

# ourNHS *our future*



NHS NEXT STAGE REVIEW

## Interim report

October 2007

**DH INFORMATION READER BOX**

<b>Policy</b> HR/Workforce Management Planning/ Clinical	Estates Commissioning IM & T Finance Social Care/Partnership Working
<b>Document purpose</b>	Gathering INFORMATION
<b>ROCR ref:</b>	<b>Gateway ref: 8857</b>
<b>Title</b>	NHS Next Stage Review Interim Report
<b>Author</b>	Professor Lord Darzi
<b>Publication date</b>	04 Oct 2007
<b>Target audience</b>	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, PCT PEC Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Local Authority CEs, Directors of Adult Ss, Directors of Children's Ss, Voluntary and Independent Sector Organisations
<b>Circulation list</b>	(See above)
<b>Description</b>	Interim report by Lord Darzi on the NHS Next Stage Review
<b>Cross reference</b>	N/A
<b>Superseded documents</b>	N/A
<b>Action required</b>	N/A
<b>Timing</b>	N/A
<b>Contact details</b>	NHS Next Stage Review Team Room 524A, Richmond House, 79 Whitehall, London SW1A 2NS 020 7210 3000 Email: ournhs@dh.gsi.gov.uk <a href="http://www.nhs.uk/ournhs">http://www.nhs.uk/ournhs</a>
<b>For recipient's use</b>	

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# Summary letter



**Dear Prime Minister, Chancellor of the Exchequer, and Secretary of State for Health,**

**As you know, I'm a doctor not a politician.** That's why you asked me to take on this task – and it's why I agreed.

With my colleagues, I have spent my career committed to doing my best to provide patients with high quality NHS care. And I am continuing to work as an NHS surgeon.

But the reason I accepted your invitation to lead this Review is because I believe that it is an important opportunity to take stock of the progress of recent years in improving the quality of care and up the pace of improvement going forward.

I want to make the most of this opportunity to listen to the views of patients, staff and public on how to do this. I have already heard from thousands of people in the weeks since the Review began – and their views have helped shape this interim report. I want to continue to give everyone the chance to contribute during the second stage of the Review.

My aim is to convince and inspire everyone working in the NHS, and in partner organisations, to embrace and lead change. I have met with some scepticism, including from clinical

colleagues. I was expecting it. I told them I would not have agreed to get involved if this was a means of avoiding awkward decisions. I believe however that this is a chance to shape the future of the NHS in a new way.

My assessment is that the NHS is perhaps two thirds of the way through its reform programme set out in 2000 and 2002. In my visits across the NHS I have detected little enthusiasm for doing something completely different; instead the majority opinion is that the current set of reforms should be seen through to its conclusion. I agree.

Making the improvements that people expect us to achieve will not be easy. Improving the quality of care means accepting that fundamental change will have to happen. No-one should see this Review as a way of slowing down or diluting what we need to do. If anything we should be seeking to respond to the rising aspirations of patients and the public and be more ambitious, to help all members of our diverse population live longer, healthier lives, especially those least able to help themselves.

I believe passionately that, through this Review, we all have an opportunity to shape the NHS for the 21<sup>st</sup> century. Our ambition should be nothing less than the creation of a world class NHS that prevents ill health, saves lives and improves the quality of people's lives.

## Summary letter

Some aspects are already world class. The challenge is to ensure that every aspect matches the best – to take our health service from good to great.

This interim report is the start of developing this vision for the next ten years. It has two purposes. It describes the key elements of a vision – an NHS that is fair, personal, effective and safe – and sets out the immediate actions that should now be taken to make progress towards it.

I have spent the last three months visiting different NHS organisations and hearing the views of staff. I have participated in lively debates with patients and the public about how they feel the NHS and its partners should respond to their needs.

This report is based on those views, visits and discussions. It acknowledges the progress that NHS and other staff have already made towards achieving that vision, challenges them to be ambitious in striving towards it, and sets out the scope for improvement and the challenges we need to meet over the second stage of the Review.

I believe that this vision for the future should not be just mine – or the Government's – but a vision for the future of health and healthcare in England that is developed and owned by patients, staff and public together.

### THE JOURNEY SO FAR

We are not starting from scratch in achieving this vision.

Back in 1997, the NHS was in relatively poor health. Investment levels had varied considerably over previous decades, hampering proper planning. Although many patients enjoyed good care, many more experienced the trauma of poor access to primary care, long waiting times, old buildings and a winter crisis that was as predictable as the season itself.

Since then, the NHS has vastly improved. I only have to look at my own experience to see the progress that has been made. There are more staff in my team; our patients do not wait as long for operations; and their care is of a higher quality and is more personalised.

Those experiences are echoed across the country. The sustained investment since the NHS Plan (2000) has allowed the NHS to grow. As a result, there are tens of thousands more doctors, nurses and other NHS staff, hundreds of new or refurbished facilities and thousands of new pieces of equipment. Together with the reforms that have been put in place this has helped reduce waiting times, raise standards and improve the quality of care the NHS provides – care that is still provided according to clinical need and not ability to pay.

But in spite of this improvement, the views I have heard from patients, staff and the public do not always fit with the description above.

Patients have told me that they still sometimes feel like a number rather than a person. They do not know how to access the services they need to help them stay well and independent. They cannot always see a GP or practice nurse when they need to.

In short, patients lack 'clout' inside our health care system.

The public say they are sometimes confused about which NHS service they should use. They hear a lot about changes but do not know why they are being made.

Some staff tell me that they haven't been listened to and trusted. They do not feel that their values – including wanting to improve the quality of care – have been fully recognised. Nor do they feel that they have always been given the credit for the improvements that have been made.

The NHS could therefore continue to make incremental improvements.

This would not resolve the frustrations I have identified. It would mean accepting that services stay broadly as they are now. It would mean accepting steady progress rather than a step-change in reducing mortality rates. It would mean the NHS facing

mounting pressure from rising public expectations and from major public health challenges.

## A WORLD CLASS NHS

Alternatively we can choose to be ambitious and set out a clear vision for a world class NHS focused relentlessly on improving the quality of care.

Based on what I have heard and seen, I believe that only this approach allows us fully to respond to the aspirations of patients, staff and the public. Only this approach enables us to deliver the kind of personalised care we all expect.

Our vision should be an NHS that is:

- **Fair** – equally available to all, taking full account of personal circumstances and diversity
- **Personalised** – tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice
- **Effective** – focused on delivering outcomes for patients that are among the best in the world
- **Safe** – as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive.

## Summary letter

This is not about changing the way NHS is funded or structured.

Successive reports have shown not only that our system is fair, but also that other comparable systems are, in key respects, less efficient. We now need to:

- move beyond just expanding the capacity of the NHS and focus relentlessly on improving the quality of care patients receive
- be ambitious – respond to the aspirations of patients and the public for a more personalised service by challenging and empowering NHS staff and others locally
- change the way we lead change – effective change needs to be animated by the needs and preferences of patients, empowered to make their decisions count within the NHS; with the response to patient needs and choices being led by clinicians, taking account of the best available evidence
- support local change from the centre rather than instructing it – providing that the right reformed systems and incentives are in place
- make best use of resources to provide the most effective care, efficiently.

### IMMEDIATE STEPS

Some immediate steps should be taken ahead of my final report:

1. To help make care **fairer** the Secretary of State has announced a comprehensive strategy for reducing health inequalities, challenging the NHS, as a key player, to live up to its founding and enduring values.
2. To help make care more **personal**, patient choice should be embedded within the full spectrum of NHS funded care, going beyond elective surgery into new areas such as primary care and long term conditions:
  - New resources should be invested to bring new GP practices – whether they are organised on the traditional independent contractor model or by new private providers – to local communities where they are most needed, starting with the 25% of PCTs with the poorest provision
  - Newly procured health centres in easily accessible locations should be offering all members of the local population a range of convenient services, even if they choose not to be directly registered with GPs in these centres
  - PCTs should introduce new measures to develop greater flexibility in GP opening hours,



including the introduction of new providers. Our aim is that, over time, the majority of GP practices will offer patients much greater choice of when to see a GP, extending hours into the evenings or weekend.

3. To support the delivery of more **effective** care, we should establish a Health Innovation Council to be the guardians of innovation, from discovery to adoption.

4. To help make care **safer**, we should support the National Patient Safety Agency (NPSA) in establishing a single point of access for frontline workers to report incidents: Patient Safety Direct. And to reduce rates of healthcare associated infections still further we should:

- legislate to create a new health and adult social care regulator with tough powers, backed by fines, to inspect, investigate and intervene where hospitals are failing to meet hygiene and infection control standards
- give matrons further powers to report any concerns they have on hygiene direct to the new regulator
- introduce MRSA screening for all elective admissions next year, and for all emergency admissions as soon as practicable within the next three years.

5. We should ensure that any major change in the pattern of local NHS hospital services is clinically led and **locally accountable** by publishing new guidelines to make clear that:

- change should only be initiated when there is a clear and strong clinical basis for doing so (as they often may well be)
- that consultation should proceed only where there is effective and early engagement with the public and
- resources are made available to open new facilities alongside old ones closing.

Any proposals to change services will also be subject to independent clinical and managerial assessment prior to consultation through the Office of Government Commerce's Gateway review process.

## THE SECOND STAGE OF THE REVIEW

Building on these immediate actions, the second stage of the Review will set out how we can deliver the vision for a world class health service through a locally accountable NHS in which health and social care staff are empowered to lead change, supported by the right reformed systems and incentives.

## Summary letter

Groups of health and social care staff – over 1,000 people in total – will be established in every region of the country to discuss how best to achieve this vision across eight areas of care:

- Maternity and newborn care
- Children's health
- Planned care
- Mental health
- Staying healthy
- Long-term conditions
- Acute care
- End-of-life care

I want each group to listen to patients, the public and others to identify what it would take over the next decade to commission and provide world class care, using the best available evidence, and set out their plans to deliver on our vision of a fair, personal, effective, safe and locally accountable NHS.

I also have come to the view that the NHS could benefit from greater distance from the day to day thrust of the political process, and believe there is merit in exploring the introduction of an NHS Constitution. I have therefore asked NHS Chief Executive, David Nicholson, to chair a national working group of experts to consider the scope, form and content that such a Constitution might take.

These steps – local and national – will form the basis for a vision for a world class NHS, to be published in June 2008 in time for the 60th anniversary of the NHS.

Best wishes



**Professor the Lord Darzi of Denham FEng, KBE, FMedSci**

Parliamentary Under Secretary of State,  
Paul Hamlyn Chair of Surgery Imperial  
College London, Honorary Consultant  
Surgeon, St Mary's Hospital and the  
Royal Marsden Hospitals NHS  
Foundation Trust

# Introduction



**The NHS has cared for us all for nearly 60 years.**

As an NHS surgeon, working in partnership with professional colleagues across the NHS, I am proud to have learnt my skills in the NHS and to have given back to the NHS as part of a professional team. I know

we cannot take the services that the NHS and its partners provide for granted.

That is why I believe the NHS Next Stage Review is so important. It is a chance to take stock of progress made in recent years towards the vision of a patient-centred NHS set out in the NHS Plan (2000). It challenges us to look ahead for the next decade and consider what more we could and should be doing to respond to people's rising aspirations. Everyone deserves the best possible health and healthcare and we should challenge people and communities to raise their aspirations to achieve it.

The terms of reference for the Review set out a number of challenges:

- Working with NHS staff to ensure that clinical decision-making is at the heart of the future of the NHS and the pattern of service delivery

- Improving patient care, including high-quality, joined-up services for those with long-term or life-threatening conditions, and ensuring patients are treated with dignity in safe, clean environments
- Delivering more accessible and more convenient, integrated care reflecting best value for money and offering services in the most appropriate settings for patients
- In time for the 60th anniversary of the founding of the NHS, establishing a vision for the next decade of the health service which is based less on central direction and more on patient control, choice and local accountability and which ensures services are responsive to patients and local communities, whatever the circumstances

To help me understand how best to meet these challenges I have spent the last three months visiting local health communities and hearing the views of staff. I have participated in lively debates with patients and the public about the priorities they feel the NHS and its partners need to adopt to respond to their needs. Specifically I have:

- visited and spoken to 1,500 NHS staff in 17 NHS organisations across the country

## Introduction

- taken part in a nationwide day of detailed discussions on the priorities for the NHS with 1,000 patients, public and health and social care staff in nine different towns and cities
- met with representatives of 250 stakeholder groups representing the full diversity of our population and staff
- read more than 1,400 letters and emails from people up and down the country
- in preparation for the second stage of the Review, brought together over 1,000 doctors, nurses and other health and social care staff in groups in every part of the country to focus on discussing how best to plan and provide care for patients
- reviewed the evidence available for what matters to patients, staff and the public, drawing on research from the NHS Leadership team this year.

The views that I have heard and the NHS organisations that I have visited are the basis for this report. It is the start of developing the vision that I believe we need to renew for the NHS – a world class NHS that prevents ill health, saves lives, improves the quality of people’s lives and treats people with dignity and respect. It acknowledges the progress that NHS and other staff have already made in achieving that vision, describes the scope for improvement that remains, and sets out the immediate steps we should take and the challenges we need to meet over the second stage of the Review.

This vision for the future should not be just mine – or the Government’s – but a vision for the future of health and healthcare in England that is developed and owned by patients, staff and public together.



# The journey so far



**We are not starting from scratch in achieving this vision. The NHS has made clear progress over the last decade.**

Back in 1997, the NHS was in relatively poor health. Investment levels had varied considerably over previous decades, hampering proper planning. Although many patients enjoyed good care, many more experienced the trauma of poor access to primary care, long waiting times, old buildings and a winter crisis that was as predictable as the season itself. The NHS simply was not big enough or capable enough to meet patients' expectations.

Since then the NHS has vastly improved. I only have to look at my own experience to see the progress that has been made. Compared with 10 years ago:

- we have more staff – I used to be the only colorectal surgeon in my hospital. Now I am one of a team of four surgeons working with colleagues in a network that reaches out into primary care

- we can detect disease earlier and treat more patients more quickly from the moment they see their GP. My patients sometimes used to wait over a year for treatment. Now they are likely to have waited a few weeks, and even less when they are suspected of suffering from cancer and require urgent surgery
- we have made systematic changes to improve the quality of care – I used to have corridor conversations with colleagues about cases. We now discuss each cancer case in a weekly meeting as a multidisciplinary team of clinicians to agree the best recommendation for each patient's care
- we are providing more personal care with greater dignity for patients – we used to have one part-time stoma nurse, now we have two full-time stoma nurses, two specialist nurses and a nurse consultant, working to help local people and practitioners improve the quality of people's care. We have a colorectal patient user group which meets every three months with staff in my team, helping to personalise people's care

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I only have to look at my own experience to see the progress that has been made

## The journey so far

- the operations we carried out used to be highly invasive – most of what we do now is keyhole surgery developed with the help of NHS investment in technology and training.

This progress is replicated right across the country.

The *NHS Plan* (2000) diagnosed the problems and wrote the prescription that provided sustained, unprecedented investment to increase capacity. Since then this investment has allowed the NHS to grow. As a result, there are tens of thousands more doctors, nurses and other NHS staff, hundreds of new or refurbished facilities and thousands of new pieces of equipment.

The NHS now sees and treats more patients than ever before. Last year, on average every day, we saw over 50,000 people in accident and emergency (A&E), held nearly 900,000 GP consultations and took over 16,000 calls to NHS Direct.

The NHS continues to provide care based on clinical need and not ability to pay and remains one of the fairest health systems in the world.

Care is more personalised than it was. New primary care services, such as walk-in centres and NHS Direct, enable patients to access and receive care more conveniently. People should wait no longer than four hours in A&E and, if they really need to, can usually see a GP within 48 hours. More people with serious mental health problems are now supported in their own homes, without the interruption to daily life that hospital admissions would bring.

The genuinely impressive reductions in maximum hospital waiting times, unthinkable even a few years ago, will be complete by December 2008. Consequently, patients will be able to expect treatment, including operations, within a maximum of 18 weeks of referral by their GP – and much sooner if the GP suspects cancer. The average waiting time should be closer to nine weeks.

Better care now results in better outcomes for patients. For example, we have now substantially reduced cardiovascular disease mortality rates meeting the target four years early, and cancer mortality has also fallen significantly. These outcomes will continue to improve – saving many more thousands of lives each year.

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**Better care now** results in better outcomes for patients



Care is more safety focused. We now have systems in place to report and learn from safety incidents, and we are using this to prevent errors occurring in the first place. A much stronger focus on cleanliness and infection control is enabling the NHS to make real progress against MRSA.

These improvements are down to the hard work of all staff involved, and are improvements to be proud of. A number of existing reforms support these improvements and help make care fairer, more personal, more effective, and safer. Independent bodies like the National Institute for Health and Clinical Excellence (NICE), the Healthcare Commission (HCC) and the Commission for Social Care Inspection (CSCI) have been created to set

standards and hold organisations to account for meeting them.

Reforms such as payment by results (making it easier for money to follow the patient) and, in some places, effective practice-based commissioning are beginning to make it easier for patients to choose where they are treated – and to get care more locally. The commissioning process itself is starting to drive improvements in the quality of care provided to patients – although there remains significant work to do to improve commissioning to fully support the delivery of our vision.

NHS hospitals, in many cases as NHS foundation trusts, are now more clearly accountable to local communities and are better placed to



## The journey so far

innovate to improve the quality of the services they provide.

Independent sector providers have also helped extend choice, add capacity and spur innovation. They have increasingly become a fixture of NHS provision, with three-quarters of a million NHS patient care episodes performed by the independent sector to date.

This evidence of progress is confirmed by external evaluation. A study earlier this year by the Commonwealth Fund, an independent health research group, found that our improvements have made this country the top healthcare system among five comparator countries, rating the UK better overall

than Australia, Canada, Germany, New Zealand and the United States – an improvement since the previous report from the same group.<sup>1</sup>

So, if the NHS is objectively in such good health, why – subjectively – do the views I have heard from patients, the public and staff not always fit with the description above?

Patients have told me that they still sometimes feel like a number rather than a person. The research shows they want to be treated as people, not as sets of symptoms or conditions. They want care to fit into their lives, not have to fit their lives around the care they receive. And of course they want us to get the basics right – they expect competent staff, to be treated with dignity and respect, their notes to



<sup>1</sup> Commonwealth Fund: Mirror, Mirror on the Wall: An international update on the comparative performance of American healthcare, May 15, 2007 (Updated May 16, 2007) Volume 59



be available and for buildings to be clean. Research shows us that while 80% of patients are satisfied with their last hospital inpatient visit, 56% of hospital patients told us they did not have an opportunity to talk to a doctor.

The public say they are sometimes confused about which NHS service they should use. They want us to treat all patients fairly – based on need, not ability to pay, or ability to ‘work’ the system – and they want the NHS to be there for them when they need it most. They hear a lot about the reforms that are being made, but do not know the reasons why the changes are being made and how it will deliver higher quality than before. We need to respond to these concerns by being much clearer about the case for change where it is necessary, and showing how it will improve quality.

Staff often feel left out of the changes that are happening. It is true that in some cases that is because greater power for patients is challenging old ways of doing things, but in other cases staff can see that changes need to be made. They now need the space to act on this.

In part, that means changing the conceptualisation but not the necessity

of reform. I recognise this from my own experiences. I don’t discuss the merits of payment by results with my colleagues in the scrub room or the nurses’ station. There is a time and a place for that – but what we talk and care about are the cases we have done, the techniques we are using and the outcomes we are getting for our patients.

I’ve seen that targets can be effective – and I have seen the difference they make for patients in terms of driving progress on reducing waiting times – but they are not always the answer and sometimes they can seem perverse.

I have considered all of these points as I have put together this interim report. We should acknowledge the undoubted progress made over the last decade – the NHS is not only back on its feet, it is world class in some areas. It could continue to move forward on this basis. That would mean incremental improvements in care but it would not resolve the frustrations and shortcomings I have identified. The challenge is to move from world class in some aspects to world class in all – to take the NHS from ‘good’ to ‘great’.

I do not believe we should change the way the NHS is funded or structured.

## The journey so far

Successive reports, including the *NHS Plan* and the reports from Derek Wanless<sup>2</sup>, have shown not only that our system is fair, but also that other comparable systems are, in some important respects, less efficient. The last few years have demonstrated that, through investment in primary, community, hospital and social care, the current model can deliver significant improvements and gives us a meaningful chance of meeting the challenges of the future.

But I do believe that we can only achieve our vision – and genuinely live up to the founding principles of the NHS – by doing things differently. This means:

- moving beyond expanding the capacity of the NHS and renewing our focus on improving the quality of care patients receive
- being ambitious – responding to the expectations of patients and the public of a more personalised service by challenging and empowering NHS staff and others locally to deliver on them
- changing the way we lead change – effective change needs to be animated by the needs and preferences of patients, empowered to make their decisions count within the NHS; with the response to those patient needs and choices led by clinicians, taking account of the best available evidence.
- supporting local change from the centre rather than instructing it – ensuring that the right reformed systems and incentives are in place
- making best use of NHS resources to provide the most effective care, efficiently.

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<sup>2</sup> Securing Our Future Health: Taking a long term view, 2002 and securing good health for the whole population: Final Report, February 2004

# A world-class NHS – our vision



Over the last three months, I have spoken to patients, the public and NHS staff about what makes a world-class NHS. I know that there is real enthusiasm to be ambitious and renew our vision for an NHS fit for the 21st century.

I am convinced we should lift our sights. Our aim should be nothing short of creating a world-class NHS that strives relentlessly to improve the quality and personalised nature of the services and care patients receive.

Achieving this means responding to the things that matter most to people. I have heard repeatedly that care should be:

- **fair**
- **personalised**
- **effective**
- **safe**

As a doctor working in the NHS, I agree. We should judge success by these criteria. I believe our vision should be of an NHS that provides care that is:

- equally available to all, taking full account of personal circumstances and diversity

- personalised to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice
- focused on delivering quality outcomes for patients that are among the best in the world
- as safe as it possibly can be, giving patients and the public the confidence they need in the care they receive

The next four chapters set out a vision for the future in each case: why these four aspects of quality matter; what we need to change; and the steps – immediate and over the second stage of this Review – I believe we must now take. I then set out how we can deliver on them – through a locally accountable NHS in which health and social care staff are empowered to lead change, supported by the right systems and processes.

During the second stage of the Review, groups of NHS and social care staff will be established in every region of the country to discuss how best to achieve this vision for each of eight areas of care:

- Maternity and newborn care
- Staying healthy
- Children's health

## A world-class NHS – our vision

- Planned care
- Acute care
- Mental health
- Long-term conditions
- End-of-life care

I want each group to listen to patients, staff and the public and identify what it would take over the next decade to provide world-class care, using the best available evidence and help to reduce health inequalities. They will consider the priorities identified by patients, public, staff and partners and set out their plans to deliver on our vision.





## VISION

**A fair NHS must continue to be equally available to all, taking full account of personal circumstances and diversity.**

## A FAIR NHS MATTERS

Our evidence shows that the public and staff care deeply about the NHS and that one of the things that matters to them is that patients are treated fairly – based on need, not ability to pay.

One of the great triumphs of the NHS, largely tax-funded, universal and free at the point of need, is that it is fair and equitable. The public are rightly proud of this and throughout the last few months I have been struck by their fundamental support for this principle. When we asked participants at the consultative event whether they agreed that the NHS should continue like this into the 21st century, an overwhelming 92% of people said yes.

The majority of the public believe that they have a responsibility to fund the NHS, that the NHS has enough money, but that it is not always well used.

## WHERE WE ARE NOW

Although major improvements in care have been made over the last decade – as I described in chapter 2 – these improvements have not been universal. The breadth and scale of inequalities within England are still striking. Major inequalities exist in life expectancy, infant mortality and cancer mortality. Too many of the poorest communities experience the worst health outcomes. Although the nation's health has improved over the years, including the health of those born with fewer socioeconomic advantages, a boy born in the City of Manchester today is now likely to die almost ten years earlier than a boy born in the Royal Borough of Kensington and Chelsea.

The gap in life expectancy between the most deprived and least deprived areas has widened, despite improvements in life expectancy in the most deprived areas. Someone's social status or where they live should not affect when they die.



## A fair NHS

There is also evidence that the opportunity to access healthcare is actually worse in areas of greater need. The maps below show how areas where life expectancy is lowest for men (red, map 1) – concentrated in London, the Midlands, Yorkshire, North West and North East – broadly match the areas with fewer GPs per head (red, map 2). The picture is the same for women.

Mid Devon PCT, for example, has over twice as many GPs per head of weighted population as Oldham PCT.

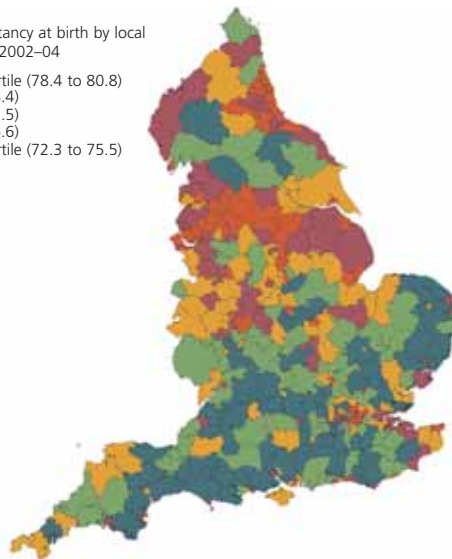
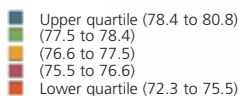
And sadly it turns out that our current GP system has actually led to a *larger*

inequality in the distribution of GPs across the country over the past two decades even as the overall number of GPs has increased. We therefore need to open up the supplying of GP services in deprived communities to a wider range of providers – be they GP practices or new private GP providers – so as to seek to improve equity in the availability of GP services.

I also believe we should ensure that taxpayers' money is used well. When compared with other countries, the NHS should achieve high levels of productivity because of the way we fund care and our primary care system in particular.

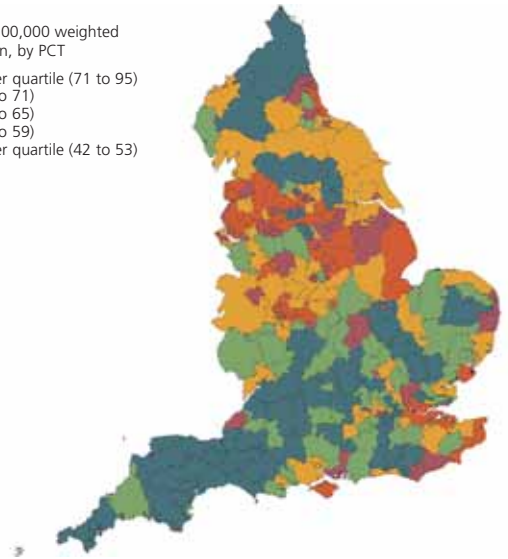
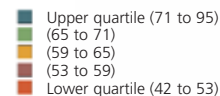
**Map 1**

Male life expectancy at birth by local authority area, 2002–04



**Map 2**

GPs per 100,000 weighted population, by PCT



Source: Office for National Statistics, Life Expectancy 2002–2004

Source: Information Centre – Workforce Census 2006

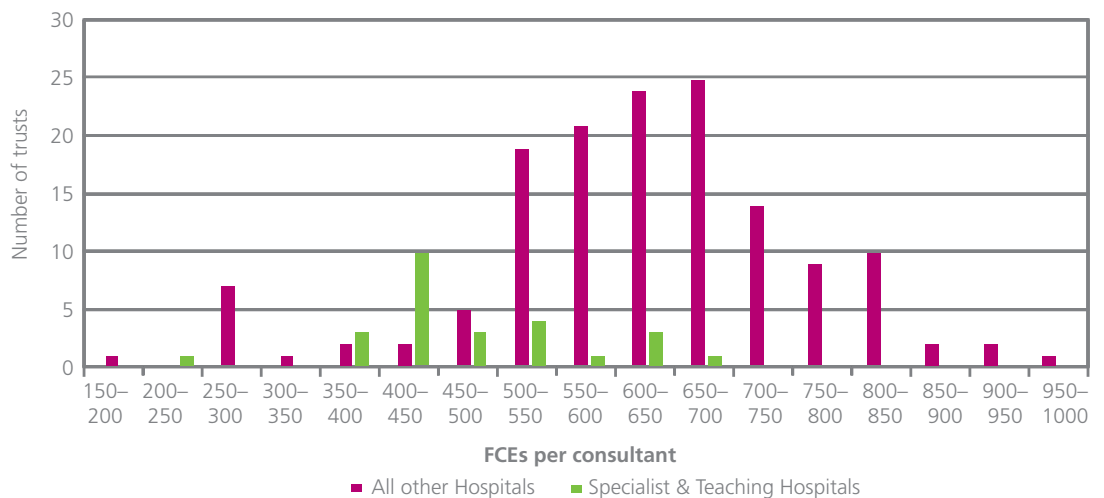
However, there are still areas in which significant variations in productivity exist – and in which we could do more to improve the way we measure productivity. For example, the graph below shows how numbers of ‘finished consultant episodes’ per consultant vary across NHS trusts on a typical index of productivity.

### SCOPE TO IMPROVE

To create a fairer NHS, we have to focus on improving access to health and social care services for people in disadvantaged and hard-to-reach groups and those living in deprived areas. This also means making services more personal: designing and delivering services that fit with people’s lives will help to reduce inequalities in health and social care outcomes.

I know from what I have seen around the country that, while the NHS has a big part to play, the NHS cannot do this on its own. Nationally, cross-government action needs to focus on the wider social determinants of health, such as early child development, poverty, lifestyle, housing etc. And locally the most successful action happens when different agencies work together. PCTs have a key role in working with local authorities, Local Strategic Partnerships, communities, industry, the voluntary and private sector and individuals to ensure a broader approach and focused action.

Finished consultant episodes per whole time equivalent consultant, 2004/05



### NEXT STEPS

Locally, the eight clinical pathway groups in each region, described in chapter 3, will consider as part of their work how to improve fairness in each pathway.

Nationally, the Secretary of State has recently announced a comprehensive strategy for reducing health inequalities, challenging the NHS, as a key player, to live up to its founding and enduring values of universality and fairness. This will aim to ensure that the NHS and other services:

- close unjustified gaps in health status between individuals, whatever their background
- ensure fair access to NHS services for everyone
- treat all patients fairly, with high quality and good outcomes of care for all.





# A personalised NHS



## VISION

**A personalised NHS must be tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice.**

## WHY IT MATTERS

People have told me consistently that personalised care matters. But we all know – as professionals, friends, family, carers and users of the NHS ourselves – that patients sometimes feel treated as numbers, are made to wait too long, do not have their condition or treatment explained sufficiently, feel lost in the system, receive poor ‘customer service’, are denied choice, and experience basic lapses in care. Care may be personal, but too often it is experienced as impersonal. And with patients coming into contact with dozens of different staff along a typical care ‘pathway’ it may only take one person to undermine a good patient experience.

Based on what I have heard, I have so far identified four broad factors on which we could improve:

- access
- dignity and the patient as a person
- integrating care/partnership
- choice and personal control

## IMPROVING ACCESS TO PRIMARY AND COMMUNITY CARE

As I set out in chapter 2, NHS staff have helped deliver major improvements in access to care over the last decade.

There have genuinely been tremendous improvements in access to care in the past decade, particularly for planned specialist care. When the ‘18 weeks’ target is finally met in 2008, all patients referred by their GP for medical or surgical consultant-led care will be entitled to choose to receive clinically appropriate treatment quicker or as quickly as patients in any comparable country. This was scarcely imaginable 10 years ago. Already, patients should not need to spend more than 4 hours in A&E (unless

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NHS staff have **helped deliver major improvements** in access to care over the last decade

there is a clinical need) and the great majority of patients can see their GP within 48 hours. What I have learned from talking to people up and down the country is that what matters is that patients really feel the difference – and that we avoid reducing it to a form-filling exercise for staff. A key measure of success ought to be listening to what our patients tell us about their experience.

The issue that has been raised with me most frequently during the first part of this Review is how difficult some people still find it to access primary care.

More than 80% of NHS patient contact takes place in primary care. Most secondary and tertiary care is accessed through primary care, and millions of people receive community-based care, for example for long term conditions. In my visits around the country, I have witnessed for myself the strength of our primary care and community services. Our registered GP list system is renowned internationally. Our primary care system co-ordinates care for patients in a way few other countries match. There are strong

bonds of trust between staff and their patients, families and carers.

But primary care faces a number of pressing challenges in terms of people's experience of access. A number of steps have already been taken. I believe we need to take further action now to meet these challenges.

**It's when my GP refers me onwards to a specialist clinic that the problems start – the left hand doesn't know what the right hand is doing.**

[Consultative event – Maidstone]



## EQUITABLE ACCESS TO PRIMARY MEDICAL CARE

As I described in chapter 4, there is a correlation between areas with lowest life expectancy and fewer GPs per head of population.

This is clearly unacceptable and so **the Government should invest new resources to bring at least 100 new GP practices, including up to 900 GPs, nurses and healthcare assistants into the 25% of PCTs with the poorest provision**, ie fewest primary care clinicians, lowest patient satisfaction with access and poorest health outcomes. These new practices will increase capacity and offer an innovative range of services, including extended opening hours. They will improve health outcomes in these areas, with more targeted and preventive interventions that identify and tackle illness at an earlier stage.

The vast majority of patients who see GPs and other professionals in primary care are highly satisfied with the care they receive,<sup>3</sup> but the consultative event in September showed that many

people are seeking the opportunity to access routine primary care from a GP in the evenings or at weekends. And a quarter of patients still report that they cannot book advance appointments at their GP practice. It is also significant that young working males and black and ethnic minority communities are more likely to report difficulties in accessing GP services.

The following further action should therefore now be taken:

- **We should invest new resources to enable PCTs to develop 150 GP-led health centres, situated in easily accessible locations and offering a range of services to all members of the local population (whether or not they choose to be registered with these centres), including pre-bookable appointments, walk-in services and other services.** The guiding principle will be to ensure that any member of the public can access GP services at any time between 8am and 8pm, seven days a week. These centres will reflect local need and circumstance and maximise the scope for co-location with other community-based services such as diagnostic, therapeutic (eg physiotherapy),

3 2006/07 GP Patient Survey:  
<http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/GPpatientsurvey2007/index.htm>



pharmacy and social care services. PCTs will be expected to commission these new health centres on a level playing field from existing GP groups or other providers.

- PCTs will work with all new and existing GP practices in their areas to develop greater flexibility in opening hours – our aim is that at least half of all GP practices will open each weekend or on one or more evenings each week. Where existing GPs do not start to offer these extended services, PCTs will be able to use the funding we make available for this to commission new services from other GPs, GP federations or other providers.
- **We will ensure that an increasing proportion of the NHS payments made to GP practices are linked to their success in attracting patients, and the views of their patients, including the ability to book advance appointments and the ability to see a GP within 48 hours.**
- **Later this month key information about all GP practices – including the results of the patient survey, practice opening times and performance against key quality**

**indicators – will be made available on a single website, NHS Choices, via [www.nhs.uk](http://www.nhs.uk).**

This service will provide people with reliable and accessible information on GP practices to help them choose which one is likely to best meet their needs, and – if they are not satisfied – how to change their practice.

I will also be considering whether more convenient hours should apply to services provided in secondary care settings. Providers should certainly be considering whether to make bookable slots available in the evenings and at weekends for patients requiring outpatient appointments.

#### **OUT-OF-HOURS SERVICES**

During the first part of this Review, I have heard many people say that they find it confusing to know which NHS service to access for routine or urgent care when their GP practice is not open. This matters especially for people with long term conditions who are usually cared for by staff at the local GP practice, but whose condition deteriorates at a time when the practice is shut. Should they go to A&E? Ring NHS Direct? Find a walk-in centre? Phone the local out-of-hours number if they can find it? Try the pharmacist? Wait until the morning?

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Our aim is that **at least half of all GP practices will open each weekend or on one or more evenings each week**



I believe that commissioners and providers need to understand how people are accessing services and use this information to ensure they are planning and providing the right mix of services to meet people's needs.

We need to find a way of enabling people with different lifestyles to access care in ways that suit them, while ensuring that everyone knows how best to access care, particularly urgent care, when they need it. And we need to find ways to engage people so that minor symptoms or lifestyle risks are not ignored until they have become established diseases. In particular, we need to do this for those people less equipped to engage with traditional general practice, who frequently lead, busy lives and find it hardest to find time to see their GP.

As I said in my London Review<sup>4</sup>, we should consider options to improve and simplify access for the public to urgent healthcare by exploring the introduction of a single three-digit number in addition to the emergency services number 999. We will also identify how pharmacies can best support seamless urgent care for patients. We know that people continue to have concerns about

prompt and easy access to medicines, including access to urgent repeat medicines.

### **FUTURE STRATEGY ON PRIMARY AND COMMUNITY CARE**

I believe we need to go further still to meet the challenges of the next decade. In part two of the Review, we will develop a vision for primary and community care services and a strategy that brings together these access issues with the other main factors determining personalisation, effectiveness, fairness and safety.

To help me, I will be drawing together an advisory board that includes GPs, community nurses and other health and care professionals.



4 NHS London: Healthcare for London: A Framework for Action, 2007

### Advisory Board

Dr Sam Everington (GP from East London and Member of BMA Council)

Dr Michael Dixon (GP from Devon and Chair of NHS Alliance)

Prof Mayur Lakhani (GP from Leicestershire and Chair of Council of Royal College of GPs)

Sir John Oldham (GP from Glossop and former-Head of Improvement Foundation)

Ursula Gallagher (Community Nurse and Director of Quality, Ealing PCT)

Andrew Burnell (Community Nurse and Director of Provider Services and Nursing, Hull PCT)

Paul Farmer (Chief Executive of MIND)

Anne Williams (President of ADASS)

Alwen Williams (CE, Tower Hamlets PCT)

Dr David Colin-Thomé (National Clinical Director for Primary Care)





The review will need to include:

- the development of a vision of world-class primary and community services, capable of tackling existing challenges of access and inequality and promoting choice and control, as well as focusing ever more strongly on promoting health, preventing illness and managing long term conditions, not least in response to the ageing of the population and lifestyle risk factors such as obesity. This is likely to mean reaching out to the harder-to-reach groups among our diverse population rather than waiting for them to present at the GP surgery
- a genuine understanding of what the barriers and enablers are to achieving this vision, in every local area
- proposals for new models of care – and linked proposals for changes to estates, workforce, training and accountability

The review will also need to identify how the contractual and commissioning arrangements for primary medical care can continue to evolve to reflect these trends and challenges, including:

- how to reshape incentives to provide a stronger focus on health outcomes and continuous quality improvements; whether there should be an independent process for setting and reviewing outcome measures in

the framework; and whether there should be greater flexibility for PCTs in setting outcomes that reflect local needs and priorities

- how to provide a more equitable link between the funding that a GP practice receives and the number of patients for whom it provides care, and the relative needs of its local population, based on the principles that practices should be fairly rewarded for taking on new patients and that 'money follows the patient' if he or she chooses to switch practices
- how to expand patient choice in primary care, including exploring new models that enable patients to switch GPs more easily and register with GP practices near their workplace, and how to make it easier for the new entrants to start providing primary care on contract to the NHS as of right in underdoctored areas without a slow and bureaucratic procurement process
- how to involve the fullest possible range of service providers, including existing GP practices, voluntary sector organisations and independent sector providers in developing innovative solutions to tackling inequalities, improving patient access, developing more responsive services and increasing patient choice.



## A personalised NHS

The introduction of nationally procured independent sector providers in planned care has been successful in introducing innovation and changing the culture of surgery. As we move from expanding capacity to focus on creating a more personalised service, so the focus of the independent sector should shift to helping services locally to respond quickly to patients' needs. This means a shift from national procurement to locally procured services and a greater role for the private and voluntary sectors in primary and out-of-hospital care. I believe that the innovative practice that independent sector providers can bring will help realise dramatic improvements for patients and challenge the established ways of working among NHS organisations.

### DIGNITY AND A FOCUS ON THE PATIENT AS A PERSON

I know from my own patients how much they value being treated with dignity and respect. I hear it most from older people, when treated in hospital, that they who are concerned about:

- feeling neglected or ignored while receiving care
- being treated more as an object than a person
- feeling their privacy was not respected during intimate care
- needing to eat with fingers rather than being helped with a knife and fork
- generally being rushed and not listened to



I believe that the innovative practice that independent sector providers can bring will help realise dramatic improvements for patients and challenge the established ways of working among NHS organisations



- beds not being cleaned
- not being helped to wash
- mixed-sex wards.

At the nationwide consultative event in September, more than 50% of patients, public and staff said there needs to be a lot or a fair amount of improvement in the dignity and respect with which patients are treated. Information and communication were also cited as important and requiring improvement. And when things do go wrong, we also need to improve the way complaints are treated.

This is a key challenge for all clinicians. Nurses have a key role to play here, but we should all be constantly challenging ourselves to find ways of improving the patient experience. For

example, when I am conducting a lengthy operation and I know that the parent, spouse or carer of the patient will be anxiously waiting for news, I will often arrange for them to receive a call to keep them informed. Similarly, we should ask ourselves, does this patient really need to travel in to get test results or to hear how successful my surgical intervention has been? For example, patients who are terminally ill, or dying, may find the bustle, limited privacy and noise of a busy ward a stressful and inappropriate environment, or that they are subject to clinical tests and interventions which may be of limited real value.

### **INTEGRATING CARE**

There is evidence that one-stop care – for example by carrying out a number of diagnostic tests together, by co-locating care under one roof, or by



making better use of information and information technology – helps improve the effectiveness and safety of care.<sup>5</sup> Basing that care where it is most needed also increases its connection to local communities, eg locating children’s health services on extended school sites.

Integrating care is also a key driver of personalisation because, for example, there are likely to be fewer appointments on a typical pathway, greater familiarity between patient and staff, better information for the patient, and a more ‘seamless’ experience for the patient. Designing services in terms of care pathways is the best way to ensure that the quality of care and the patient’s perspective are foremost, with organisational boundaries a secondary consideration. This pathway approach will be taken locally for part two of the Review. At the heart of this will be the relationship between local government and the local NHS. In effect, we need a single health and wellbeing service in every local community, shaped around the user, not the organisation.

In my experience, the best care is provided when there is collective accountability for the outcomes at each point along the pathway. Based on this and on what I have heard from NHS staff on my visits, we could do

more to ensure that current processes, including the NHS tariff, support this approach.

Not all of the conclusions of my review of London’s health services will apply nationally, but one which I believe does is the principle of ‘localise where possible, centralise where necessary’. As we know from the consultation for the *Our Health, Our Care, Our Say* White Paper (2006), patients, families and carers prefer where possible to be treated close to home, and medical advances make this increasingly possible. For instance, modern surgery allows more day cases, outside major hospital settings. The US health system has its challenges but the shift in outpatient appointments from hospital to community settings (90% in hospital in 1981; 50% in 2003)<sup>6</sup> shows the scope for care to become more personalised in this respect. In England, it is estimated that over 90% of outpatient appointments still take place in hospital.

### **CHOICE AND PERSONAL CONTROL**

Patients increasingly aspire to greater control and choice over the services they receive. I have seen how greater control can be offered to patients by ensuring that they have excellent information about the care options available to them and then by sharing decisions between patient and

5 Making the shift: Key Success Factors, July 2006, University of Birmingham Health Services Management Centre.

6 American Hospital Statistics; CSF; AHA Trendwatch Chatbook; CMS; Office of the Actuary

clinician, leading to a personalised care plan tailored to the patient and agreed with them and their carers.

So far, the drive towards greater choice in the NHS has been focused largely on those patients referred for one-off elective treatments. Surely equally important is offering more choice to those patients who have to live for many years with an enduring medical condition. National patient groups are keen that the NHS should increasingly offer such patients greater choice and control, through the care planning process and supported with better information and help.

I have also been impressed by what I have heard about the introduction of individual budgets in social care linked to direct payments and individual budget pilots, which have clearly transformed the care of some social care users. From this, we need to learn how to support and allow eligible service users increasingly to design their own tailored care and support packages. This could include personal budgets that include NHS resources. As a first step, we will encourage practice-based commissioners to use NHS funds much more flexibly to secure alternatives to traditional NHS

provision where this would provide a better response to an individual's needs, eg through respite care or support, installing grab rails to help maintain independence, self-monitoring equipment for people with long term conditions, supporting carers of terminally ill patients, and so on.

### **NEXT STEPS**

This chapter has set out my view of the difference personalised care can make – and some of the steps we should take now to act on this. In the next stage of the Review, the eight clinical pathway groups in each SHA region, described in chapter 3, will consider how to improve personalisation in each pathway. They will do this in partnership with patients, carers and their advocates.

# An effective NHS



## VISION

**An effective NHS must therefore focus on delivering outcomes for patients that are among the best in the world.**

Providing effective treatment and care is what saves lives, improves the quality of people's lives and prevents them getting ill. In my experience it is also the reason that most staff join the NHS in the first place.

At the consultative events, we asked people what the top priority for improvement was. 'Getting the right treatment and drugs' came out top.

Preventive care matters because if the NHS can support people to make healthier choices, they can avoid ill health. The alternative is that smoking and unhealthy eating, for example, can lead to long term conditions such as heart disease, diabetes, asthma and respiratory problems such as chronic obstructive pulmonary disease.

There are currently over 15 million people in England with a long term condition and who are proportionately far higher users of health services. They account for 55% of GP appointments, 68% of outpatient and A&E attendances and 77% of inpatient bed days.<sup>7</sup>

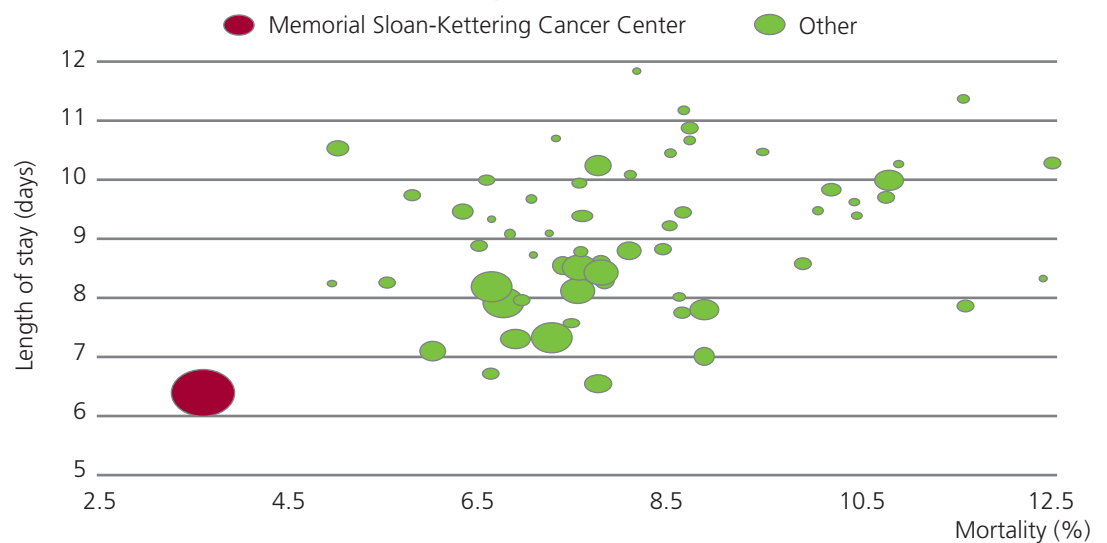
It also matters because it can provide better value for money. This was an argument Derek Wanless made in his 2004 report *Securing Good Health for the Whole Population*. He made the case for engaging the public in making healthier choices to save a potential £30 billion by 2022/23.

Effective care matters of course because patients should get the best outcomes. The evidence also shows that the most effective treatment is very often the most efficient treatment.



## Risk-adjusted mortality from cancer against length of stay for institutions in New York State

The size of the circle indicates the number of patients treated



Source: BMJ 2005; 330; 530-533 "What can the UK and US health systems learn from each other: Lois Quam and Richard Smith"

The Memorial Sloan-Kettering Cancer Center in New York provides an excellent illustration of this point. Here, it is possible to see how volume and specialisation can be linked to clinical excellence.

Reductions in the last decade in mortality from these two diseases have saved 50,000 and 150,000 lives respectively through a combination of better prevention, earlier detection and better treatment.

### WHERE WE ARE NOW

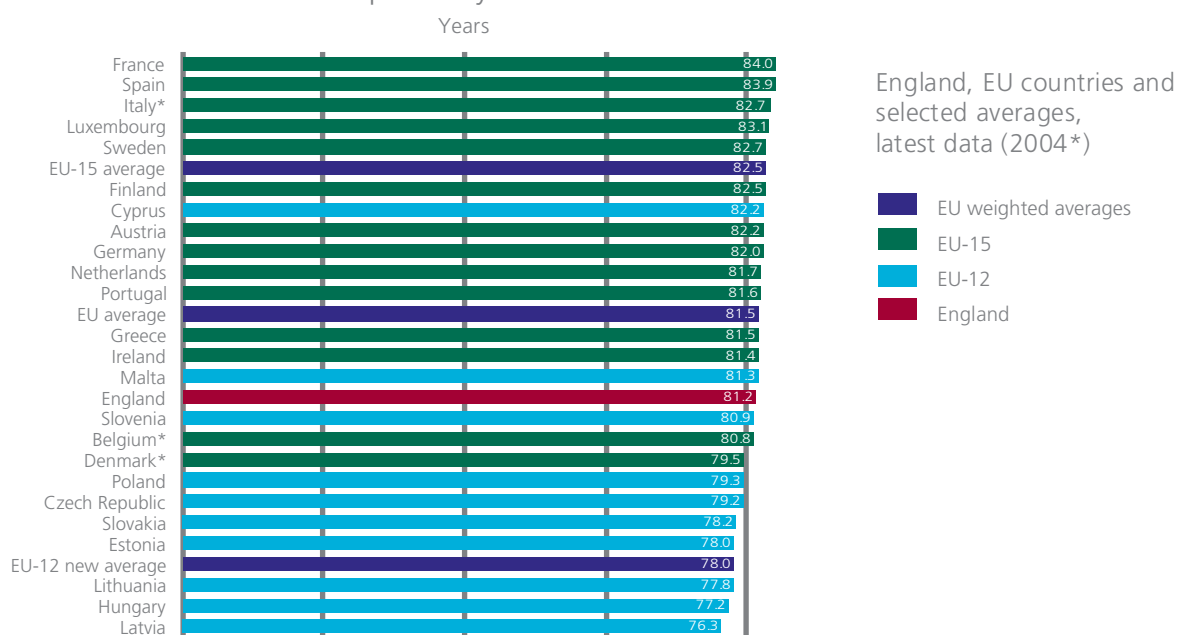
There have been clear improvements in life expectancy over recent years. Male life expectancy at birth in England is at its highest recorded level: 76.9 years in 2003/05 compared with 74.8 years in 1996/98. The same is true for women, with average life expectancy at birth standing at 81.2 years in 2003/05 compared with 79.8 in 1996/98.

These improvements in life expectancy can, in large part, be attributed to tackling the major diseases – cancer and cardiovascular disease in particular.

### SCOPE TO IMPROVE

Despite these improvements, there remains much more we can do – in terms of both effective prevention and effective treatment. The scope for improvement and the challenges facing us can be illustrated by looking at how we compare with other countries, the variations in the effectiveness of care that exist within England, and how we are responding to the emergence of new treatments and technologies.

## Female life expectancy at birth



\*Denmark, Italy 2001; Belgium – 1997

Source: England – Government Actuary's Department. Web link [www.gad.gov.uk/](http://www.gad.gov.uk/),  
All other countries – WHO, Health For All Database, June 2007. Web link [www.euro.who.int/hfad](http://www.euro.who.int/hfad)

Although we have seen significant increases in life expectancy over the last decade, average life expectancy in England is still not as high as in some other countries. This is particularly true of life expectancy for women.

Healthy life expectancy is not increasing at the same rate as overall life expectancy. For men in England in 2003, the difference between overall life expectancy at birth and the expected number of years lived in good health was 8.7 years. For women the difference was 10.7 years.

**74% of the public at the September consultative event agreed that the NHS should focus more on preventing people becoming ill than on further reducing waiting times.**

Although we have seen significant increases in life expectancy over the last decade, average life expectancy in England is still not as high as in some other countries

The September consultative event illustrated the growing appetite among the public for the NHS to provide greater support and advice to help them stay healthy. And with unhealthy behaviours currently forecast to rise, the economic viability of the NHS demands this.

We therefore need to pursue evidence-based interventions that support people to make healthy choices and prevent ill health. For example, we need to do more to tackle the problem of obesity, especially in childhood.

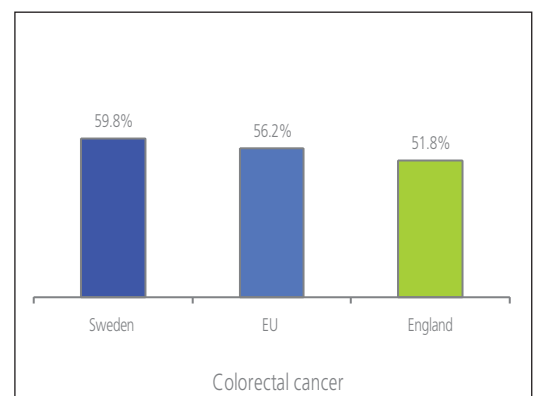
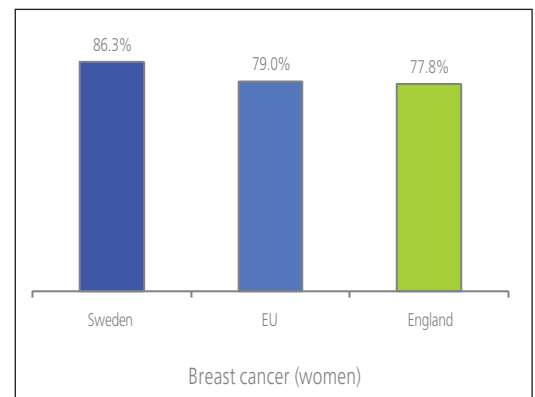
And as the NHS moves from being a sickness service to a wellbeing service, we need services that engage members of the public much sooner, which help them understand their risk factors and which equip them to take better control of their health and the lifestyle factors that affect it, such as exercise, obesity, smoking. In the next stage of the Review, I will continue to look at the case for shaping services which provide this kind of life and health checkup and at other routes that encourage individuals to take greater responsibility and control over their own health.

The focus on prevention and on early intervention means the Government

must ensure that the NHS is rapidly able to adopt new vaccines or new approaches to screening which are recommended by the Joint Committee on Vaccination and Immunisation and the UK National Screening Committee.

And while the mortality rate for cancer has fallen, there is still scope to improve outcomes. For people diagnosed with cancer in 2000/01, before the NHS Cancer Plan took effect, the proportion who were alive five years later is significantly lower in England compared with the best

Cancer survival – percentage alive five years after diagnosis<sup>8</sup>



8 Recent cancer survival in Europe: a 2000–02 period analysis of Eurocare – 4 data, Verdecchia et al (published 21 August 2007)



performing countries. This is largely because people in England were diagnosed with more advanced stage disease. To improve survival rates we need to focus on getting people to come forward earlier when they have symptoms and on ensuring they are diagnosed quickly.

Even within England there are significant variations in the quality and effectiveness of care that people receive.

Taking stroke as an example, the graph below shows that in the North East of England patients were more likely to be treated in stroke units with the six key features associated with high quality stroke care, namely:

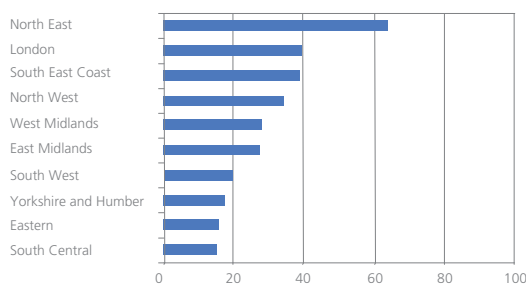
- continuous physiological monitoring (ECG, oximetry, blood pressure)
- access to scanning within three hours of admission

- access to brain imaging within 24 hours
- policy for direct admission from A&E
- specialist ward rounds at least five times a week
- acute stroke protocols/guidelines.

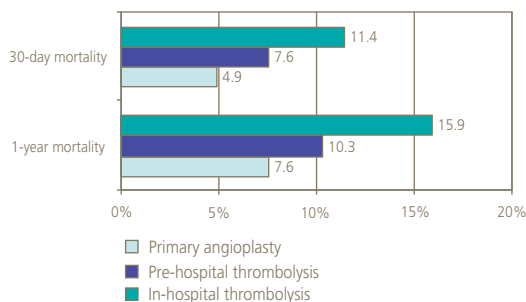
The statistics in the graph are far from impressive. And recently, many countries, including Australia, Canada and Germany, have taken advantage of new developments in stroke care and now give some patients a type of clot-busting treatment that has been shown to improve outcomes. Here, this treatment is available in only a handful of specialist centres.

We are also beginning to lag behind other countries in treating heart attack patients with primary angioplasty (a technique for unblocking arteries carrying blood to the heart muscle as the main or first treatment for patients

Proportion of sites with acute stroke units with five or six key features<sup>9</sup>



Outcomes from angioplasty vs thrombolysis<sup>10</sup>



<sup>9</sup> National Sentinel Stroke Audit 2006

<sup>10</sup> Long-term outcome of primary percutaneous coronary interventions in prehospital and in-hospital thrombolysis for patients with ST-Elevation Myocardial Infarction. Journal of the American Medical Association. 2006 296:174a-175e



suffering a heart attack). For some patients, the effectiveness of this new treatment compared with the

more conventional treatment of administering thrombolysis is stark.

I am pleased that the Department of Health is running a feasibility study, looking at the extent to which primary angioplasty can be rolled out as the main treatment for heart attack in England. But we need to accelerate this to get it in place much faster.

We need to build an NHS that is able to harness the tremendous benefits that can flow from new treatments and technologies such as these as swiftly as possible.

But effectiveness is not just about making use of the very latest treatments and technologies. It is also



about ensuring that patients receive well co-ordinated and integrated care.

For example, we know that the care of patients with long term conditions is not as good as it could be and does not always meet recommended guidelines. Taking diabetes as an example, the National Service Framework recommends that patients with diabetes should agree to a care plan to manage their conditions, as the best results are achieved by:

- patients engaged in their own care and empowered to manage it themselves or with the help of carers
- organised diabetes teams that actively seek out people to ensure that they get the best care
- partnerships between people with diabetes and health and social care professionals to solve problems and plan care.

However, despite this guidance we know from a 2006 Healthcare Commission survey of people with diabetes that nationally less than 50% of people actually have an agreed care plan to manage their diabetes.

In terms of people with serious mental health problems, 2007 Healthcare Commission survey reported that 25%

## An effective NHS

are still not involved in drawing up their care plan.

And looking across a range of long term conditions – cardiovascular disease, diabetes, dementia, COPD – some initial analysis by the Department of Public Health and Epidemiology at the University of Birmingham suggests that less than 50% of patients eligible for treatment were receiving optimal treatment for their condition.<sup>11</sup>

### NEXT STEPS

I believe the emerging picture is clear. Although some progress has been made, we can do much better in delivering the most effective care and outcomes for patients.

Locally, the eight clinical pathway groups in each SHA region, described in chapter 3, will consider how to improve effectiveness in each pathway in the second part of this Review.

Nationally, I believe we should focus on facilitating innovation and on creating a clear quality framework for healthcare.

### Innovation

Since the creation of the NHS, innovations in pharmaceuticals, medical devices and clinical care have improved the quality of patients' lives.

But the NHS does not always make best use of innovation. While there have been increases in research and development funding, including the recent commitment to invest £15 billion over the next decade for medical research, and good progress in the uptake of clinically and cost-effective innovative technologies appraised by NICE, more needs to be done.

Despite some excellent work taking place locally, there remains some reluctance within the NHS to adopt new products and procedures. For example, my team and I performed the first colorectal keyhole bowel operation in the early 1990s in London. But across the NHS we are still well behind other European countries in the uptake of this technique. The NHS needs to move away from cost containment and seek to harness innovation. To encourage this change in culture, there needs to be better demonstration of the benefits of innovation in terms of improved safety, effectiveness, personalisation, fairness and value.

A new Health Innovation Council (HIC) will be established to act as the overarching guardian for innovation from discovery through to adoption, holding the Department of Health and the NHS to account for taking up innovation and helping overcome

<sup>11</sup> Harrison W, Marshall T, Singh D and Tennant R, *The Effectiveness of healthcare systems in the UK – scoping study*, Department of Public Health and Epidemiology and HSMC University of Birmingham, July 2006.

barriers to doing so. Organisations including NICE, the National Institute for Health Research and the NHS Institute for Innovation and Improvement will have key roles to play and will be members of the HIC.

Linked to this, we need to think about how we can best bring together world-class research, teaching and patient care to encourage innovation and deliver exemplary care for patients. The concept of Academic Health Sciences Centres (AHSCs), which do just this, will be rolled out in major teaching centres across the country.

### **A clear quality framework**

A key part of providing more effective care is being able to assess what clinicians do so we can compare our performance with others. And patients should be able to see this information before choosing where to be treated.

There is a wealth of information already available but it is not normally directly comparable and not benchmarked in a systematic way. For example, while I record the clinical outcomes of the surgery I undertake, the data is not regularly benchmarked against that of other surgeons carrying out similar work. There are individual examples of excellent practice, such as some clinical audits, but these are

isolated examples. This is a significant hindrance to progress.

Establishing a clear framework and standard ways to measure results will allow us to demonstrate the high quality of what we do, and identify what is needed to sustain and improve that high quality. Any framework will need to be comprehensive, rooted firmly in the recurring questions about their care that people tell us are at the forefront of their minds, but also scientifically valid and clinically relevant. It could be useful to build on recent advances in measuring outcomes as assessed by patients themselves, and make these patient-reported outcome measures a stronger part of our approach to clinical quality.

I have asked the Government's Chief Medical Officer, Professor Sir Liam Donaldson, to develop a standard quality framework and proposals for systematic measurement against this framework. I have asked Professor Sir Bruce Keogh, the NHS Medical Director, to advise on how best to implement it within the NHS.

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Despite some **excellent work taking place** locally, there remains some **reluctance** within the NHS to adopt **new products** and **procedures**

# A safe NHS



## VISION

**A safe NHS must be as safe as it possibly can be, giving**

**patients and the public the confidence they need in the care they receive.**

## A SAFE NHS MATTERS TO PEOPLE

Safety should be the first priority of every NHS organisation. People rightly expect to receive the safest possible care and to be confident that this will be the case.

At the consultative event I attended in September, I heard patients and the public voice their concerns about safety. They wanted the places where they go for care to be clean, safe environments where the risks of infection are minimised. They felt there should be rigorous attention to cleanliness in particular. In a study by the NPSA in 2007, 71% of patients wanted to be involved with daily hand hygiene practice in hospital. Some 82% of those at the consultative events wanted information on infection rates when choosing which hospital to go to.

And staff agree that it is important.

## WHERE WE ARE NOW

Significant progress has been made towards improving safety in the NHS. The report *An Organisation with a Memory* (2000) brought the problem

of unsafe care to national attention for the first time in the UK.

Since then, the NPSA has been established, along with independent regulation underpinned by improved clinical governance. When errors occur they are investigated, lessons learned and systems changed. We are about to embark on a new chapter of this journey. The recent report *Safety First* (2006) set out a national blueprint for patient safety and has led to a fresh approach by the NPSA.

The National Reporting and Learning System has shown that healthcare professionals will report adverse events – there have been rapidly increasing numbers of incidents reported in the last three years. The objective is to capture and report patient safety incidents and promote learning and awareness in order to reduce harm to patients.

We also need to extend local accountability for all aspects of safe care. Local patient safety action teams will be responsible for encouraging reporting of errors, investigation of incidents and ensuring local learning.

One area of safety practice of particular concern to patients is the control of HCAI. International data shows that this is a shared problem.

Tackling MRSA has therefore been a priority for patients, the public and NHS staff. Action has been taken over

recent years, as a result of which MRSA infection rates are coming down (although there is variation in progress between localities).

During this time, there has been an increasing focus on *C. difficile*. Mandatory surveillance of *C. difficile* was introduced in 2004 and specific interventions to combat *C. difficile* have been added to the widely used *Saving Lives* delivery programme.

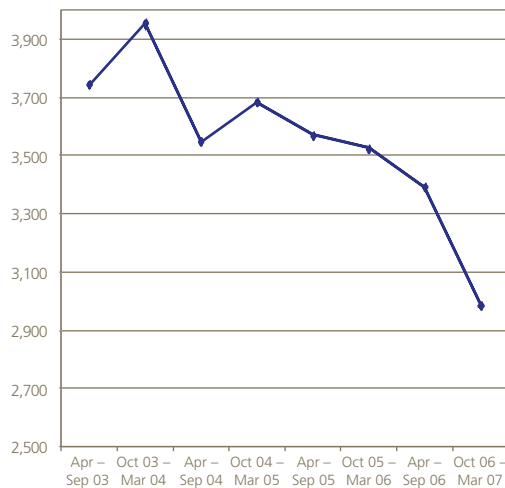
Prevalence of HCAI		Incidence of MRSA bacteraemias per 100,000 patient days	
USA	5–10%	Netherlands	0.35
Australia	6%	Germany	3.29
Norway	7%	Spain	6.00
England	8.3%	Italy	6.44
Denmark	8%	Greece	7.36
France	6–10%	UK	9.56
Netherlands	7%	France	11.79
Spain	8%	Portugal	17.58

These tables are based on international surveillance data and other available evidence

**SCOPE TO IMPROVE**

Tackling safety issues, cleanliness and infection control is the responsibility of everyone who comes into contact with the NHS – from visitors to managers to nurses to surgeons. I believe we must do more to develop a culture of safety, and in some cases staff have told me that they need more powers and greater authority to tackle these issues. A local focus is crucial – the problem cannot be addressed by central direction.

MRSA bloodstream infections by six-month period (April 2003 – March 2007)<sup>12</sup>



In the last few months, more action has been announced to tackle HCAI. These actions are designed both to improve patients confidence in the safety of their care and also to tackle the root causes of infection. The Government has:

- introduced a ‘bare below the elbows’ dress code to improve the quality of hand washing
- released new guidance on isolating infected patients

## A safe NHS

- extended the NPSA's *cleanyourhands* campaign to care settings outside hospitals
- announced that the forthcoming Bill will introduce a new legal requirement on chief executives, backed by fines, to report MRSA bloodstream infections and *C. difficile* infections to the Health Protection Agency
- set out plans for a deep clean of all hospital wards as part of the drive for a culture of cleanliness.
- made £50 million available for SHA Directors of Nursing to spend on tackling HCAI
- doubled the size of the expert improvement team
- announced quarterly reporting to trust boards by matrons and clinical directors on infection control and cleanliness

### NEXT STEPS

There will now be further action to build on this. We will:

- use the Bill to give a new health and adult social care regulator tough powers, backed by fines, to inspect, investigate and intervene where hospitals are failing to meet hygiene and infection control standards


**Cleanliness isn't just about infection. It also gives an impression to patients so that they can be confident about the standard of care they are going to receive.**

(South East Coast – consultative event)

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We should **build on the action** we have taken already to tackle HCAI **by going even further**




- 
- introduce annual infection control inspections of all acute trusts using teams of specialist inspectors
  - introduce MRSA screening for all elective admissions next year, and for all emergency admissions as soon as practicable within the next 3 years.
  - look into ways of building financial penalties or rewards into the commissioning process linked to providers' performance in terms of HCAs and cleanliness.

And we must empower staff, particularly nurses. For this reason, I have asked the Chief Nursing Officer, Professor Christine Beasley, to take forward work as part of the Review to develop a clear plan and guidance for the NHS which increases the powers of local staff. This means empowering matrons to:

- report any concerns they have on hygiene direct to the new regulator
- order additional cleaning

I also believe we should build on the National Reporting and Learning System, responding to feedback from the service, and support the NPSA in establishing a single point of access for frontline workers to report safety incidents: Patient Safety Direct. This would use email, telephone and letters to streamline the reporting process, providing a quicker and more systematic service 24 hours a day.



# A locally accountable NHS



## LOCAL CHANGE

**Realising our vision for a world class NHS means working differently.** If we are

genuinely to make the most of the talents of staff and respond to patients' expectations, we need to empower patients and give health and social care staff greater flexibility to respond and lead.

## NEW STANDARDS FOR LOCAL CHANGE

At the same time, I have heard during the first part of the Review that where change does go ahead, it does not always happen as transparently as it should. We need to reassure patients and the public that change is necessary and that it will improve the care they receive. I believe we can and should do more now to improve this process.

We should be clear from the outset that no major service change should happen except on the basis of need and sound clinical evidence. Specifically we will:

- raise the standard of evidence we expect before change takes place – we will publish by the end of this year a set of guidelines for how local areas should undertake changes to NHS services. These will be founded on the principles and recommendations set out in the Carruthers Review (February 2007). They will make clear that change should only be initiated when there is a clear and strong clinical basis for doing so; and that consultation should proceed only where there is effective and early engagement with the public, clear evidence of improved outcomes for patients, and resources available to enable new facilities to open alongside old ones closing
- ensure that local decision-making processes are subject to greater public and clinical scrutiny including by ensuring that the local case for change is led by clinicians, and is subjected to independent clinical assessment prior to consultation – through the Office of Government Commerce's Gateway review process whose main findings and recommendations will be published. The public should be reassured that the NHS will not pursue changes that have not been verified as safer and of a higher quality

If we are genuinely to make the most of the talents of NHS staff and respond to patients' expectations, we need to empower health and social care staff locally

- streamline the process – I have observed that the process of consultation is often too protracted, delaying decisions unnecessarily. There are currently few timescales for any part of the reconfiguration process other than the formal public consultation stage (minimum 12 weeks). We will therefore publish for consultation options for streamlining the reconfiguration process, including introducing clear timescales for all key stages
- improve the evidence base – a national clinical evidence base will be created, housing what local, national and international clinicians believe to be the best available evidence about clinical practice, pathways and

models of care and innovations. This will be available to commissioners, practitioners, patients and the public alike. We will work with the relevant bodies, such as NICE, the National Library for Health the new Health Innovation Council and the Independent Reconfiguration Panel (IRP) to take this forward.

### SUPPORTING ACTION

The second stage of my Review will also focus on supporting the frontline NHS in responding to these challenges. To understand what is required to do this, I have held discussions during the first part of this Review with a wide range of stakeholders – including professional bodies, trade unions and voluntary sector organisations – and



## A locally accountable NHS

identified a number of areas on which action is needed. Those areas include:

- workforce planning, education and training
- leadership
- information to support excellence
- enabling systems and processes
- the case for an NHS Constitution.

I will be using the second part of this review to work with the senior NHS leadership team – clinicians and managers – to bring together experts from this country and abroad to discuss the key issues in more detail and identify the best way in each case to support change to happen locally. I want this work to involve professional bodies, trade unions, voluntary sector organisations and other partners.

To ensure that the NHS benefits from the best available advice, I will also be commissioning research, analysis and contributions from a range of organisations, in this country and abroad.

### **Workforce planning, education and training**

The NHS currently employs over 1.3 million people – 70% of its costs are linked to staffing. The NHS spends over £4 billion annually on training and developing its staff so they can provide the best quality care. Yet despite an increasing NHS budget, education and training expenditure has not increased as much as planned in the last year. This has often affected those who needed it most – the staff who have benefited least from development opportunities. We also know that commissioning of training places has not always matched commissioning of services. We therefore need to do more to grasp the potential of education as a lever for service improvement.

Despite the highly publicised problems with the Medical Training Application Service (MTAS) recruitment system, I believe that the principles of the Modernising Medical Careers (MMC) programme developed with the



professional bodies and regulators are sound. It is the implementation that has fallen so far short.

But overall, our approach to workforce planning and the commissioning of education and training needs an overhaul, so that we can avoid any repetition of the problem where many NHS-trained physiotherapists who graduated last year were not able to find posts in the NHS despite rehabilitation after illness (such as stroke) being vital to the recovery of hundreds of thousands of NHS patients.

And we need to look at the content of curricula to ensure that they are aligned with the care our vision is intended to deliver.

Workforce planning needs to be more evidently and consistently linked with new models of care and with financial and service planning at all levels in the system. Education and training providers also need to be more involved and forward looking.

We need to strengthen education and training commissioning so that training for all staff delivers the skills and competencies required to meet staff and patient expectations. We should develop robust quality-assessment

tools to ensure we are getting the right quality of education, not just the right quantity.

### Leadership

The essence of clinical leadership is to motivate, to inspire, to promote the values of the NHS, to empower and to create a consistent focus on the needs of the patients being served. Leadership is necessary not just to maintain high standards of care but to transform services to achieve even higher levels of excellence.

I often hear clinicians say that they feel constrained and undervalued by managers, and this also applies between different clinical groups. But it is also true that managers sometimes see clinicians as stubborn and slow to change. Most importantly, however, recent research (*What Matters to Staff*, 2007) has demonstrated just how much clinicians, managers and other staff want to collaborate on improving local services. There is evidence that where this is already happening, patient and staff satisfaction is higher.

The challenge now is to accelerate our progress. I will ask the NHS Chief Executive, David Nicholson, to convene a national working group to identify actions we can take. Included in this

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Our approach to workforce planning and the commissioning of education and training needs an overhaul

## A locally accountable NHS



group will be professional and representative bodies. It will draw on best NHS and international practices. I will ask them to consider how to put the business of care at the heart of what local NHS boards do and, specifically to:

- define what excellent leadership looks like, including collaborative leadership
- develop a strategy for health leadership development, including research
- examine how leadership development can be built into formal and informal education and training for all professional groups, and role models identified, building on existing work
- consider how to identify and encourage healthcare professionals to take up leadership roles as part of normal career paths.

### *Information to support excellence*

All modern organisations serving consumers rely on high quality information to provide consumers with

choice, to assess progress, to cement accountability and to evaluate the input of new policies or programmes.

The NHS has a great deal of data, but a paucity of information. Much of the information we do have is available to limited numbers of people, is often inconsistent with that held elsewhere, and is frequently not available at the point of need.

The NHS's recent investment in technology has created the opportunity to make a step-change. The national infrastructure established by the National Programme for Information Technology has connected every hospital and GP surgery to a common secure network. Clinicians should benefit from the implementation of digital access to X-rays and scans – Picture Archiving and Communications System (PACS). But I believe more work is now needed to ensure that the Connecting for Health programme delivers real clinical benefits, and I will be considering in the second stage of my Review how best to achieve this.

### *Enabling systems and processes*

The NHS is perhaps two-thirds of the way through its reform programme set out in 2000 and 2002. In my visits



across the NHS I have detected little enthusiasm for doing something completely different; instead the majority opinion is that the current reforms should be seen through to their conclusion. I agree. A more personalised NHS requires services that are locally designed and can adapt quickly to patients' needs. In turn that means that if we are to have world class services across the board, then we need world class commissioning. PCTs working with practice-based commissioners and local authorities will need to commission services based on the models of care that the local clinical pathway groups devise.

Commissioners need to look at best practice across the globe and ensure that a range of independent and commercial skills are adopted or brought in, where they can improve population health and healthcare. Given the variation in NHS commissioning skills currently on offer, in my view – and that of the Government – that needs to mean extensive use within every SHA of the new Framework for procuring External Support for Commissioners (FESC).

### ***The case for an NHS Constitution***

The way the NHS is run has evolved to meet today's challenges. There is already much less top-down intervention, with NHS foundation trusts much more free to innovate locally, and PCTs able to decide on service priorities to a greater degree than before.

While there is a consensus that the shape and delivery of local services should be determined locally, where this is not possible, people want a clear and transparent process for arbitration and decision making. They feel that without this clarity people cannot be held to account properly for the decisions they do take.

In my terms of reference, the Prime Minister and the Secretary of State said that, at the end of the Review, a decision will be taken on whether there is a case for an NHS Constitution, as part of a new and enduring settlement for the NHS as it approaches its 60th birthday. The objective would be to enshrine the values of the NHS and increase local accountability to patients and public.

## A locally accountable NHS

The Secretary of State and I have asked the NHS Chief Executive to establish and chair a national working group of experts to consider the scope, form and contents of an NHS Constitution or settlement, in particular how it might:

- help secure the enduring principles and fundamental values of the NHS, based on evidence of what matters to our patients, the public and staff
- establish a stronger framework of responsibility, accountability and legitimacy for decision making within the service, both nationally and locally including in PCTs and NHS foundation trusts
- establish the responsibilities of all organisations who work for NHS patients
- include an open and accountable process for arbitration and decision making where decisions on the shape and delivery of local services cannot be resolved locally
- embed a stronger focus on rights and responsibilities for patients, the public and staff, based on evidence of what matters





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A stronger focus on rights and responsibilities for patients, the public and staff, based on evidence of what matters

- set out a right of engagement for patients and staff covering consultation, independent assurance and rights of redress
- strengthen the opportunity to work in partnership with other agencies to improve access and the integration of care
- review the process for NHS appointments, in line with the Governance of Britain green paper.

This work will be underpinned by what our patients, staff and the public tell us over the coming months. I have been delighted by the enthusiasm that people have shown for the Review so far – and it is clear that there is an appetite for more engagement as this work progresses. Whether we devise an NHS Constitution or not, part of my responsibility is to ensure that everyone who wants to can feed into that process and have a real opportunity to influence the shape of our NHS for the next decade.

# How to get involved



I want people across the country – patients, the public and staff wherever they are working in the health and social care system – to discuss this report and to get involved in shaping a world class NHS. I encourage you to discuss, deliberate and examine the proposals and let me know your comments.

Engagement will be locally led; I envisage many more discussions taking place up and down the country, similar to the events we held nationwide in September.

The Review website, [www.nhs.uk/ournhs](http://www.nhs.uk/ournhs), contains information about the Review and updates about what is happening in your area. It will shortly contain an online resource pack to support your discussions locally; the material includes tailored agendas for a full-day and half-day event, standardised feedback forms to record the outputs from your discussions and supporting documents.

An online questionnaire will be made available soon, downloadable from the site, and I encourage you to share it among your friends, family, carers,


neighbours, colleagues and peers. Hard copies of the questionnaire are available on demand from:

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PO Box 777  
London SE1 6XH

email: [dh@prolog.uk.com](mailto:dh@prolog.uk.com)  
Tel: 08701 555455  
Fax: 01623 724524

I have also arranged for a number of new forums and groups to be created to enable people to contribute their views. The many organisations involved in health and social care will be continuing their normal processes for dialogue with stakeholders as well.

If you are unable to hold or attend a local event, or cannot contribute to the questionnaire, I still want to hear your views. You can email [ournhs@dh.gsi.gov.uk](mailto:ournhs@dh.gsi.gov.uk) or write to me at the Department of Health, and I will ensure that your views are taken into account.




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I want people across the country – **patients, the public and staff** wherever they are working in the health and social care system – to discuss this report and to get involved in **shaping a world class NHS**





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Produced by COI for the Department of Health  
283411 1p 5k Sep 07 (CWP)

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