2006/07

Our patients and public, at the heart of services

Our staff, united by shared values

the year.

NHS Chief Executive's annual report

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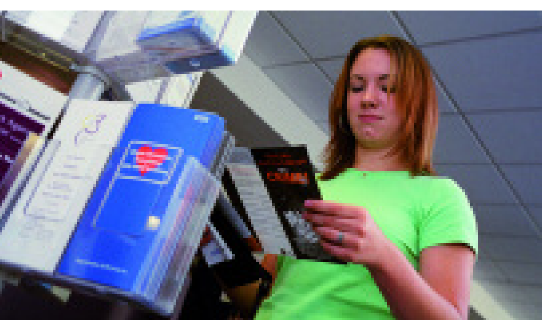


1

Introduction

David Nicholson
NHS Chief Executive

2006/07 has been one of the most challenging years in our 60-year history and has seen us drive through some of the most fundamental changes to our service since its inception.

This, my first annual report since becoming NHS Chief Executive eight months ago, outlines the key achievements of the NHS over the last year and sets out what I believe are the clear challenges that we need to grip as we move forward.

Change is nothing new to the NHS:

Change is nothing new to the NHS: it has been a constant theme in the 30 years I have worked in the service. However, the scale of what we are doing today – genuinely transforming the system that underpins the NHS – marks this period as unique. I don't have a crystal ball, but I am clear about four things over the next few years:

- Changes and improvements for patients will accelerate, not slow down, but will be locally driven to create more effective services for patients.
- We won't succeed unless we take our patients, staff and public with us.
- We won't succeed unless NHS leaders start to look out toward their patients and populations as a guide to action, not up toward the Department of Health.

The fourth thing I am confident about is that we now have the right leadership in place at all levels to deliver the challenges ahead. The past year has proven this. The NHS has done what it said it would do – delivered overall financial balance whilst delivering ever faster and better care for patients. But now is not the time for self-congratulation. Patient expectations are rightly high, but public perceptions and confidence are low. We have no time to lose in building on the foundations we have put in place this year and delivering the transformational changes we know are needed.

AIMS OF THE REPORT

Annual reports are traditionally the opportunity for the Chief Executive to set out all they have achieved over the preceding year, focusing on successes and glossing over challenges. But I have never believed in following tradition or precedent for the sake of it. Whilst I do want to recognise the genuine progress and achievements that NHS staff have made this year, I want to use this report to take an honest step back and assess where we are as a service on the wider NHS reform journey. Why, despite clear improvements for patients, does it feel so difficult? In this report, I set out my thinking on how we best achieve transformation, and the roles, responsibilities and behaviours of the different organisations within our health care system needed to achieve this.

it has been a constant theme.

It is my hope that this report will help all staff better understand where the NHS is going, and the importance of looking out to your local populations and patients, rather than up to the Department of Health. Clarity and consistency of purpose will give us all the confidence to act, and to really drive the system to deliver better care for patients and better value for citizens.

We should build on the foundations we have put in place this year to deliver the transformational changes needed.

2

The past year

There's been a lot to do in the NHS over the last year – and there's been a lot achieved. Against a backdrop of delivering financial balance and reorganisation, the NHS has continued to deliver against its key pledges.

There's been a lot to do –

We have delivered on our promises:

What we said we would do	Delivered?
1. Return to financial balance – we've delivered a surplus of £510 million	✓
2. Reduce cancer waiting times from diagnosis to treatment to one month	✓
3. Make progress towards our target of reducing waiting times from referral to treatment to just 18 weeks by 2008	✓
4. Make progress towards our target of halving MRSA rates by 2008	✓
5. Extend payment by results to cover £22 billion of payments in the NHS	✓

and a lot achieved.

In May this year, the Commonwealth Fund, a private foundation that supports independent research on healthcare issues, found that the UK had the best health system among five comparator countries. The UK outscores Australia, Canada, Germany, New Zealand and the United States on a whole range of measures, including quality of care, efficiency, equity and access.

OVERALL RANKING (2007)

AUSTRALIA	CANADA	GERMANY	NEW ZEALAND	UNITED KINGDOM	UNITED STATES
3.5	5	2	3.5	1	6

Source: Calculated by Commonwealth Fund based on the Commonwealth Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, and the Commonwealth Fund Commission on a High Performance Health System National Scorecard.

In April 2006, the NHS faced a huge challenge. At the end of 2005/06 the NHS was carrying an overall deficit of £547 million, eroding public and stakeholder confidence in our ability to manage the service. Consultations were launched on one of the most ambitious reorganisations of the NHS, reducing the number of primary care trusts (PCTs) from 303 to 152, the number of strategic health authorities (SHAs) from 28 to 10, and the number of ambulance trusts from 31 to 12. Because of this, many NHS staff, not just at senior level, faced uncertainty about whether they would have jobs.

At the same time, the NHS was asked to deliver against a demanding set of targets to improve patient access and care, whilst developing and implementing radical new reforms, such as the roll out of choice, foundation trusts and the independent sector treatment programme.

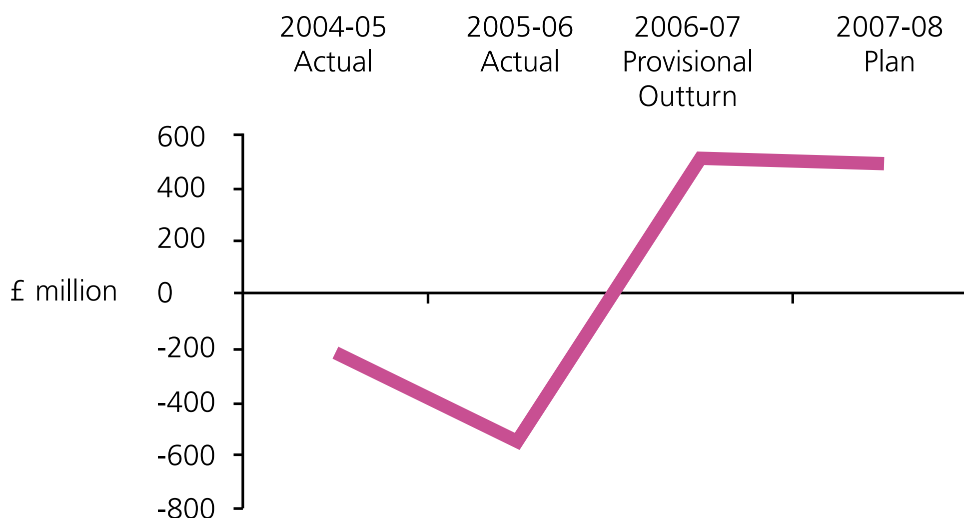
NHS staff have turned around a £547 million deficit

Against this backdrop, the achievements of the NHS and the people who work for the benefit of patients have been remarkable. NHS staff have turned around a £547 million deficit to a forecast surplus this year of over £500 million.

For the last 20 years, the NHS has been in underlying deficit, which has been managed using a variety of mechanisms. We have tackled not just this year's problem, but created a strong foundation for sound financial management and net surplus in the years to come.

to a forecast surplus this year of over £500 million

All England NHS Surplus/Deficits (excluding foundation trusts) 2004/05 to 2007/08



The surplus we're on track to deliver means we can

900,000

GP consultations each day

During this period of challenge and change, the NHS has continued to see and treat more patients than ever before. Last year, on average **per day**, we saw over 50,000 people in accident and emergency departments across the country, held nearly 900,000 general practice consultations and took over 16,000 calls to NHS Direct. And, according to a recent independent survey by the Healthcare Commission, nine out of ten hospital patients who used our services over the last year rated them as good or better – which most private sector companies would surely envy.

But these achievements have come at a cost. Tough action has had to be taken at a local level to get a grip of finances. The latest workforce census figures show the number of whole time equivalent staff fell by 0.8 per cent overall, although the total number of professionally qualified clinical staff grew by 0.9 per cent. Elsewhere, parts of the education and training budget were diverted last year. This was necessary to ensure we achieved financial balance while minimising the impact on patient care and services.

This has to be seen against the overall increase in training spending of 25.2 per cent between 2003/04 and 2007/08, and the fact that this year alone, we have committed more than £4.3 billion to training budgets in the NHS. Any cuts have been reinstated as well as putting extra growth back in for this year. It also needs to be recognised that the Department of Health allocated training and workforce budgets to SHAs, rightly judging that they were best placed to understand what kind of workforce they would need in the future to meet the needs of their populations.

Failure to tackle the financial problem head-on would have had a serious impact on our ability to continue to improve our services year on year. The surplus we are on track to deliver in 2007/08 means that the NHS can better plan and invest for real change and improvement, such as delivering a maximum 18 week wait for patients. The money is only important because of what it allows us as a service to do for patients. In the past, surplus has been seen as a sign of poor management. We need to change the culture to one where surplus is recognised as a success, and an opportunity to invest in better patient care.

plan and invest for real change and improvement.

These surpluses do not sit idly in a bank account at the Department of Health, they are out in the NHS, giving local organisations the headroom and flexibility they need to be more responsive to the needs of the community they serve. This headroom is already having a positive effect on patient care, freeing up NHS organisations to pursue positive changes and improvements in productivity. That we have been able to achieve a surplus in this financial year is important, but not as important as how we did it.

The net deficit was reversed because managers, clinicians and staff in the NHS gave it a real priority and focused hard on the need to address it. Systematic local action – as part of an overarching financial strategy – has really made us concentrate on productivity improvement and developing innovation at a PCT and trust level (for example, emergency bed days reduced from 32.5 million to 30.7 million between 2003/04 and 2005/06). And whilst an overall net surplus is good for the NHS, we still need to bear down on the small number of individual trusts who continue to spend more than they earn.

Failure to tackle the financial problem head-on would have had a serious impact on our ability to continue to improve services.

We are coming to the end of a period of planned and unparalleled growth. It is therefore more important than ever that the NHS manages its finances well and plans for surplus so that we can build on the achievements to date.

There are three key lessons that we need to learn from the last year in terms of how we handle finance going forward:

1. **Never let it happen again:** Deficits don't happen overnight. They take two to three years to build up. People in the NHS and the Department of Health knew that it was happening and didn't take sufficient action when necessary.

The service needs to start planning

2. **There are no clever answers:** Turnaround teams were useful, because they exposed the real gap, which is the skills to put ideas into action. We need to get much better at implementation.

3. **Three-year time horizons:** Financial problems cannot be resolved in a week. Sustainable solutions need three-year time horizons. The service needs to start planning now for the next three years. The early publication of the *Operating Framework* allows you to do this.

With thanks to the Clatterbridge Centre for Oncology NHS Foundation Trust

now for the next three years.

The final lesson is that the transparent way in which we now deal with finances, including quarterly reporting at national level, has meant that all of these changes have happened in the full glare of public scrutiny.

Turning the money round on this scale has been high profile, and the cost in terms of public and political confidence in our ability to manage the service has been high. We all need to invest a lot of time and effort to win this back, as we can achieve nothing without the confidence and support of the staff who work in the NHS, the patients who use it and the citizens who fund it.

3

Where we are on the NHS journey

On virtually all objective measures of progress, the NHS continues to make considerable improvement. But it is also clear that for many, both within and outside the service, it simply doesn't feel like that.

We are trying to transform the NHS

Why do things feel so difficult? Why does it feel so uncomfortable? It is because we are about half way through a massive change programme, and we are where we should expect to be at this point in the change process.

We are trying to transform the NHS on two levels: firstly at a systems level, from a monolithic provider of care based on organisations, to a more plural and open system, using reforms such as choice and contestability; and secondly we are driving through transformation at a structural level – our model of care – by shifting the care we provide for patients outside of hospitals and into the community, closer to home.

There are three stages in this journey of transformation and change.

1. The first stage of the current NHS reform journey started with the publication of the NHS Plan, and was about increasing capacity and getting us up to European levels of spending. The extra resources were invested in more doctors, more nurses and more buildings, with high profile national targets to drive reductions in waiting and improvements in the biggest killers such as cancer and heart disease.

at both a systems and a structural level.

2. The second stage of the journey saw the introduction of the health reforms such as choice, practice-based commissioning, payment by results, foundation trusts and independent sector treatment centres, which are giving patients and staff new levers to create a more responsive NHS.

3. We are now entering the third and most difficult part of change, which requires us to take investment and capacity on one hand, together with the reforms on the other, to drive the necessary transformation to deliver real benefits for patients.

But these three stages do not represent a simple linear process. All three elements are still in play, creating a dynamic that is difficult to manage in the old ways. But we are exactly where we should expect to be given the amount of change in the system. We have new capacity in the system and the levers are in place to make the NHS more responsive: we now need to use these elements to transform our services.

We are exactly where we should expect to be, given the amount of change in the system.

4

Drivers of change

By 2051, four million people in the UK will be over 85 – these are the high use/high cost group

Change is always difficult, but it is a necessity, not an option, in the NHS. It would be a mistake to think that the changes we have undertaken so far have been made simply because of a new managerial emphasis or because of political imperatives.

Significant changes in patients and care

Earlier this year I spoke at the World Health Congress with colleagues from across Europe and the rest of the world and I was struck by the fact that every country faces the same challenges. Those global drivers are clear:

PATIENTS ARE CHANGING

- Populations are ageing meaning both higher costs and fewer people to pay for them
- People have more sedentary lifestyles and are exercising less
- There are rising levels of obesity

PATIENT CARE

CARE DELIVERY IS CHANGING

- Continuing advances in costly medical technology
- More sophisticated and expensive pharmaceuticals
- Greater emphasis on integrated care and chronic disease management
- Day cases mean fewer hospital beds are required

delivery will impact all advanced healthcare systems

PATIENTS ARE CHANGING

- The number of people aged over 85 is expected to rise sharply, to approximately four million by 2051. These are the high use/high cost group.
- 15 million people have a long term condition (LTC): patients with LTCs account for 80 per cent of GP consultations and 5 per cent of patients with multiple LTCs use 50 per cent of in-patient bed days.
- The rise in obesity is increasing the risk of strokes, heart attacks and type 2 diabetes.
- Rising consumer expectations mean that patients increasingly want 24/7 access to high quality services, and even the English are no longer happy to queue.
- Our increasingly diverse communities require public services to be more responsive to the needs of all individuals. Local NHS and local councils will need to work closely to deliver seamless, integrated health and social care services, based around the needs of the patient.

We need to radically re-think how we help individuals to manage their own health and avoid hospital admissions.

CHANGES IN CARE

- The development of medical technology is changing the way we are able to provide care within hospitals. In 1998/99, the NHS performed 17,000 angioplasties. By 2005/06, the figure was 54,000 – more than a three-fold increase, which has made a significant impact on reducing the length of stay in hospital for patients compared to having a coronary artery bypass graft.
- Technology is also rapidly changing our ability to treat more and more people with conditions like diabetes out of hospital and closer to their own homes, helping to reduce the average length of stay in hospitals from 8.2 days in 2000/01 to 6.6 days in 2005/06 – that's nearly a 20 per cent fall in five years, by changing the way we work.
- Developments in IT offer opportunities for information sharing, decision support, remote diagnosis and treatment.

Successful transformation means aligning the needs of patients

Investment alone will not meet the challenges that these drivers present.

Investment alone will not meet the challenges that these drivers present. If we are to provide better care for the increased numbers of elderly people with long term conditions, then we need to radically re-think how we help individuals to manage their own health and avoid hospital admissions which are unnecessary for the individual and costly for the tax payer.

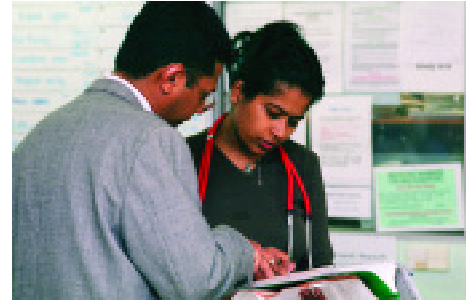
We have to face up to the challenge of promoting health, preventing illness and supporting independence to meet the needs of an active and ageing population and a massively rising burden of lifestyle diseases.

Now that people can get access to timely care, we have to focus on delivering safe and effective care in every place, every time.

With resources rising more modestly in the future, delivering greater value and driving up productivity is key to ensuring that extra resources are available to fund new needs and developments in drugs and procedures.

THE GOAL OF TRANSFORMATION

The goal of transformation is to develop a healthcare system that meets the needs of patients, whilst also meeting the requirements of equitable access on the one hand, and affordability on the other. Today, these three aims are not always aligned, but they will need to be in the future for successful transformation.



Living with long term conditions that are poorly controlled, which is often the experience of the most disadvantaged members of our society, can reinforce that disadvantage. It can have a serious impact on key areas such as schooling or ability to hold down employment. Our capacity to deliver more tailored services for our patients therefore not only reduces costs and inappropriate admissions for the NHS, but creates a virtuous circle.

with the requirements of equitable access and affordability.

5

How we will drive transformation

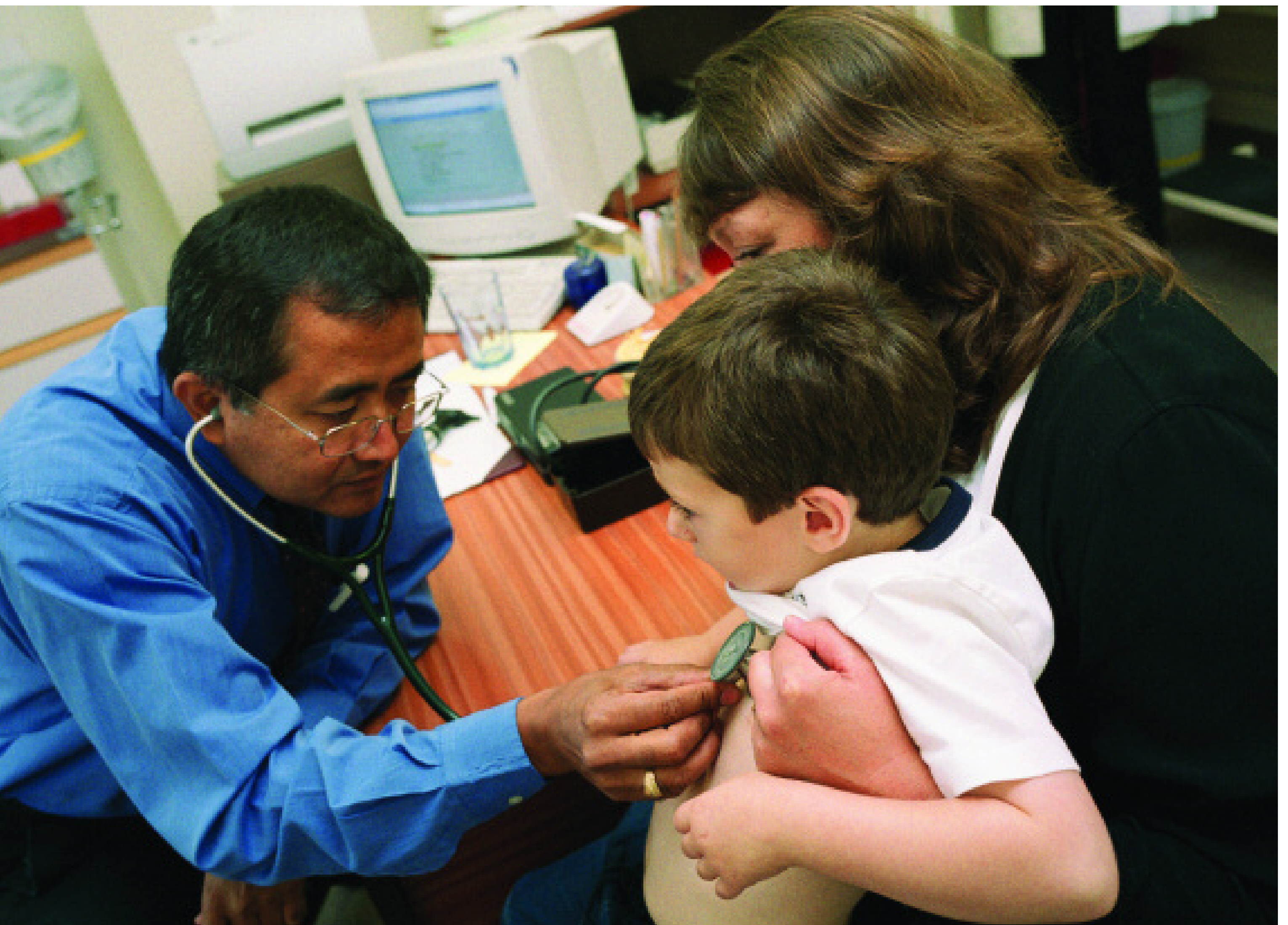
The sheer size of the NHS makes the

1.3 million

staff are employed in the NHS

The NHS employs 1.3 million staff, and over 1.5 million patients and their families are in contact with NHS services every day.

The sheer size of the NHS makes the task of transformation challenging, to say the least.



task of transformation challenging.

I have had over 30 years' experience in the NHS of managing and leading change. Based on my experience, I believe we will only succeed in transforming the NHS for the benefit of patients if we focus on the following four key approaches:

- developing the right incentives, levers and enablers
- being clear about the 'NHS offer' to patients, staff and the public
- building leadership based on values
- putting the power in the hands of patients and staff to drive change at the front line.

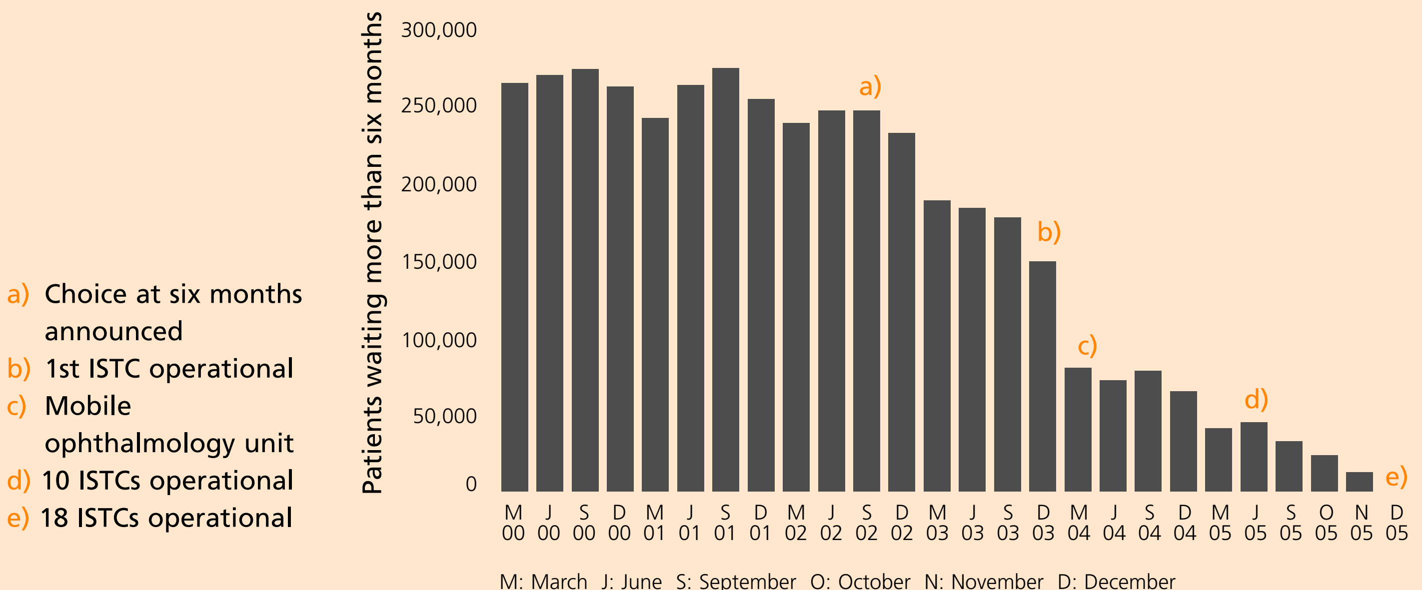
INCENTIVES, LEVERS AND ENABLERS

Over the past few years, the Government has introduced a range of incentives, levers and enablers to help shift the NHS from being a monopoly provider, less able to customise the care it provides around the needs and demands of patients, to a health system with the patient at the centre of all it does.

There is a range of connected reforms involved. For example, patient choice, combined with payment by results, means that money follows the patient. And a flat tariff means that providers must compete on quality, not cost, and that the successful providers will be those who understand and respond to the needs of patients. Payment by results is leading hospitals and commissioners to focus on value, for example, getting patients into operating theatres and home again more quickly and safely.

There are a range of incentives, levers and enablers

The impact of the reforms on patient waiting times



Moving from a monopoly to a plurality of providers has allowed independent sector treatment centres to deliver care for NHS patients. As well as directly providing extra capacity, the very presence or threat of alternative providers has encouraged the NHS to find more capacity too – with the overall effect being to significantly reduce waiting times for the benefit of patients.

There is no doubt that in some areas, reforms such as competition from the private sector have provided a powerful incentive for the NHS to improve its response to patients' needs. But it is equally true that we need to do more to connect these reforms to the needs of staff, the public and patients.

Successful providers will be those who understand and respond to the needs of patients.

to help us shift to a patient-centred system.

THE NHS 'OFFER' TO PATIENTS, THE PUBLIC AND STAFF

If we want the reforms to be implemented in a way that improves the patient experience, then we have to connect the reform tools and levers to the needs of our staff, patients and the public. And for that to happen, we need a deep understanding of what matters to each of these groups. What do they want from the NHS? What is the distinct offer the NHS can make to them? We need to be able to describe very simply how they will support our staff to do what they come to work to do – save and improve lives.

Despite improving patient experiences, public perception by comparison is negative, and some staff groups report low levels of morale.

It is clear that the NHS is continuing to deliver ever-improving services for patients on whatever level you look at it – patient satisfaction data, performance data for access, outcomes data for coronary heart disease and cancer.

But we are in a peculiar place, where despite these objective measurements of improving patient experience, public perception by comparison is negative, and some staff groups report low levels of morale and engagement with the reform agenda. For example, although regular Ipsos MORI polling for the Department of Health shows that patients report over 80 per cent satisfaction with the services they have used, when the public are asked how satisfied they are with the NHS overall, this falls to below 60 per cent.

The way to achieve transformation is through the

We need to get much better at identifying what matters to staff, patients and the public, and communicating what the NHS 'offer' is to them, and how the changes we are introducing will help better meet their needs. This is not about spin, it is about core delivery. All my experience teaches me that we simply cannot deliver the reforms without the understanding and support of our staff, particularly in the face of public opposition.

The way we engage our staff is through connecting the reforms to their everyday jobs and their values, describing how the reforms will enable staff to do their job better for the benefit of patients. For example, rather than talk about a national IT programme, we have to talk about the very real patient benefits (see comments on the next page).

If a baby is treated in different hospitals you can end up where there are hospital numbers floating. An NHS Number at Birth ensures information goes to the right place.[1]

The new despatch system is amazing, it's cut our response time from ten minutes to just three minutes and that helps us to save lives.[2]

One patient's life was saved after his consultant was able to access images of their brain at 4.15am from home and diagnose a brain haemorrhage.[3]

1 MELANIE EVERY, ROYAL COLLEGE OF MIDWIVES
2 DR MICHAEL CREAGH, ASHFORD & ST PETER'S HOSPITAL
3 PAUL JONES, HELICOPTER PILOT, YORKSHIRE AIR AMBULANCE SERVICE

mobilisation of our staff to drive change.

LEADERSHIP AND VALUES

The third aspect to successful transformation is leadership. Leadership is the neglected part of reform. The NHS, like all health care systems, is the sum total of the people who work in it and the day-to-day interactions they have with patients and colleagues. A health care system is a powerful coalition of organisations and professions, not just a set of individual organisations operating in a market. The way to achieve transformation is through the mobilisation of our staff to drive change. For this to happen our clinical and managerial leaders need to understand what it is that we are trying to do, and how it connects with our wider values.

Our clinical and managerial leaders need to understand what it is we are trying to do, and how it connects with our wider values.

Since becoming NHS Chief Executive I have made clear that my number one priority is to establish clarity of purpose about what the NHS is for – what are our values? Not as a piece of theory, but as a guide to understanding and action. If we are clear about the values of the NHS, and how they connect with the reform programme, it will provide the basis for a successful strategy to transform the NHS. It also provides a clear and common purpose for our most important asset – the people who work for NHS patients.

We are embarking on a bottom-up approach, in partnership with NHS staff, patients and the public, to establish not just what the purpose and values of the NHS are, but what the NHS offers to patients, staff and citizens. This will be the key foundation on which we can take forward the strategy for the NHS that supports successful transformation.

Our most important asset is

EMPOWERING STAFF AND PATIENTS

I have described perhaps the biggest reform programme for the largest publicly-funded health care system in the world. How can you drive this degree and nature of change from the centre?

The simple answer is that you can't. Neither I nor Ministers can make a £90 billion system, with over a million staff, be responsive to patients from our offices in Whitehall.

On the first stage of the reform journey, which was essentially about expanding capacity and reducing waits, central targets could be set and driven nationally.

In the second stage of the journey, reform policies were initiated and developed in Whitehall, drawing on the lessons of other sectors and countries.

the people who work for NHS patients.

But the third stage, using the investment and reforms to drive transformation, can only be delivered through successful implementation by our staff working in the many NHS and NHS-funded organisations across the country.

Improving the management of long term conditions and reducing the number of inappropriate admissions to hospitals requires us to put the power in the hands of staff and patients to develop and deliver the services they need. Local GPs, hospital clinicians and patients need to work together to re-design care pathways, and use the reform tools, such as payment by results and practice-based commissioning, to help them to achieve this.

But I am conscious that for people to have the confidence to act, they need greater clarity about the nature of the system they are working within, and about their particular role and responsibilities, as well as about what I and the Department expect them to deliver.

My number one priority is to establish clarity of purpose about what the NHS is for – what are our values?

6

System management and roles and responsibilities

I have been Chief Executive many times before, of trusts and various regional structures.

Fewer top-down, centrally driven targets mean greater

But my current job has forced me to think harder about what the NHS is. It is not one organisation – we are quite rightly moving away from the old top-down monolithic model.

The NHS is not a collection of separate and autonomous units of varying degrees of independence responding to the invisible hand of the market and incentives and reforms. It is in fact a healthcare **system**.

The different parts, whether GPs or consultant nurses, working in primary or acute care, are all working for the benefit of patients, whose pathway of care often crosses the boundaries of professions and organisations. Again, this may sound like warm words or theory, but if you understand that the health service is a system, then this has real implications for how the different parts relate to one another, particularly with regard to performance management. We are inverting

freedom to determine what will be delivered locally.

the triangle, so that instead of a top-down pyramid of hierarchical management, we now need to work from the bottom up, starting with the lynchpin of the system, GPs and their practice teams.

Each part of the health care system has a unique responsibility to add value to the wider objective of better care for patients and better value for citizens.

GPs and their practice teams, as practice-based commissioners, are responsible not just for the patient in front of them, but for using their budgets and knowledge to improve the patient pathway and outcomes. GPs can use practice-based commissioning to reduce unnecessary, costly and inconvenient outpatient appointments and ensure that diagnosis and treatment is provided in a way that is better for patients, and better value for money. Any savings are ploughed right back into better services for patients. Practice-based commissioners will be supported by PCTs, who will provide the strategic framework within which they operate and the business support models for delivery.

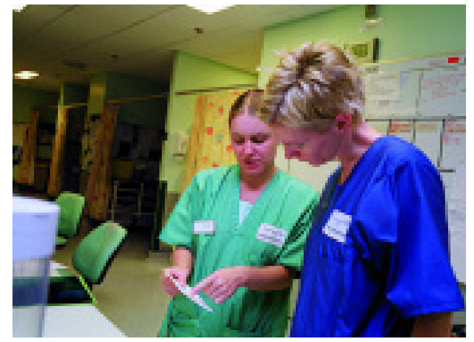
We are quite rightly moving away from the old top-down monolithic model.

I am confident that we now have the right leadership in place to deliver the challenges ahead.

Providers, whether public or private, are responsible for using the NHS pound they are paid to provide the very best care for patients. The introduction of payment by results and choice will provide a strong incentive for them to respond to the needs of patients. But providers also need to be actively engaged in re-shaping pathways of care. The reforms will only be truly effective if providers devolve the same powers to their clinicians that practice-based commissioners have, so that they can work together with GPs across secondary and primary care to provide better care for patients. Devolution must not end at the boardroom door.

PCTs are responsible for understanding the needs, experiences and expectations of all their communities, and will develop world-class commissioning as a lever to ensure that appropriate services and pathways of care are available locally. Their commissioning strategies will increasingly be based on intelligence and data, both on what their communities need, and on what patients currently experience from the service. PCTs are responsible not only for commissioning better health care services, but for using their commissioning muscle, in partnership with other agencies such as local authorities, to deliver better health outcomes. They

Our job is to create the right environment and tools



will be supported and performance managed by SHAs as to the extent to which they measure and meet the needs of their population, whether they delivered what they said they would do, and to ensure that their ambitions are sufficiently challenging.

SHAs are accountable for the performance and management of the healthcare system. The NHS is not a self-improving system. It needs active management to protect the needs of patients and citizens, and this is the role of SHAs. SHAs will actively ensure that all patients have access to sustainable primary, secondary and specialist care, and that across the regional health care economy, there is equity of access to choice and quality for all. SHAs are responsible for using all of the reform tools to their best effect, and will need to identify where promoting competition or cooperation is appropriate, to improve local services in the best interests of patients and citizens. The power relationship between users and providers of care is so stacked against the patient, that the system needs active management to ensure that patients' interests are protected and promoted. SHAs are the system

so that local people can drive transformation.

managers at a regional level, and will be held to account by the Department of Health and Secretary of State for how they use their leverage and judgement to best effect.

The **NHS Leadership Team's** role is to make clear to the service the role of the system and the rules within which it should operate. We will use the *Operating Framework* to make clear the priorities for the NHS, increasingly devolving power locally for how these are achieved, and holding the NHS to account through SHAs for the delivery of better health for all, better care for all and better value.

NHS Boards have a crucial role to play in all of this, in whichever organisation they sit. Boards need to be well organised, confident and skilled, to hold the executive to account for the delivery of their promises, both to the Department of Health, and to their local populations. Strong governance will be key to building public confidence in the ability of the NHS to continue to improve services to patients, whilst providing better value to tax payers.

With the power of the whole system working together, there is nothing we cannot achieve.

BEHAVIOURS WITHIN THE SYSTEM

The next six months will lay the foundation for the next three years for the NHS and the patients it serves. The conclusion of the *Comprehensive Spending Review* will be announced, which will set the financial envelope for the next three years. Building on our work with staff, patients and the public, in the autumn we will set out a clear strategic direction for the NHS going forward, establish a vision for world-class commissioning and outline the priorities for the service in the *Operating Framework*.

These are important milestones, but I am clear that it is our behaviours, both what we do and how we do it, that will have the most impact on healthcare services and the patients who use them. That is why I place so much emphasis in this final section on behaviours.

What we do and how we do it will

Regardless of which organisation staff may work within, I expect them to work together for the benefit of patients.

Regardless of which organisation our staff may work within, there are four key behaviours I think we now need to address in the system:

1. Individual organisations working within the system for NHS patients need to become more businesslike, professionalising their skills and processes.
2. But at the same time I also expect organisations and individuals to work together for the benefit of patients, and to recognise the importance of their individual behaviours on both the system in general and public confidence in particular.
3. Each organisation, whether public or private, treats and cares for NHS patients funded by taxpayers' money, so we need to get much better at listening and responding to our populations and patients and accounting for our decisions.

4. Local staff need to start looking out at their patients and populations, not up to the centre, for permission and advice. The basis for confident and local action should be robust data about what your staff, patients and public want from local services.

MORE BUSINESSLIKE

The successful NHS organisation will be patient focused and data literate, understanding the behaviours and needs of their patients and driving provision and commissioning to meet those needs. NHS organisations need to use system-wide thinking, and plan and invest over much longer-term horizons than just the financial year, planning three to five years ahead to invest for better health and health care.

NHS organisations need to use system-wide thinking, and plan and invest over much longer-term horizons.

have the most impact on services and patients.

To develop ever-improving patient pathways, we need to genuinely work in partnership across primary, secondary and social care.

WORKING TOGETHER FOR THE BENEFIT OF PATIENTS

As with any system, all the different parts are interdependent. Our staff may work for individual organisations, but they also work for NHS patients within a healthcare system. Our behaviours need to reflect this.

Reforms for the benefit of patients, such as practice-based commissioning will not succeed unless the powers devolved to GPs and their teams are matched by equal degrees of devolution from acute sector management to their clinicians.

It is unacceptable for different parts of the system to rubbish each other, whether public or private, in a misguided attempt to 'win' more patients or create a 'power base'. The reforms are there for the benefit of all our patients and citizens, and are not the playthings of management.

Organisational interests must not be

We need to work even more closely together across primary, secondary and social care – genuinely working in partnership to develop ever-improving patient pathways. Organisational interests must not be a barrier to improving patient care.

LISTENING, RESPONDING AND ACCOUNTING

The NHS also needs to get much better at explaining to the public and their representatives why changes are necessary, what the benefits to patients will be and what, if anything, will be the impact on local services. The work that Sir Ian Carruthers carried out for me on service reconfiguration illustrated the need for us to raise our game both in terms of the evidence base for change, the need for genuine clinical

and public engagement and improvements in how we explain and account for any decisions to the public and their representatives. Transformation cannot and should not be delivered on the quiet: the scale of challenge we are delivering cannot be dreamt up in Whitehall and then imposed in the dead of night before anyone notices.

LOOK OUT NOT UP

Over the next six months, there are a number of publications, such as the conclusion of the *Comprehensive Spending Review* and the *Operating Framework*, which you need to be aware of to inform good planning, but this should not be an excuse for inaction.

Again, my key message to you all as you move forward this year is to stop looking up to the Department – as you've been asked to do so often in the past – and start looking out to your local populations and patients.

a barrier to improving patient care.

The data and intelligence that you are increasingly gathering should be your guide for action and investment, within the framework of national policy. When in doubt don't wait for permission.

Instead, ask yourself three simple questions:

1. How will my actions benefit patients?
2. Are they consistent with what other health care services locally are trying to achieve?
3. Can I account for my decisions on this to the public and their representatives?

We need to get much better at listening and responding to our populations and patients and accounting for our decisions.

If the answer to all of these questions is 'yes', and your actions have the support of your SHA, then get on with what you do best: delivering better care for patients.

This annual report makes clear what I expect from the NHS over the next 12 months:

- Firstly, we must all continue to do what we say we will do. The NHS needs to keep focused on delivering better access to more responsive care for all of our patients, whilst delivering a small surplus. It is the surplus that will give the NHS the headroom to really develop and deliver better patient services.

- Secondly, we all need to recognise the scale of the change we are embarking on, and that old methods of management and leadership simply will not work. Success will require the active engagement of our staff, and better understanding of and communication with our patients and the public. I will be focusing on this during the coming year, but I expect each organisation to make this a priority.

Our patients and public, at the heart of

- Thirdly, all of our behaviours need to be consistent with the values of the NHS and the fact that it is a system, not a collection of autonomous organisations. The NHS needs to be more businesslike, data-driven and evidence-based. And at times we need to use the reform tools such as competition and contestability to drive and promote better patient care where needed. The reforms are the means by which we deliver better care for the patients who use the NHS and the citizens who fund it.

7

Conclusion

One of the great privileges of this job is that I get to meet people from all over the world managing different health care systems.

Without exception, they are envious of our ability to provide care not just for 60 or 70 per cent of our population – but for 100 per cent of our population. One of the things that makes our service special is that we don't just treat the patients who walk through the door, but we actively reach out to address the unmet needs of all our communities. And that we are increasingly moving from a 'diagnose and treat' service to a 'predict and prevent' service.

services; our staff, united by shared values.

The prize is that we have a health care system that is universal, comprehensive, and free at the point of need.

The prize is that we have a healthcare system that is universal, comprehensive, and free at the point of need. It is these values that made me join the NHS 30 years ago, and I know it is what motivates most of our staff.

The challenge we all face is to use the investment and reform that has gone into the NHS to deliver better health and care for all and to strengthen the values that our staff, patients and public share.

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