Engagement Analysis

NHS Next Stage Review
What we heard from the *Our NHS, our future* process

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Engagement Analysis
NHS Next Stage Review

What we heard from the *Our NHS, our future* process

Contents

Executive summary

This report sets out responses to Lord Darzi's wide-ranging review of the NHS which used a variety of mechanisms to engage over 60,000 participants. Participants belong broadly to three groups who contribute from their own perspective as follows:

> patients and public – personal experiences at point of care; expectations, needs and wishes

> staff – hands-on experience of providing care in various settings, often over a long period, giving information from the front-line, and demonstrating the challenges they face

> stakeholders – overviews, based on aggregate experience captured in anecdotal, commissioned or academic research, often informed by groups of patients and staff.

Many different opinions were expressed, with a range of views on the direction the NHS should take. This report, however, focuses only on issues where there appears to be most consensus among people across all groups. These include:

> the quality of care varies across the NHS. Some aspects are excellent but there is scope for improvement in many areas

> the NHS is a much loved institution and patients and the public have very high expectations of it

> there needs to be a greater emphasis on preventive care and early intervention

> there needs to be a continued emphasis on upholding basic standards of care, including cleanliness, and safeguarding the dignity and respect of patients and staff

> patients want more and better information so they can play a greater role in managing their own care

> new roles and new partnerships, involving a range of people and organisations across health and community services, are needed to provide personalised care for patients, delivered close to home, as quickly and conveniently as possible

> patients place less importance on choice than on access to high quality local services

> carers and patients need to be listened to and made partners in their care – progress has been made, but there is still further to go.

1 The story of the *"Our NHS, our future"* engagement programme

1. We have actively engaged, involved and solicited the views of patients, service users and the public, staff and stakeholders through a number of different channels.

2. We have used new and innovative ways to engage them, as well as tried and tested more traditional methods. These include:

Engagement events

> visits to SHAs (July and August 2007) – we began the process with a series of early visits to SHAs, where Lord Darzi and David Nicholson (NHS Chief Executive) visited NHS organisations across the country. The purpose was to outline the terms of reference of the Review and engage NHS staff in the process – seeking their views on what the Review should cover

> a stakeholder forum (September 2007) – attended by over 240 organisations representing a wide spectrum of health and social care organisations, many from the voluntary sector affiliated to the Long-term Conditions Alliance. The purpose was to raise awareness of the Review, outline the terms of reference and progress so far, as well as explain to stakeholders how they could get involved and feed into the Review

> two deliberative events (18 September 2007 and 24 January 2008) – the events, one held in each SHA region outside London, were linked together by video conference, with over 1000 patients, members of the public and NHS staff at each session. The discussions centred on what people want from healthcare in the future and how the NHS can deliver the best quality patient care into the 21st Century. The days were comprised of an interactive mix of table discussions, presentations, films and electronic polling – the results of the discussion beamed into football stadiums and conference halls across the country

> an international clinical summit (21 and 22 November 2007) – this was hosted at the Excel centre with 850 clinicians and stakeholders. It included presentations from UK and overseas speakers – selected to inspire and motivate the clinical pathway groups and influence their thinking when designing future models of care for their local areas. It was also a chance to exchange ideas, experiences and knowledge, and engage with a diverse range of healthcare experts. The event allowed participants from the local clinical pathway groups to come together to discuss their progress, share their thinking and contemplate ways of working together

> stakeholder engagement events (February to May 2008) – we have worked closely with a wide variety of stakeholders throughout the Review, ensuring we are inclusive by working across the whole spectrum of health and social care. Stakeholders have included patient representatives, professional bodies and unions, voluntary and third sector groups, as well as local government, regulators and the commercial/independent sector

> through proactive engagement, a number of stakeholders offered to host engagement events with their members and representatives to feed their views into the Review. Lord Darzi attended a number of these personally to hear the debate first hand. Next Stage Review engagement events were held in partnership with the following stakeholders:

– The Royal College of Physicians

– Royal Pharmaceutical Society of Great Britain

– Asthma UK in partnership with LTCA, British Heart Foundation, Parkinson's Disease Society, Arthritis Care, Stroke Association

– The Royal College of Nursing

– Allied Health Professionals Federation

– The Royal College of Surgeons

– The Standing Commission on Carers

– Rethink

– Remedy, BAMMbino & BMA Junior Doctors, Royal Society of Medicine & Academy of Medical Royal Colleges

3. The national clinical directors for older people's services, mental health, learning disabilities and kidney care have also held meetings and events with their key stakeholder groups and fed back the results to the Review team to be taken account of.

4. We also utilised existing Department of Health forums, for example the Social Partnership Forum, the National Stakeholder Forum and Third Sector Sounding Board who have held specific events focused entirely on the Review. Around 4,000 stakeholders and representatives were engaged nationally through joint hosting of engagement events and stakeholder meetings.

5. A further tool of engagement was a "call to action" letter from Lord Darzi to over 300 stakeholders which asked for views, policy ideas and submissions to overcome the barriers and develop the enablers in the following key areas: quality, innovation, workforce, leadership, primary and community care, informatics and systems and incentives. This generated over 200 responses which were analysed for a final report that was fed back to the national workstreams to consider.

6. At both a local and national level, particular attention was placed on engaging with hard to reach groups and those who are often excluded from participating in consultations that are more traditional. Some examples of this include:

> in the East Midlands, healthy schools co-ordinators were used to engage with children and young people

> in Yorkshire and the Humber, focus groups were used to engage with local populations, which included a number of people from a black and ethnic minority background

> in the South East, the age of participants ranged from 16 years to late 80s and came from all areas and sections of the differing communities in the region. The maternity focus group included 21 teenage parents and their children

> in the North West, one local PCT worked with the Cumbria Disability Network to reach people with physical disability, and with the help of the 'learning disability local implementation team', information leaflets were produced for service users

> in the South West, the mental health clinical pathway group held an engagement day for service users and carers

> in the North East, local PCTs organising a number of meetings with local groups and community organisations to ensure they include opportunities to hear the views of hard to reach groups

> the West Midlands hosted an engagement event specifically for patients and carers, over 130 people attended who had a range of needs and requirements, for example people who are totally deaf, totally blind, wheel chairs users and terminally ill patients

> throughout the South Central region over 10,000 interviews were carried out with residents in their homes

> the East of England commissioned a special sample survey of eight marginalised groups in the area. This included amongst others, gypsies and travellers, those involved in the criminal justice system, migrant workers as well as asylum seekers and refugees.

Online communication channels

Web chats via forums

7. We piloted two online chat forums with a selected audience. The website was devoted to motherhood and the collective forum was known as 'Net-mums'. Following the success of this, we also did a webchat with Mums-net. The aim was to reach an interested audience and understand their view of the health service, get an understanding of their priorities for the Review and respond to the issues and questions they raised.

8. From the *Our NHS, our future* website*, there was the option to post a question to Lord Darzi: visitors to the site were redirected to the No10 website for a live web chat. The questions were answered on Thursday 27 September.

Questionnaires

9. We carried out three questionnaires as part of the engagement programme. The first sought staff's priorities for the Review – condensing the data which was responded to in the Interim Report, October 2007**.

10. Two questionnaires, one for patients and the public, the other for staff and stakeholders were hosted on the *Our NHS, our future* website*. The questionnaires were promoted locally by the NHS, as well as by utilising the internal and external communication channels of our stakeholder networks. We received around 3700 responses from patients and the public and over 4200 from staff members and stakeholders. In addition, over 1600 calls were made to the public through an omnibus survey. The outputs were fed back to the regions to inform the local work and the development of the SHA visions. The results were also fed into the national workstreams to consider during the development and formulation of policy.

Note on attributing responses

11. Throughout this report, all quotations (from emails, blog comments, formal stakeholder submissions, questionnaire responses and records of engagement events) are given verbatim. However, we have normalised spelling and grammar.

12. We have also 'silently' cut the odd word or phrase where nothing is added to the argument – for example, 'I must say ... ', or 'in fact ...'. More substantive cuts are indicated by suspension points [...].

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2 Quality

1. The NHS is clearly much loved. Many respondents praise NHS staff and speak highly of the standards of care they received.

2. Many respondents also raised issues about the quality of care they received, including:

   > there is room for improvement in the hospital environment and cleanliness

   > there needs to be a higher regard to the patient experience, for example bedside manner, communication with staff, information and consultation

   > there is demand, especially among working people, for more GPs to operate extended opening hours

   > many patients do not know which services are available locally or how to access them – as a result they often access services (like A&E) inappropriately

   > many patients in rural areas find it hard at times to access services.

Quality of patient experience

Patients want a clean hospital [...] They want kind, caring staff – and sufficient of them on each ward. They want effective clinicians, who are courteous and caring. They would also like all staff to be au fait with current knowledge on their particular complaint. (Patient email)

3. Respondents often praise highly one aspect of the care they have received from the NHS only to condemn another. Inconsistency in the quality of care received over their pathway, and often even within the same setting, is a common theme among patients. A patient's experience can be affected even by relatively minor things.

   Many raise concerns over conditions or attitudes which they find unacceptable. This is a uniform finding across all groups: patients, staff and stakeholders. Further, many believe that attentiveness to basic standards and core principles of care could improve quality.

4. The submission from MRSA Action UK expresses the point particularly well:

Staff should take every opportunity to engage with patients and carers. The simplest things such as responding to a patient who is thirsty, talking to them [... One hospital] puts beds through a 'car wash', everything is cleaned and decontaminated – every patient is in a clean environment when they are admitted. The environment speaks to staff and patients and people feel and behave differently. Proper cleanliness is important because it is a marker for diligence and commitment and it shows that staff are taking their work seriously.

5. Areas of concern for patients about experience can be grouped as follows.

   > cleanliness: environment and infection control

   > staff behavior and attitude to patients:

      – staff congregating in groups and seemingly ignoring patients

      – unfriendly or inattentive staff

   There needs to be a lot more thought and training devoted to changing the attitude of staff at all levels towards the patients. Patients are customers and should be treated with the same level of respect that customers expect in shops, hotels and restaurants. (Patient email)

   > communication:

      – patients and their carers not being consulted about clinical decisions

      – patients and carers not having access to appropriate information

   Although the carer is regarded as being perfectly acceptable to look after the loved one at home they are, in my experience, never regarded as partners in care once their relative enters hospital. (Patient email)

   > dignity and respect:

      – patients left unattended for long periods in inappropriate settings

      – no help with personal care – bathing and toileting

6. Suggestions on how to get the basics right include:

   > cleanliness:

      – 'old-style' matrons or ward managers to oversee standards on one or two wards only, with the power to take action (for example, close a ward down) in case of infection

      – matrons/ward managers should be on the ward (not away in meetings) as much as possible

- more cleaning staff employed as part of the ward staff and answerable to the matron/ward manager

- set rules for hand washing and ensure staff, patients and visitors observe them

- make sure staff uniforms are kept clean and are not worn outside the hospital

> attitude of staff/communication:

- return to 'old values' of nursing 'as a vocation'

- encourage a culture of staff talking to and engaging with patients

- train staff to deal with expert patients and expert carers and to take into account their knowledge and experience

> dignity and respect:

- ensure there are sufficient nurses and healthcare assistants on wards to attend to all patients' needs.

Patient information

7. Most patients and stakeholders agree that information available for patients and the public could be better and more consistent across the NHS. The main issues are:

> since there can be a range of different services operating in any one locality, patients need up to date information on how to access them. This can also be true for health professionals themselves, who may need to signpost patients to appropriate services

> different groups have different information needs, for example older people or people with disabilities: information needs to be tailored to them

> consistent and up-to-date information, resources need to be available on: common illnesses and injuries; long-term conditions; public health and health prevention. These should be standardised across the NHS and widely available

> standards of local service provision need to be measured and made public so patients can make informed choices, for example in selecting a GP

> locally relevant information needs to be available for people with long-term conditions on, for example, support groups, practical help, childcare, benefits and welfare advice.

8. Many patients may also need direct face-to-face contact and guidance from a health professional as well as comprehensive information.

Improving quality

9. Many staff and stakeholders comment on the need to continue to drive quality improvement in the NHS.

10. Some responses, particularly from staff were concerned that target measures were not necessarily the best way of achieving improvements in quality. Respondents agree that targets have contributed to improvements in NHS services, in particular waiting times. Some suggest that a broader, more structured focus on continuous improvement across the whole of the NHS was needed.

11. Some suggestions for improving outcome measure include:

   > targets should all be evidence-based, based on outcomes, and should demonstrably contribute to improvements in patient care at all points of the patient pathway

   Service user/patient defined outcomes should be used to determine whether outcomes have been achieved. Service users often have different views of what constitutes a good outcome and a positive experience, but targets tend to focus exclusively on symptom reduction. (Role not given)

   > there should be streamlined, 'smarter' outcome measures

   > priority setting should be long-term and focused on sustainable and continuous improvement

   > measures should be set by clinicians and clinicians should be empowered to achieve them

   > priorities should be also set locally or regionally.

12. Key ideas for improving quality in the NHS include:

   > appoint a named individual responsible for quality at every level across the board in the NHS, with leadership provided nationally by a Medical Director

   > integrate quality management and quality improvement systems across the NHS

   > set up a 'coalition of reform' – politicians, DH, civil servants, managers and clinical leaders – to address the key quality issues

   > collate, disseminate and audit examples of good practice through national and regional quality improvement and advice networks

   > add a 'quality coefficient' to the Quality Outcomes Framework and Payment by Results to further encourage quality patient services in primary and secondary care

> assess health services on a range of quality criteria including provision of personalised care and the extent to which patients, service users and carers are consulted and involved in care decisions

> monitor the performance of commissioned services and ensure commissioners are held to account for poor quality provision

> give greater power to regulators to point out and intervene in cases of poor quality

> identify the weakest point in every patient pathway and target it for ongoing improvement

> benchmark against service industries and learn lessons about customer care.

Commissioning for quality

13. How services are commissioned is an important determinant of quality. World Class Commissioning is only possible if commissioners have the appropriate support on how to commission and procure services. Responses called for:

> widespread involvement of local people and service users in commissioning decisions

> extending consultation to vulnerable and 'hard to reach' groups, through greater involvement of the voluntary and community sector who can act as intermediaries and advocates for people in these groups

> involvement of professionals and lay-people in commissioning:

  – involve secondary care professionals in commissioning decisions for primary care

  – involve more clinicians in commissioning decisions

> ensuring commissioning decisions are evidenced-based

> a long-term strategic framework for commissioning services: contracts should be extended beyond one year and up to three years

> Practice Based Commissioning to work across primary/secondary boundaries – with GPs and hospital clinicians working together to provide effective care pathways

> monitoring the performance of commissioned services and ensuring they meet national minimum standards

> ensuring commissioners can be held to account to local people for their decisions

> mapping and disseminating the most effective commissioning approaches.

3 **Primary and community care**

Access and convenience

1. Services which are high quality and easy to access are important to many respondents.

2. Travel is often cited as a difficulty which disproportionately affects families with children, older people and those reliant on public transport.

3. The main messages on accessing local services are the following:

   > travel times and the availability of public transport need to be considered as part of any service reprovision (in particular, the impact on older people and people dependent on public transport should be taken into account)

   > population density should not be the only determinant of where to locate a service:

   Everyone has the right to receive the same service whether they live in a town/city or a rural setting.
   (Engagement event participant)

Access to a GP

4. Many patients responding to the engagement have spoken highly of their GPs. They value the continuity of care that a GP can offer. This is often built up on a relationship that has grown up over years.

   I just wanted to voice how important I feel the role of the 'family doctor', or GP is. During various complications following the birth of my daughter, it has been my GP who has co-ordinated my hospital care, been aware of how the various problems interlink and given me quick, sensible solutions to the problems.
   (Patient email)

5. Many working people express a desire for their GP to be open on Saturday mornings and late evenings at least a day or two during the week.

6. The main messages from patients on accessing GPs are:

   > there is demand for extended opening hours, particularly among working people

   > there should be better availability of information on common conditions

> telephone consultations and nurse-led clinics are convenient and popular: nurse-led clinics can help free up a GP's time to focus on patients with more complex or urgent needs

> walk-in centres and occupational health centres can be used to supplement GP services and provide extended hours

> more GPs are needed in areas of high deprivation.

Integration of services

Health and social care need to be more fluid and seamless – one example is waiting in hospital for six days for a social worker to see you. It is a waste of money. (Participant in Parkinson's Disease Society Engagement Event)

7. The notion of integrated care is widely regarded as good in principle.

8. However, stakeholders point out that there are some challenges to overcome. Joint commissioning (between health and social care organisations) is necessary wherever pathways require coordinated care. Local workforce planning needs to take account of local needs and be consistent with Local Strategic Plans and Area Agreements.

9. Health professionals will increasingly need to work together in local teams which cross service boundaries. To do so effectively, they need greater understanding of each others' roles.

10. At the Royal College of Nursing's engagement event in April 2008, which involved staff from across the profession, several suggestions were made for addressing this issue:

> more joint posts should be available across health and community care providers

> there should be more opportunities for staff to rotate in different settings

> clinical teams should be centred on care pathways

> joint training and accreditation of health and community care professionals

> strengthen the role of generalists

> ensure that public and patients understand the new roles and new approaches.

11. Integration also implies sharing patient information, with the challenge of:

> having reliable, up to date and (appropriately) accessible information on each patient's individual needs

> safeguarding confidentiality

> having IT systems which 'speak to each other'

> ensuring patients do not 'fall into the gap' in the boundary between one service and another

> better discharge planning – in particular, involving and consulting carers.

Our members have cited a number of examples where the NHS has done an excellent job in stabilising a relative's or friend's condition only to discharge the individual back home at short or no notice, with the apparent expectation that a family member will be there to provide necessary care and support without any forward planning or a realistic understanding of what is involved. (Standing Commission on Carers)

12. Integration can mean a range of relevant services being located in one building. Patients can access coordinated support, including diagnostics, all in a single visit. The convenience of such an approach is welcomed by many stakeholders.

Look at the one-stop shop clinics with podiatrists, dieticians, etc. all together. In three to four hours you can see everyone that you need to, all under one roof. (Participant in Parkinson's Disease Society Engagement Event)

13. However, many respondents, particularly among stakeholder groups, were wary of making local changes as a result.

14. These respondents recommend that for any reconfiguration of services from hospitals to the community:

   > patients, staff and the public need to be fully consulted (feedback on how their views have shaped decisions should also be provided)

   > there needs to be sound evidence for change based on reviewing local needs

   > risks and benefits to all patient groups should be taken into account

   > there should be national minimum standards which all local services should be obliged to reach.

We have a great service in our area but I know it not the same everywhere. It doesn't seem fair. (Parkinson's Disease Society event participant)

Partnership working

15. At their engagement event, members of third sector organisations expressed the need for PCTs and local authorities to work collaboratively with each other and with local community organisations.

16. Concern was expressed that the commissioning process and procurement decisions have tended to exclude the third sector, and that local commissioners do not always have a good understanding of how the sector can contribute. This can mean that local communities miss out on the additional dimension of care which the sector is uniquely able to provide, for example:

   > local knowledge and ability to bring services into people's homes or close to home

> ability to reach, engage, inform, work with and act as advocates for people in vulnerable groups

> ability to add value to healthcare, responding to the full range of an individual's psychosocial needs, not just their health needs.

17. Allied health professionals (AHPs) at their engagement event in March 2008 set out ways in which their contribution could underpin a community based model of care.

18. These include:

> supporting patients to make informed choices

> signposting patients through local care options

> acting as advocates as necessary.

19. AHPs can help to develop health solutions which take account of the whole person's individual needs, not just their clinical diagnosis.

20. In addition, community pharmacists point out the benefits of their local, high street presence, flexibility and long opening hours. Pharmacists can thus provide enhanced services such as:

> minor illness and injury, including prescribing medicines

> medication: advising on and resolving problems with medication; conducting Medicine User Reviews; supporting self-medication

> advising on healthy lifestyle and self-care

> screening and diagnostic tests.

21. The move from hospital-based care to the community setting necessitates a change to the skill mix. Patients are seen earlier, before illness can progress, and problems can be identified by other staff groups. Acute services are able to target their resources on the patients who need them most.

22. Some stakeholders suggest that any changes to skill mix should be made with caution. If specialist services, once only available in the acute setting, are to be provided by community based practitioners, the quality of care needs to be monitored. This was a particular issue raised by junior doctors at their engagement event in May 2008.

The role of carers

23. At an engagement session attended by representatives of the Standing Commission on Carers the following points were raised:

   [...] As healthcare shifts into the community, so the role of family carers will be crucial in improving the quality of life for a much wider range of older, sick or disabled people.

24. Health professionals need to become much better at working with carers, keeping them informed (and being informed by them).

25. Emails from carers and carer groups suggest that there is still some way to go before the role of carers and expert patients is understood and appreciated by health professionals.

   The junior doctors and nurses were wary of us and had no idea how to use our knowledge and experience to secure the best care for my husband.
   (Carer and NHS professional – email)

   Please do not forget family carers when looking at services, they save the NHS an enormous amount of money and their needs are not overtly taken into account.
   (Carers Support and Advocacy Worker)

26. The NHS also needs to take account of the impact of caring on the mental and physical health of the carer. Promoting the health and well-being of carers leads to good health outcomes for the person they support, avoiding crises and reducing the need for inpatient care.

27. Some stakeholders suggest that the NHS should recognise that many of its staff are carers themselves and that it should offer them appropriate support and understanding.

Complex care needs

28. People with long-term conditions want information and support to manage their own care and live their lives as normally as possible. They want health professionals to recognise their expertise in their condition and to be treated as partners in their care.

29. Most welcome the emphasis on personalised care plans, putting patients at the centre of support which integrates health, social and quality-of-life needs. However, these can only work if professional groups work together and there is effective integration of the care pathway.

30. Common areas of concern include:

   > organisations still need to work better together to reduce avoidable emergency admissions

> care planning needs to be better
integrated and there needs to be
better communication between health
professionals at different institutions

– discharge: a care plan needs to be in
place before a patient leaves hospital
– otherwise patients can be left to
navigate local care themselves, with
no one taking single responsibility for
their care

– pathways need to be streamlined to
reduce the length of patient journeys,
and stop the 'to-ing and fro-ing'
between GP and consultant

– a named person should coordinate
care for the individual across health
and social services

– there should be a needs based, rather
than purely diagnosis based approach

> information is needed at all points of the
pathway – consulting and talking to the
patient, standard information booklets
on particular conditions, information
on local healthcare and informal
support groups

> more local support groups needed –
support from other sufferers can provide
practical insights, advice and information
on the challenges of living with and
managing conditions.

*Peer based support is helpful and,
particularly for the younger generations,
more use could be made of IT such as the
internet and email.* (Diabetes UK event)

> the role and expertise of carers needs
to be acknowledged and there needs
to be support for carers – particularly in
emergencies and at key times

> training of health professionals: people
with long-term conditions can find that
the knowledge of health professionals
about their condition and care pathways
is variable and sometimes poor:

*An example was given of a GP who had
not heard of Zolair.* (Asthma UK event)

*But I do need to have a label so that
people can understand my conditions
– that I am not being difficult [when in
hospital].* (Parkinson's Disease Society
event participant)

> access to a disease specialist nurse
can be vital for patients, providing
information and support to manage
symptoms and reducing the likelihood
of need for emergency care:

These posts must not be cut
(Diabetes UK event)

> there needs to be a systematic approach
to mapping patients' self-care abilities
at diagnosis and throughout patients
should be able to self-refer

> providing mixed care for people with long-term conditions and complex needs.

31. Concerns were raised about accessibility and continuity of care. Many argue that patients with complex needs are often best served by an ongoing relationship with a trusted health professional.

As the evidence collected below suggests, integration may help prevent some of the following:

Six days' school missed each month because of six different appointments; two year delay in getting a recommended drug because a letter from a doctor had got lost; doctors using drugs they had been told the patient was allergic to; could send for all tests needed ahead of first consultant appointment so diagnosis and referral can be quicker with fewer trips to hospital. (Asthma UK event)

Groups with additional support needs

32. Several respondents mention groups of patients who have additional support needs, for instance specialist staff available to provide their care, and greater knowledge and expertise among all staff of their illness and the challenges they face.

33. These groups, and some of their requirements from health services, include:

> children and their families

> people with disabilities (including learning disabilities) and their families: care plans, integrated health and care services

> people suffering from mental illnesses or at risk of poor mental health: better resourced counselling and community services; joined-up social, health, education and employment services and initiatives

> older people: integrated health and care services to support independent living; better dementia care

> the dying: greater recognition of living wills, better palliative care, better pain relief.

34. Many respondents, often acknowledging themselves as members of Dignity in Dying, asked for the debate on assisted dying to be reopened.

4 Prevention

1. There is consensus on the need to focus on prevention and early intervention as follows:

   > prevention:

   – working with the well, not just the sick

   – more consistent funding available across the country for prevention activities and initiatives

   – using social marketing to target, reach and influence 'at risk' groups

   – an emphasis on 'staying healthy' and healthy ageing

   – better information, advice and guidance for health and illness

   > early intervention

   > multidisciplinary teams working together, with the patient at the centre

   > better integration between primary and community care staff and agencies

   > greater partnership between the NHS, community care services and the voluntary sector.

2. By encouraging people to become more responsible for their own health, by identifying and intervening earlier when problems arise, resources can be better used.

3. This helps invert the so-called 'triangle of care' – investing in the front-end of care to reduce spending on avoidable care down the line.

4. Stakeholders from professional groups in the NHS stress how they can support people in making healthy choices and advise on prevention (midwives, health visitors, allied health professionals, pharmacists and social workers, for example).

5. A key factor is being able to engage day to day with healthy people who are otherwise unlikely to access health services, in a range of community settings, including schools and children's centres.

   Education is needed for the general public on strokes. Would everyone know to call 999? Most people don't know there is emergency treatment for stroke. Many people ignore the signs. (East Midlands deliberative event participant)

6. Preventive care means interagency working at all levels, from government departments to local commissioners. Clearly much of this work is already happening. However, several suggestions were made to stimulate and sustain this work:

> screening should be targeted at vulnerable groups

> there should be more joint commissioning (health and social services), and more support and resources offered to commissioners to help them procure high quality and cost-effective services

> there should be nationally coordinated research and development and dissemination of good practice on prevention and public health.

5 **Workforce**

1. The main findings and recommendations from staff and stakeholders on workforce are:

   > implement all recommendations of the Tooke Report (2007), including:*

      – new body for medical education in England

      – new national body for workforce development

   > plan for and develop multi-disciplinary teams, providing joint accreditation and training across NHS and community care

   > integrate workforce, service and financial planning and take account of shifting disease and treatment patterns when planning training and recruitment

   > ensure DH and Government formally consult the NHS and medical profession on all policies which affect education, training, research or service delivery

   > embed the Knowledge and Skills Framework across every aspect of employment in the NHS – education, training, recruitment, appraisal

2. Staff working in health and social care and a number of stakeholder organisations mainly raised points about education and training.

Education and training

3. As services increasingly become delivered in community settings and the focus shifts toward prevention and early intervention, so new ways of working are needed. These require new approaches to training, including cross-boundary, cross disciplinary training for professionals in both health and social care.

4. Ideas to enhance training and development so staff are equipped to manage their changing role include:

   > align staff training to the health needs of local communities

   > leadership and management training (in particular for clinical staff so that they can move into management roles)

   > improve the patient experience by training staff in core basics, for example hygiene and cleanliness (including hand-washing), customer care,

* Tooke J., *Aspiring to Excellence – Independent Enquiry into Modernising Medical Careers* (2007)

communicating with patients and carers, multidisciplinary working

> training for community nurses in long-term conditions management and supporting early discharge from hospital

> greater consideration to training or re-training options for existing employees as an alternative to new recruitment

> use 'blended learning' – including distance learning, e-learning, open learning, with a 'greater availability of online interactive packages'.

6 Innovation

1. Barriers to innovation raised by both stakeholders and staff include:

    > unwillingness of some staff to make change

    > recommendations from commissioned reports, NICE and best practice reports are implemented too slowly

    > too few incentives to promote innovative technology.

2. Ideas to promote innovation include:

    > adopt an "invest to save" approach to innovation – budgeting for the long-term

    > Trust boards to have a change and innovation team to support and deliver innovation at local level

    > measure Trusts' comparative performance in adopting innovation through an 'innovation index'

    > strengthen the role of Intellectual Property hubs and build these into research and development strategies

> incentivise NHS organisations to collaborate with academic institutions and the independent sector

> enhance and speed up NICE change processes and criteria, making greater use of interim reports

> give uptake incentives for medicines or technologies that have had positive appraisal (through Quality Outcomes Framework for GPs, and a similar system for hospital consultants)

> ensure staff are trained in the proper use of new technologies and products and provide ring-fenced budgets for this training

> give senior specialists a role as national reference point for research on technology and new methods relevant to their specialty

> draw better on resources, develop partnership with independent sector, third sector, universities and academic institutions

> provide an online forum for staff where they can discuss new ideas and share good practice

> develop a national database of good practice accessible to all staff

> develop primary care 'early implementation units' – to pilot, evaluate and improve innovative service models before they are adopted nationally

> set up an NHS bank – to provide venture capital for new approaches, pilots and service change.

7 Conclusion

1. Throughout the NHS Next Stage Review process the findings, comments, themes and key messages we heard helped to inform proposals in "High Quality Care For All: NHS Next Stage Review Final Report", June 2008*. This document summarises the findings at the end of the process

* High Quality Care For All: NHS Next Stage Review Final Report, HM Government, June 2008. Crown copyright 2008