning Needs Observatory** which will work to identify the changing skills needs of the NHS and social services agencies, and ensure that NHSU provides programmes which address those needs directly
- a service-wide **learning platform** delivering online learning, providing individuals with information, advice and guidance on learning needs and opportunities, and establishing communities of practice focusing on specific priorities and areas of development
- working at community level, developing networks of **Local Learning Resource Centres** – located within strategic health authority areas – so that learning is available locally
- **research expertise** focusing on the contribution of learning to effective practice and the extent to which it results in real, tangible improvements for patients and service users.

to the NHS and provide services that are tailored to the needs of the local population.

6.16 The **new primary care contracts**:

- will deliver 33% increase in investment over the next three years in primary care, building extra capacity in primary care
- are based around the GP practice, driving new employment models and skill-mix
- are based on quality indicators with providers rewarded for outcomes not inputs. This will drive skill-mix as GP practices tailor services with the investment they have to meet local need
- include opportunities for new entrants into the market place through new routes such as Alternative Provider Medical Services, designed to bring private and voluntary sector providers into the field
- include guaranteed investment in enhanced services, designed to deliver specialist care in primary care settings and helping to develop new types of practitioner
- support the development of higher quality care for people with long-term conditions
- provide new opportunities for flexible working.

6.17 The **new contract for consultants**:

- offers greater rewards to those who give more to NHS patients
- helps to increase efficient use of time and clinical provision
- includes objectives linked to service priorities
- allows flexible working and has incentives for those working evenings and weekends, leading to improvements in access
- provides sustained incentives for high-quality performance over the course of a career
- contributes to improvements in recruitment and retention
- offers stronger assurance that private practice will not disrupt provision of care to NHS patients.

6.18 The Agenda for Change programme includes:

- a job evaluation-based process that harmonises reward mechanisms and improved structures for learning common learning, knowledge and skills framework, continuing professional development
- a common pay spine, rather than separate pay arrangements for different staff groups
- rewards for increased knowledge and skills rather than time served
- real incentives for staff and managers to change existing patterns of working and embrace new ones.

6.19 The contracts are just part of making the NHS a better place to work, which in turn will enable staff to give better patient care. There will be more flexible employment schemes, allowing staff to have part-time roles and career breaks whilst still keeping abreast of clinical practice. Ensuring staff have a better work-life balance and better working conditions means that more staff will either stay or return after a spell away.

6.20 In addition, some of the principal elements of reform in the NHS have the potential to raise workforce productivity in new ways. In particular:

- Payment by results and choice for patients will provide trusts and staff with far greater incentives to improve performance and reap the gains that changes in skill-mix, for example, can deliver. Similarly, the new GMS contract will provide incentives to review and change skill-mix in primary care to the benefit of staff and patients

- As cost effective, low-wait NHS Trusts expand as a result of the implementation of payment by results and choice, activity will flow to those trusts that get the best from their staff, which will deliver a significant improvement in efficiency.

Modernising services

6.21 A world-class workforce also needs world-class management. There is now a wealth of research that makes the link between progressive people management and improved productivity and patient outcomes. The NHS is now in a position to capitalise on the progress made to build world-class managers with the knowledge, skills and support from human resource services to apply the good practice from that research. In particular, we will improve team working, appraisal and diversity and create a working environment that supports the acquisition of new skills and a culture responsive to change.

6.22 By 2008 there will be an improved capability to drive forward and sustain new ways of working. This will be delivered through the cumulative impact of the NHS Modernisation Agency-led work to build capability and the appetite for change, the delivery of new contracts such as Agenda for Change to incentivise staff to embrace change, the business imperatives that drive change and sustained leadership, and support at both local and national levels.

Chapter 7
Getting information to work for the patient

Better use of information and information technology will drive improvements in patient care:

- The patient care record will enable healthcare professionals to have 24-hour access to information about patients; this will improve diagnosis and treatment and reduce errors, with the first phase going live in 2004
- By 2005 the electronic booking service and e-prescribing will make it easier for patients to arrange appointments and to order repeat prescriptions
- NHS Direct, NHS Direct Online and NHS Digital TV will help people to take more responsibility for their own health and to communicate with healthcare professionals
- Patients will have a bigger say in how they are treated and will be able to enter information about their preferences on *HealthSpace*.

Information and the NHS

7.1 Accurate information is crucial if patients are to have choice and receive the right care at the right time. A key aim of the National Programme for Information Technology in the NHS is to give healthcare professionals access to patient information safely, securely and easily whenever and wherever it is needed.

7.2 The National Programme for IT is an essential element in delivering *The NHS Plan*. It will create a multi-billion pound infrastructure, which will improve patient care by enabling clinicians and other NHS staff to increase their efficiency and effectiveness. It will do this by:

- creating an NHS personal care record service to improve the sharing of patients' records across the NHS with their consent
- making it easier and faster for GPs and other primary care staff to book hospital appointments for patients
- providing a system for electronic transmission of prescriptions
- ensuring that the IT infrastructure can meet NHS needs now and in the future.

7.3 Better IT is needed in the NHS because the demand for high-quality healthcare continues to rise and the care now provided is much more complex, both technically and organisationally. There are over 300 million consultations in primary care annually. Last year, there were 650 million prescriptions dispensed in the community; nearly 5.5 million people were admitted to hospital for planned treatment; there were 13.3 million outpatient consultations; and nearly 13.9 million people attended A&E, of whom 4.3 million were emergency admissions.

7.4 In parallel, diagnosis and treatment are increasingly specialised. Managing many conditions can require a number of organisations and people to work together predictably, reliably and safely. Also, patients' knowledge and understanding has increased and many want more ownership of and involvement in the management of their care.

7.5 Traditional paper-based recording and storage systems have long since ceased to support the health service in an efficient and effective manner. As a result, many general practice surgeries and hospitals now have some form of personal care record that can be shared internally. But this information cannot currently be shared across the NHS.

7.6 The National Programme for IT will address this, creating an NHS electronic highway. The NHS will in this way take a major step towards providing seamless care for patients through GPs, hospitals and community health services. It will also provide fast, convenient public access to information and care through online information services and telemedicine, and ensure effective use of NHS resources by facilitating the secondary use of information, for example, for medical audit purposes.

7.7 For all this to happen, major co-ordinated investment and change must take place. Most existing IT systems in NHS trusts are based on either buildings or departments. They do not usually support the movement of information between buildings and departments. Consequently, within a single organisation, several records are often created for the same patient.

7.8 Similarly, in primary care, individual practices have their own IT applications and databases, so that personal care records are not easily transferred to other practices or care providers. As a result, the development and effective implementation of care pathways is inhibited. Many are still paper-based, delaying modernisation and the delivery of National Service Frameworks.

7.9 By creating world-class IT infrastructure and systems for the NHS, the National Programme for IT will ensure that organisations and staff can work together more effectively. This strategy has long been recognised as essential by many within the NHS, but achieving robust information systems, including personal care records, has proved difficult to achieve. However, there are now the resources and determination to achieve this goal.

7.10 Information technology is now being designed and delivered around the needs of patients and service users. A shift has begun from systems running along institutional lines, dealing only with a portion of patient interactions, to integrated health and social care community systems that track and record a user or a patient's progress in the NHS. The main healthcare elements of the National Programme for IT are now described in more detail.

The NHS Care Records Service

7.11 The NHS Care Records Service is being developed to provide a live, interactive personal care records service accessible 24 hours a day, seven days a week by health professionals, whether they work in hospitals, primary care or community health services. It will enable clinicians to access personal care records securely, when and where they are needed, via a nationally maintained information repository. When fully implemented, the NHS Care Records Service will function across care settings and organisations and will support planned, emergency and unscheduled care.

7.12 Patients will benefit because the NHS Care Records Service will improve the quality and convenience of care by ensuring that the right information is available to the right people at the right time. It will also improve choice for patients and, in due course, will allow them easy, secure access to their NHS personal care record. Clinicians will benefit from being able to access patient information wherever it is needed. This will improve diagnosis and treatment, and facilitate the provision of safer and higher-quality care. Clinicians will also be

able to identify patients missing out on optimal care, and they will be able to support clinical audit through the use of information drawn from the NHS Care Records Service.

7.13 The first phase of the NHS Care Records project is expected to go live in summer 2004. It will provide clinicians with basic functionality, including the ability to view and communicate an initial set of patient information and to book outpatient appointments. The second phase, due to be introduced in June 2005, will give access to more detailed personal care records and allow electronic referrals, requests and orders.

The electronic booking service

7.14 "Choose and Book" is the name of the new national IT system that will connect all GPs and primary care services to all hospitals and other secondary care providers. It will allow patients and staff to book initial hospital appointments at a time and place convenient to the patient. Patients will be able to leave the surgery with their appointment time and date. If they prefer, they will be able to make their appointment later after consulting with family or work colleagues, either online or via a telephone booking management service.

7.15 The first patient booking using this system is scheduled for summer 2004 and roll-out will be completed by the end of 2005, when all hospital appointments will be booked in this way.

E-prescribing

7.16 The e-prescribing programme will enable prescribers to create and transfer prescriptions electronically to a patient's community pharmacist and the Prescription Pricing Authority. As well as being more convenient for patients, this should improve safety by reducing prescription errors and providing better information at the point of prescribing. It will also ensure that prescription information forms part of each person's NHS personal care record. In addition, e-prescribing will save staff time and costs by requiring information to be entered only once, instead of on three occasions as at present. With over 600 million prescription items issued annually, the benefits will be considerable.

7.17 Following a number of pilot projects, the scope and objectives of e-prescribing have been agreed with the overall aim of implementing a national service by 2005 for 50% of transactions, with full implementation by 2007.

HealthSpace

7.18 The National Programme for IT will help to empower patients through the development of *HealthSpace*. This was launched in 2003 and enables patients to access their personal care records held in a secure place on the internet. Users are able to add personal information to their *HealthSpace*, such as their blood group, weight, allergies and medication. In addition, users can register to receive e-mail reminders to attend appointments.

7.19 Using *HealthSpace* people are able to add addresses and telephone numbers, dates and times of appointments, and favourite health related weblinks. *HealthSpace* ensures that whenever a clinical team consults the personal care record, they are reminded of these important points about the patient, without the patient having to repeat them.

7.20 As well as *HealthSpace*, patients are able to access information from NHS Direct, NHS Direct Online and from 2004 NHS Digital Television. This will be the biggest dedicated public service on digital television and will offer an innovative way of providing health information to the public. The service will include information on health conditions, treatments and healthy living, health advice for travellers, health and safety information, and information on local NHS services. Using digital television, it will be possible to reach groups in the population who are currently underserved by other information channels such as the internet.

Telecare

7.21 Telecare involves the use of IT to support the delivery of care to people in their own homes or in the wider community. Evidence indicates that telecare can bring substantial benefits in providing people with greater choice over their care, assisting people to remain in their own homes, reducing inappropriate admissions, facilitating discharge from hospital, and providing advance warning of deterioration in a patient's condition. People with long-term conditions are particularly likely to benefit from telecare, for example by being able to monitor their conditions and relay information by phone to surgeries and hospitals. A range of technologies are used in telecare, and many of these are being piloted in different parts of the NHS. The Department of Health will monitor the development of telecare and will ensure that the benefits are realised in the NHS when cost-effective approaches have been identified.

Chapter 8
Aligning incentives with patients and professionals

Incentives will be aligned with patients and professionals:

- The performance management regime for commissioners will support more effective purchasing of care
- Primary care trusts will be supported to develop incentives to enable GPs to deliver care that is more responsive and of a higher standard
- The new system of payment by results will provide strong incentives to increase efficiency and improve access, and it will be implemented in full by 2008
- Patients will work increasingly in partnership with professionals with the support of decision aids and information to help them make the right choices.

8.1 The new NHS will be incentivised to deliver for patients more effectively. Developments are now being made in three broad areas. Firstly, the performance management framework is being developed in line with the new lead role of commissioners, in order to ensure that personalised care is commissioned effectively. Secondly, we are both empowering patients and users to have far more choice of their provider and extending legal contractual relationships with a more diverse range of providers. Thirdly, we have introduced a system of financial incentives, of which payment by results is a major first step.

8.2 Recognising that the system being put in place will need to be modified in the light of experience, the Department of Health will be monitoring how the new incentives work, and will make changes where necessary. This is a dynamic system which requires both consistency and flexibility to make it work.

Developing commissioning systems

8.3 Commissioning of care to promote the efficient management of long-term conditions will be led by PCTs. PCTs will commission from a range of providers and will use the incentives contained within new General Medical Services and Personal Medical Services contracts to ensure that practices are delivering high standards of care to people with chronic diseases. PCTs will also use their leverage to achieve more effective integration of care, both between primary and secondary care and between health and social care.

8.4 For those requiring planned hospital care, PCTs will be able to use information and payment by results to select and then commission services from those best able to provide them. This will be achieved through a combination of core contracts with significant local (and sometimes regional and national) providers, as well as more flexible arrangements to support the flow of funds to

alternative providers where patient choice and/or capacity demands dictate.

8.5 As greater diversity of provision emerges, the Department in partnerships with strategic health authorities and PCTs will undertake national development work to ensure that there is a clear process for specifying and monitoring performance under contracts, and a clear route for action where organisations are failing to deliver. PCT development will receive higher priority in the next stages of reform with strategic health authorities supporting PCTs to realise the potential of commissioning and the financial incentives being put in place to improve access, extend choice and improve the quality of care for people with long-term conditions.

8.6 As waiting times continue to fall and choice is extended, it will be important to ensure that care is provided to patients in need and who are able to benefit clinically. Experience in other countries highlights the risk that referral and treatment thresholds may fall with patients being treated unnecessarily as capacity expands and responsiveness improves. PCTs are well placed to manage this risk. As the organisations that control over 80% of the NHS budget, PCTs have an incentive to provide as much care as appropriate outside hospital, and to avoid unnecessary hospital admissions and investigations.

8.7 As part of the support programme for PCTs, the Department of Health will be giving priority to ways in which PCTs can make better use of information and care pathways to promote the appropriate use of services. PCTs will also work with practices and the providers of acute services to develop explicit criteria for referral and treatment thresholds and trigger points within service level agreements and contracts. This includes involving patients more directly in decisions about treatment and promoting shared decision-making between patients and healthcare professionals.
A further strand will be the devolution of commissioning to GP practices.

Practice-level commissioning

8.8 Consistent with the principle of greater devolution of responsibility, the Department recognises the important role that GP practices play in commissioning services for their patients and local populations. Practice-level commissioning models may include profiling and peer review, indicative budgets, real budgets with PCT-facilitated collaboration between practices, partial real budgets or fully-devolved practice budgets. The Department continues to develop appropriate models of practice-based incentives in partnership with strategic health authorities, PCTs and GPs.

8.9 We have already undertaken national development work (through North Bradford PCT) to support indicative budgets, and the Department of Health will be evaluating fully-devolved models as they become established. These devolved arrangements will support the empowerment of patients through enabling more decisions to be made locally. As a first step, from April 2005, GP practices that wish to do so will be given indicative commissioning budgets. This will provide GPs with further incentives to manage referrals effectively with any savings being reinvested in NHS services.

Social care commissioning

8.10 The Department of Health in partnership with local government will also develop the system for commissioning social care. The social care system already has an established system of payment for results. This is based on local price negotiation, as is appropriate given the local accountability of councils. Reimbursement against delayed discharge of people from hospital is promoting more efficient use of services to allow people to leave hospital at the appropriate time. The Department will also review whether use of the existing flexibilities for combined working between health and social care are supported by sufficiently strong direct incentives.
In particular, the Department, with the NHS, will look to develop incentives that help to reduce unnecessary hospitalisation.

Developing direct incentives

8.11 Payment by results will support patient choice by enabling funds to follow individual patient choices for treatment. By 2008, patients referred by their GP will be able to choose any provider able to meet NHS standards and to deliver care at tariff.

8.12 *Delivering The NHS Plan,* published in April 2002, introduced a new national system of payment by results. Under this system, hospitals and other providers of care will be paid a fixed price for each patient treated. Prices are based on healthcare resource groups (defined by the patient's condition and diagnosis) that reflect the complexity and cost of providing care. A national tariff is now being implemented in stages and it is expected that within the next four years the majority of hospital and community healthcare will be paid for through the tariff.

8.13 The incentives within this system will help to increase the number of treatments provided, by rewarding providers for the work done. They will also stimulate greater efficiency as providers take action to bring their costs into line with the tariff, for example by reducing lengths of stay in hospital. Providers will be able to invest any financial gains from the tariff in quality-enhanced local services and facilities.

8.14 For primary care trusts, payment by results will support the development of a more effective approach to commissioning. In place of block contracts or service level agreements, primary care trusts will commission the volume and mix of activity needed by their communities. The introduction of a national tariff will remove the need for price negotiation and focus discussion on the quality of care.

8.15 As the organisations that control over 80% of the NHS budget, primary care trusts will have an incentive to provide as much care as possible in the most appropriate settings, and to avoid inappropriate admissions to hospital. In this way, the new system will help support the development of care closer to home, and the emphasis on improving the quality of care for people with long-term conditions. In particular, primary care trusts will be able to explore ways of commissioning alternatives to hospital care, and develop services in accessible "high street" locations.

8.16 Payment by results is a major reform and draws on international experience. Similar schemes are already operating or are being developed in the United States, Australia, Norway, the Netherlands, Germany and other countries. Experience of these schemes has helped to inform the development of payment by results for the NHS. The system now needs to develop into a more sophisticated regime of direct incentives that will promote the delivery of the overall vision for health services of which hospital care is only a part. This will involve:

- continuing with improvement of the current payment by results arrangements
- developing incentives for the whole patient journey – not just the hospital element
- developing commissioning systems to achieve strategic aims
- engaging practices more directly in commissioning
- improving incentives to integrate social care provision into the patient experience.

Improving the existing system

8.17 The existing payment by results system will need regular review, to ensure that the effects are in line with the policy aims. Following consultation, the clarification and revisions will be made from April 2005. (A summary of which is set out overleaf).

8.18 We are already aware of other issues that could cause unintended consequences, and we are planning to address these as follows.

8.19 *Coding and costing*: it is possible for tariff systems to result in an increase in funding for hospitals due to accounting issues, such as selective interpretation of coding or categorisation rules, and a resulting mismatch

Clarification and revision in response to consultation on payment by results

Separate tariff for planned and non-planned activity – we will retain a dual tariff for the near future. This will ensure that access to emergency services, which tend to cost more than non-planned, will be paid for at full cost. There is therefore no financial penalty in maintaining sufficient capacity for non-planned patients.

Short stay patients – we are to introduce a tariff that adequately compensates for short stay patients. This will ensure that there is no financial incentive to inappropriately retain, or classify, patients for very short stays. This will also impact on capacity and balance this with the needs of access.

Long stay patients – we will introduce a system that will allow for additional payments for patients who, for clinical reasons, remain in care beyond the expected length of stay recognised in the tariff. There is therefore no incentive to discharge patients until their clinical position determines it to be right.

New technologies – to ensure that new technologies and services are developed and introduced, we will introduce a process that allows for local, time-limited, payments in addition to the tariff.

Choice – we will set tariffs for a wide range of services. From April 2005 any patient exercising choice will be paid for, by their host PCT, at the national tariff. There will be no price negotiation, and hence no administrative delays, to frustrate choice. The tariff will be predetermined and known to all.

Independent sector, extended capacity and choice – services for NHS patients provided by the independent sector will, in time, be paid for at no premium to NHS tariff. This will give certainty to the independent sector in planning new developments, and enable the NHS, and patients, to judge the relative merits of providers on the basis of access and quality, not price. As with other NHS providers, independent sector providers will be required to offer both care and appropriate hotel facilities free at the point of use to NHS patients.

Transition – in order to allow providers with costs currently above the tariff price to make efficiency savings gradually, in line with full tariff implementation in 2008/09, we will allow a transition period during which these providers can be paid above the standard tariff. These providers will be expected to make gradual savings year-on-year until their costs fall sufficiently.

Local unavoidable cost variation – we are wedded to the principle of commissioners having to pay the same price for the same procedure from any hospital. We will therefore use a centrally funded arrangement to reimburse hospitals for unavoidable cost differences that result from the different costs of staff, land and buildings in the locality in which hospitals operate.

between codes and the full range of actual activity providers undertake. This runs counter to the policy aim that financial rewards should reflect real results.

8.20 As coding and costing improve, this should become less of an issue, but we recognise the need to ensure the system is robust in the short term. We are therefore developing plans to undertake regular audit compliance reviews of providers in line with international best practice. There will be significant penalties for deliberate non-compliance.

8.21 *Perverse incentives*: payment by results creates incentives for increased activity in elective or planned care in order to reduce waiting lists and improve access. Roll-out of

similar systems elsewhere suggests that incentives of this kind can lead to providers undertaking inappropriate levels of activity and/or engaging in other actions (such as premature discharges) which might not be in the patient's best interests. This runs counter to our intention that we should improve choice, responsiveness and quality through increased use of community-based care and management of long-term conditions. The role of the market-forces factor (which aims to equalise the costs of delivering services in different regions) can also lead to undesirable price competition across regional boundaries, and we will develop processes that ensure that any competition is based on quality, access and choice and not on price.

8.22 We will develop the expanded system at a pace that will ensure these problems are avoided. Subject to testing the effects in practice, we intend to manage these issues by reviewing utilisation rates, reducing payment for re-admissions, grouping episodes, improving audit, and assessing PCT commissioning behaviour. Where appropriate, we will also extend payment by results to cover care services provided outside the hospital.

8.23 *Incentives for staff*: the financial incentives created by payment by results work on organisations. It is important that these incentives are transmitted down to the staff directly providing care. We are, therefore, also piloting the use of fee-for-service payments direct to clinical teams that can augment their contracted income in return for higher levels of quality care.

8.24 Payment by results will be extended to cover services outside the hospital where that is appropriate. Work has begun to incorporate mental health and primary/community care into the system, as well as the balance of hospital activity. This comprehensive system will be based on the principle of a single national tariff for comparable treatments, to support choice and quality rather than cost reduction.

8.25 In addition, we will consider new groupings of healthcare activity, which reflect the desired patient journey, rather than traditional institutional boundaries. We will be seeking a solution which allows payment by results for care packages. We will develop the tariff so that discrete elements of it (e.g. diagnostic procedures) can be taken in isolation, and made to fit appropriate local circumstances. This is particularly important if we want to achieve our goals in respect of long-term conditions.

Contestability

8.26 The introduction of greater choice for patients, the flow of funding through commissioners and the extension of the range of providers is designed to support more responsive, innovative and efficient provision of service. It will allow the majority of providers to grow and flourish in response to patients' needs, whilst the poorest performers will either improve their ability to satisfy patients' needs or face remedial action ultimately leading to closure. We want to ensure that this contestability remains real so that patients and the public, rather than monopoly institutions, can make choices about where, when and how care is delivered. As part of this, we understand the need to manage the loss of poor performers in order for contestability to function effectively.

8.27 We have also considered the question of contestability of commissioning – whether patients should be able to choose their commissioning body. We have concluded that the current population-based system based on PCTs is the right model. In reaching this conclusion, the deciding considerations were:

- the need to ensure that commissioners were prepared to accept vulnerable or highly-dependent patients
- the need to ensure that commissioners would be motivated to address inequalities.

Both goals are better achieved through assigning a defined population base. Strategic health authorities should, however, be able to transfer commissioning responsibilities to another organisation if a PCT is failing in its commissioning role.

Performance assessment and management

8.28 Healthcare professionals, NHS managers and organisations have values and beliefs which strongly influence how they behave and how systems work. Professional standards and the service ethos are a dominant force which will be used as a powerful lever to enhance patient care; conversely, if the wrong approach is used, these commendable values can have the opposite effect. *Shifting the Balance of Power* recognised the need for a new approach, based on the Government's principles of public sector reform. This policy created a new system of planning, management and performance assessment based on devolving power to the front line. This includes not only the possibility of achieving NHS Foundation Trust status for high-performing organisations but also to the possibility of franchising for under-performing organisations.

8.29 We are developing this system to make it work more in line with the new emphasis on commissioning. We have also devolved the annual performance assessments (star-ratings) to the independent inspectorates. We will ensure that star-ratings reflect our evolving aims for both health and social care, and the Department of Health will develop a close relationship with the Healthcare Commission and with the Commission for Social Care Inspection to ensure that this happens each year. Within this policy, one of the most powerful incentives for delivery is earned autonomy (the reduction of central controls for high-performing organisations). We will continue with our aim of maximising the number of organisations that can achieve earned autonomy.

Empowering patients

8.30 Increasingly, patients will be involved in decisions about their treatment and care. Ensuring that all patients are empowered to make decisions about their care and treatment means that individuals must have the necessary skills to access, understand and use information. Improving the population's health literacy will be a key element in realising the potential of the information revolution we have embarked on and ensuring that access to information results in reduced inequalities in health and reduced inequities in access to care.

8.31 Patients will be further supported to consider treatment decisions that keep them in the community as far as possible and may result in a reduced need for hospital interventions. Some evidence suggests that decision aids are particularly effective where used together with interviews and advice. Building on current pilots and research evidence, the Department of Health will support the development and application of decision aids that support patients and help them to make the right choices.

Chapter 9
Empowering local communities

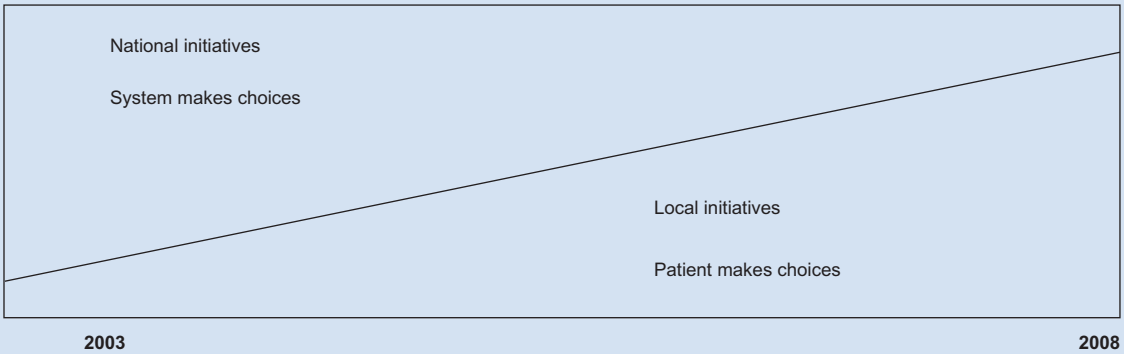
Local communities will take greater control of budgets and services:

- The balance of power in the NHS will shift even further towards PCTs and NHS Foundation Trusts, within the context of national standards
- There will be fewer national targets for the NHS, linked to a new emphasis on NHS organisations setting stretching local targets
- There will be fewer arm's length bodies at national level, reducing the regulatory burden on local NHS organisations
- Patients and the public will be given more voice in how services are planned and provided
- The Department of Health will have a continuing role in supporting reform.

National to local

9.1 As in any major transformation, phase one of the reform of the NHS focused on a concerted effort from the centre to drive through necessary changes at all levels of the service. Now that improvements are being delivered, we are moving on to a second phase in order to further engage front-line staff and patients in building on these successful reforms. In future, therefore, there will be an increasing emphasis on devolving decision-making to as near the point of delivery as possible in a partnership between commissioners, service providers and patients. The objective is to create a dynamic system where responsibilities and roles increasingly gravitate to those best able to deliver them. The centre will continue to have a leading role in creating the environment for such dynamism to thrive.

Figure 9.1: Shifting balance: between national/local and patient drivers



9.2 Improving choice for patients and the overall responsiveness of the system is central to our plans. Breaking down some of the institutional and other barriers in the system will allow patients to have greater options. Developing a more diverse supply side with a greater plurality of providers will support patients to exercise real choice. Within the NHS, PCTs will control over 80% of the budget, and NHS Foundation Trusts will symbolise the shift towards greater local engagement in the NHS.

9.3 We have already made progress here. Examples of the new freedoms and benefits for NHS organisations since 2000 include:

<table>
<tr><th></th><th>For all</th><th>For good performers – earned autonomy</th></tr>
<tr><td>Strategic Health Authorities</td><td>– Three-year allocations and plan approval (previously annual)
– Fewer national targets
– Reduced monitoring
– Reduced bureaucracy
– Participation in national policy and leadership forums</td><td>– Less frequent national monitoring
– National requirements for planning reduced
– Intervention from the centre only in the event of failure</td></tr>
<tr><td>Primary Care Trusts</td><td>– Control 80% of NHS funding
– Three-year allocations and plan approval (previously annual)
– Fewer national targets
– Reduced monitoring
– Reduced bureaucracy
– More scope for local flexibility in GP contracts</td><td rowspan="2">– Removal of management cost limits
– Opportunity to shape and pilot national policy
– Higher delegated limits for capital projects
– Retention of more of the proceeds of land sales
– Less frequent national monitoring
– Eligibility for NHS Trusts to apply for NHS Foundation Trust status</td></tr>
<tr><td>NHS Trusts</td><td>– Fewer national targets
– Reduced monitoring
– Reduced bureaucracy
– Local flexibility within new consultants’ contract and Agenda for Change
– More access to capital through NHS Bank</td></tr>
<tr><td>NHS Foundation Trusts</td><td colspan="2">– Freedom from Department of Health performance management
– Freedom from central control – accountability is to local people, commissioning PCTs and the Independent Regulator, rather than to the Secretary of State
– Flexibility to implement new governance structures to reflect local circumstances
– Freedom to borrow from either private or public lenders
– Freedom to retain surpluses and the proceeds of surplus asset sales to invest in developing new patient-centred services</td></tr>
</table>

Stewardship, regulation and inspection

9.4 The Department of Health will increasingly narrow and deepen its core focus to promote effective stewardship of the nation's health. This will involve the fulfilment of the following functions:

- Agree priorities, direction and standards.
- Maintain and develop the values of the NHS.
- Secure and allocate resources.
- Develop the capability and capacity of the system.
- Account to Parliament and the public for the performance of the whole system.

9.5 The Department of Health will be held to account through public service agreements with HM Treasury that define agreed priorities and resource allocation at the national level. The Department of Health will not, in future, micro-manage local-level commissioning or delivery decisions.

9.6 Strategic health authorities will lead in performance-monitoring PCTs to ensure effective commissioning on behalf of patients. Where necessary, strategic health authorities will trigger new commissioning arrangements if a PCT is consistently failing in its duties.

9.7 Regulation and inspection of both commissioning and supply of health services will increasingly be devolved to a small number of key agencies. Functions will centre around accreditation, compliance and developmental standards.

- The Healthcare Commission will monitor and report on the *quality* of commissioning and services across the NHS and, increasingly, the private sector. The Healthcare Commission will be independent of the Department of Health and will report to Parliament, whilst also working with the Department of Health and with the Independent Regulator for NHS Foundation Trusts to support quality delivery of services.
- The Office of the Independent Regulator for NHS Foundation Trusts will authorise the establishment of and then regulate the corporate conduct of NHS Foundation Trusts, including the enforcement of any sanctions resulting from non-compliance with national standards.
- The Commission for Social Care Inspection will perform similar functions in the monitoring and regulation of social care commissioners and providers. In addition, CSCI will lead in the development of standards and specification against which commissioners are assessed.

9.8 The Department of Health's arm's length bodies are currently under review. The Department of Health will shortly be publishing its findings in order to ensure that the regulatory burden on local NHS delivery organisations does not exceed that essential to promote quality and effective delivery of care. The review will also ensure that, whenever possible, resources are released to support front-line delivery.

9.9 The Department of Health and its responsible agencies will also continue to require information on commissioner performance and on the public's health, to bid for and allocate resources and to ensure that care is being commissioned in line with agreed priorities and to the appropriate standards. A Health and Social Care Information Centre will be opened to facilitate accessible and reliable information flows between patients, commissioners and suppliers. The Health and

Social Care Information Centre will improve the credibility of reported NHS performance.

Planning and priority-setting for a devolved NHS

9.10 In order to be effective, we not only need to reflect the goals for the changing system in our new Public Service Agreements (PSAs), but the form of the PSAs must meet our goal of devolution. We will move towards fewer national targets in the PSA. There will be no new requirements beyond these national PSA targets in the next Planning and Priorities Framework, which operationalises the PSA targets for the NHS. There will therefore be greater headroom for locally-determined priorities and target-setting.

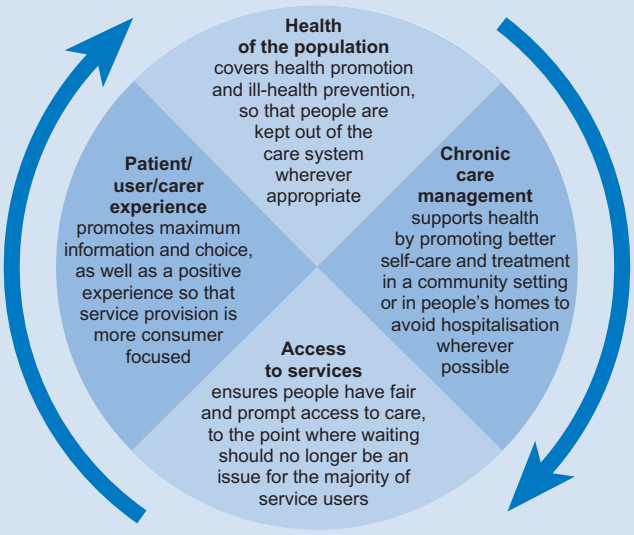
New target areas

9.11 Four broad themes for new PSAs for 2005-08 have been agreed between the Department of Health and HM Treasury.

9.12 The new PSA approach will ensure that:

- there is a degree of continuity from the previous PSA, with a continued emphasis on access, patient experience and health outcomes
- there are now only **four** PSA areas as opposed to the previous 12
- there is a new target area for long-term conditions, highlighting a new emphasis on changing patterns of care from a secondary to primary setting and increasing use of self-care and preventative approaches
- there is a stronger emphasis on overall health
- we retain the flexibility tightly in operational terms to set more high-level generic targets that allow the service to determine through local target setting how improvements will be delivered.

Figure 9.2: Future objectives for the NHS



Assessing and managing performance – clarifying roles

9.13 In 2005/06 several important elements will come together in a redesigned format. There will be:

- a new Planning and Priorities Framework process for 2005–08, as the basis for a new three-year planning round which will lock in a commitment to the reforms set out in this document, in order to allow more scope for locally determined targets and priorities, whilst not setting any further national targets beyond the key PSA ones
- agreed healthcare standards criteria, and defined methods which the Healthcare Commission will use to review performance against standards and priorities as set out in the PSA
- a redesigned performance ratings system from the Healthcare Commission, incorporating the healthcare standards
- confirmation of NHS funding, already secured to 2008.

9.14 Although the Department of Health, strategic health authorities and the Healthcare Commission have three distinct roles, they are clearly linked, and the revised performance regime that will oversee delivery of the new PSA will be at its most effective if they form part of an integrated system. Each of the three has responsibility for a key component of the new performance regime, so it is essential that these components map closely to each other so as to avoid creating perverse incentives and conflicting priorities for the service.

9.15 The components are:

- *national targets and standards*, set by the Government in its PSA, the Planning and Priorities Framework and the new healthcare standards document
- *delivery of national and local priorities*, managed and monitored by strategic health authorities, in partnership with NHS Trusts and PCTs, through the local delivery planning process
- *assessment and inpection*, undertaken independently by the Healthcare Commission and publicised through inspection/review reports and performance ratings.

Greater patient/public involvement

9.16 The NHS is becoming more accountable to local communities as more power is devolved. There is a statutory duty on the NHS to involve and consult patients and the public in service planning, service operation and the development of proposals for changes. Local authority overview and scrutiny committees, made up of elected representatives, are now able to scrutinise local service changes and ensure adequate public consultation takes place. Patient Forums in every NHS trust ensure that local views inform the development of local services. The new governance structures of NHS Foundation Trusts mean that increasingly the providers of health services will be directly accountable to the public and their members. As the NHS moves from a centralised service to one that is more community-based, the voices of patients and the public, together with greater choice, will play an important role in shaping the health service in future.

Managing the transformation

9.17 Four years ago, at the time of the launch of *The NHS Plan*, the Department of Health dealt directly through its Regional Offices with all NHS organisations. Currently it manages the NHS through the strategic health authorities, each of which acts as the local headquarters of the NHS. The Department of Health performance manages the strategic health authorities, which in their turn performance manage PCTs and NHS Trusts. Other partners such as NHS Foundation Trusts and the independent sector have separate accountability for governance purposes, but are contractually responsible to PCT commissioners.

The Department of Health will lead the transformation to the new system:

- The NHS Chief Executive and the Departmental Management Board have overall responsibility for leading the transformation, working with ministers
- The Healthcare Commission, Commission for Social Care Inspection and the Office of the Independent Regulator for NHS Foundation Trusts have key roles in ensuring accountability for quality and financial viability
- The NHS Chief Executive and the Departmental Management Board work closely with NHS leadership – consisting of the leaders of the 28 strategic health authorities together with clinical directors
- Strategic health authorities as the local headquarters of the NHS lead the transformation at a local level
- PCTs have the capability to commission services from a more diverse provider base
- Providers are increasingly accountable to patients and the public, augmented by accountability to PCTs through contracts
- Patients will be empowered to take an active role in maintaining their own health, choosing which provider treats them and controlling healthcare decisions.

9.18 To ensure a cohesive management approach, the NHS Chief Executive brings together the NHS leadership consisting of the Departmental Management Board, the national clinical directors and the chief executives of strategic health authorities. This group takes an overview of performance, addresses national issues corporately and contributes to national policy. Each chief executive in turn meets with their local leadership group drawn from the local NHS organisations and, frequently, their partners from local authorities. Increasingly, as the provider base develops, these discussions will also need to include key provider partners.

9.19 During the next five years we will need to introduce four changes to supplement and in part replace these arrangements:

- devolving more responsibilities to the NHS itself to take corporate decisions and actions – for example, through the strategic health authorities working together to manage the NHS Bank or through the NHS Confederation taking on a new role as an employers' organisation
- moving away from a system of departmental monitoring and regulation of organisations, to one where responsibility sits with new inspectorates and the new Office of the Independent Regulator for NHS Foundation Trusts, and developing a system where incentives start to have an impact
- strengthening commissioning of services by PCTs to create a system of alternative service providers within which patients can exercise individual choices and where they have more control over their care
- developing new relationships between the Department of Health, the NHS, local authorities and the new bodies – the Healthcare Commission, the Office of the Independent Regulator for NHS Foundation Trusts, the Commission for Social Care Inspection and National Institute for Clinical Excellence, and the Social Care Institute for Excellence – which between them manage and shape the whole system within which health and social care are delivered.

9.20 This period of transition needs careful management. It will not be a linear process – it will require continual dialogue between ministers, the Department of Health, local leaders and associated bodies to ensure that sensible short-term decisions are taken which allow both day-to-day services to be well managed and the new system to be introduced. Relationships throughout the system will change and will be reviewed in the light of experience.

9.21 Responsibility for overall management – integrating the strategic and the day-to-day – rests with the NHS Chief Executive and the Departmental Management Board. In the longer term the Department of Health will move away from its managerial role but retain responsibility for the whole system, its values and standards, its direction, its major investments, its integrity and its accountability. The current restructuring of the Department of Health is designed to support this, with the Chief Executive supported by three business groups:

- Quality and Standards: setting the standards within the widest context of health, health services and well-being
- Delivery: managing implementation and the interface with the NHS
- Strategy and Business Development: developing the strategy and ensuring its integrity and coherence whilst maintaining the core accountability and governance functions.

9.22 By 2008, we expect to have a system where:

- patients have a choice, they have more control over how they are treated, and they are empowered to take control of their own health
- providers, whether NHS or independent, providing NHS services are empowered to respond to patients' needs and choices, and are primarily accountable to patients and their local communities
- primary care commissioners are able to commission what their patients need and want
- the strategic health authorities develop local strategy, set the local framework for planning services and performance manage PCTs
- the independent inspectorates and the Office of the Independent Regulator for NHS Foundation Trusts ensure that provider organisations meet national standards and governance duties
- the Department of Health sets national strategy, develops the system and accounts to Parliament for overall performance.

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