The year

NHS Chief Executive’s annual report

2008/09
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1. **Introduction**

“Society becomes more wholesome, more serene, and spiritually healthier, if it knows that its citizens have at the back of their consciousness the knowledge that not only themselves, but all their fellows, have access, when ill, to the best that medical skill can provide.”

It was with those words from Nye Bevan’s *In Place of Fear* that I addressed the NHS60 Service of Celebration at Westminster Abbey. I was enormously proud to have the opportunity to speak at that celebration and to talk with people who have contributed so much to the NHS over the years.

It was part of celebrations up and down the country and showed how much we have to be proud of. In this, our 60th year, it has been incredibly important to develop the NHS Constitution, setting out the values of those who work in the service and those who use it. It sets the foundations for the NHS going forward from here.

In this, my third report as NHS Chief Executive, I want to celebrate our achievements and take the opportunity to set out how we are taking the NHS forward.
In 2008/09, the NHS started to reap the benefits of restructuring and getting into financial shape. We achieved the space we needed to focus on our priorities and start injecting real pace into improving services for patients.

During the year, both staff morale and public confidence in the NHS rose to the highest levels on record. It is a great achievement to win back that confidence when you consider where we were just two years ago.

We delivered on the key priorities patients told us they wanted – making the system safer by driving down healthcare associated infections, extending GP opening hours and reducing waiting times to the lowest levels on record.

These are hard-won achievements and there is no room for complacency. The scale of the credit crunch has become clearer and the spectre of a national emergency such as pandemic flu has come closer. The need to go further and faster with system reform has taken on an even greater urgency.

Giving ourselves the best chance of responding to these pressures and delivering sustained improvements in care in the future relies on the entire system uniting around a shared sense of purpose and direction.

We are on a fascinating journey of reform in the NHS. Since 2000, we have seen record investment in building capacity, and the introduction of reform levers to increase choice and contestability. This year we sought to pull all this together and clearly define the direction we are taking.

The Next Stage Review and its final report, High Quality Care for All, have played a key role by uniting the service around the principle of quality. The 10 regional visions are the local blueprints for making this happen.

The NHS was founded partly as a movement for social change. The engagement process generated by the Next Stage Review and the 10 regional plans has revitalised that movement and mobilised our management and clinical communities. There is an alliance for change being built around quality.
To achieve quality means becoming truly responsive to what our patients, local communities and staff want and putting them at the heart of what we do.

Events at Stafford Hospital were a shocking reminder of the consequences of failing to listen to patients and act on their concerns. The NHS must learn from the events at Stafford and take all necessary steps to ensure this is not allowed to happen again.

The challenge for the NHS now is how to make quality a reality for patients and staff. Change on this scale has never been attempted before in the NHS. The NHS leadership team has been guided by evidence from across the globe about large-scale change and what works. We have used that evidence to define the guiding principles for this work and to develop a model for change to support the system to achieve quality.

My role is about creating the right conditions for the NHS to deliver high quality care today while also preparing it for the demands and challenges of the future. The NHS has achieved what it set out to do this year and more. We are well placed, with 11 per cent growth over the next two years. But for the three years after that, we face a much tighter financial environment.

The NHS must not allow itself to repeat the mistakes and failures of the past. We have a choice not to repeat those failures.
“The challenge for the NHS now is how to make quality a reality for patients and staff.”

We need to stay focused and use these two years of growth to plan for the next five years and beyond. We have a shared vision of quality to guide us and a framework for taking quality forward.

Our best chance lies in understanding that improving quality and value for money go hand in hand and that we can link them together using innovation to prioritise the most effective treatments across the system and reduce waste and errors.

The achievements of the NHS this year mean we are well placed to face the challenges ahead. We are in a good financial position, we have great leadership across the system, we have a compelling vision on quality which managers and clinicians are signed up to, and we have two years to plan and get things in place.
2. Looking back over the year

The NHS achieved what it set out to do this year and a bit more. We improved our performance across the board, made the system safer and more responsive to the needs of individual patients and were rewarded with consistently high levels of patient satisfaction and staff morale.

Five national priorities

Our five national priorities for 2008/09 (which remain the same in 2009/10):

- improving cleanliness and reducing healthcare associated infections (HCAIs)
- improving access through achievement of the 18-week referral to treatment pledge and access (including at evenings and weekends) to GP services
- keeping adults and children well, improving their health and reducing health inequalities
- improving patient experience and staff satisfaction and engagement
- preparing to respond in a state of emergency, such as an outbreak of pandemic flu
Improving cleanliness and reducing healthcare associated infections (HCAIs)

A relentless focus on making the system safer for patients and staff has driven down rates of HCAIs this year. We built on the lessons of Maidstone and Tunbridge Wells to seek to involve everyone who has contact with the system – patients, their families and visitors, clinicians and staff – to give us the best chance of success. We set an ambitious target of halving MRSA bloodstream infections, achieved that in September and had reached 62 per cent below the 2003/04 baseline by the end of the year.

The NHS also made positive progress on tackling Clostridium difficile (C. diff), reaching in one year the reduction in infection rates we had been seeking over three years.

During the year, I focused a number of my visits on how hospitals are tackling HCAIs. When I visited Rotherham General Hospital, Medical Director Professor Walid Al-Wali summed up what success looks like: “Strong leadership, a ‘can do culture’, empowering first-line clinical staff and embedding infection control across our governance structures”.

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Looking back over the year 7
The Green Ribbon initiative

The drive to reduce HCAIs has resulted in some terrific examples of innovation from frontline staff. At Broomfield Hospital in Chelmsford, in the East of England, the vascular ward staff have devised the Green Ribbon initiative.

A green ribbon placed across the bed flags to show everyone that the area has been thoroughly cleaned and is ready for a patient. The ward staff explained that it was part of ensuring that cleaning standards are consistent throughout the hospital. It is an example of frontline staff making a hospital-wide change with real benefits for patients and huge potential to be adopted and spread across the wider system.

The registration process for the new Care Quality Commission (CQC) has flushed out some trusts that still need to lift their game significantly. The Commission put registration conditions on 21 trusts for failing to comply with national hygiene standards. We must continue a relentless focus on improving performance in this area. The work of the CQC, led by Chief Executive Cynthia Bower, will play a key role in driving up quality in the system.
18 weeks

Our performance on 18 weeks referral to treatment is nothing short of a revolution in patient care. NHS patients no longer have to wait more than 18 weeks from referral to starting hospital treatment unless there is a clinical reason or they choose to wait. We promised we would achieve this by 1 January 2009 – we first delivered this in August 2008. Ten years ago there were 284,000 patients waiting longer than six months for admission to hospital, and it was not uncommon to wait two years or more.

It is a tremendous achievement across the system and just one example of how we are seeking to improve quality for patients. We still need to work hard to ensure that patients have access to good quality information, know they have a choice of hospital and doctor and are supported in making that choice.

A key part of reducing waiting times is also how long patients have to wait for diagnostic tests. The NHS has significantly improved in this area this year, and patients can now expect to wait just two weeks for any of the 15 key diagnostic tests. This leads to earlier diagnosis and access to appropriate treatment.

Improving access to GP services

Health improvements are largely driven by patients’ expectations, along with changes in technology and demography. The way GP services were being delivered was out of step with many people’s lives. Patients had been telling us for some time that they wanted more flexible hours.

Primary care trusts (PCTs) have worked with their local GPs to make this happen and by the end of January this year 71.1 per cent of GP practices were offering extended opening hours. The Prime Minister had set us the target of 50 per cent of GP practices providing extended hours by the end of 2008 – we met that target three months early.

Alongside the focus on this target, a number of PCTs have developed innovative approaches to improve access to primary care services, such as GPs working in supermarkets and pharmacies offering the flu jab to people in at-risk groups.

People have rightly identified waiting times and HCAIs as their key concerns and we have responded accordingly. But we need to continue to be vigilant across a range of areas where we have what are now accepted as minimum standards. They must not be allowed to slip.
Accident & Emergency
We dipped below the 98 per cent target of patients waiting less than four hours in A & E during part of the year. While we achieved the four-hour A & E target over the year, this is the second year running in which we have fallen short of that target during the year, which is disappointing.

After the Healthcare Commission’s report into events at Stafford Hospital, I wrote to every trust raising a number of issues. One of these was that PCT boards need to look closely at the A & E services they commission and assure themselves that those services meet the standards that patients and the public expect.

We are not keeping true to the values of the NHS Constitution by leaving people, often in a distressed and vulnerable state, waiting for treatment in A & E.

Keeping adults and children well and reducing health inequalities
The NHS is continuing to make inroads in tackling the main causes of death. We have significantly reduced the rate of deaths from cancer and circulatory diseases over the past 10 years, and the prevalence of smoking among adults has fallen to the lowest rates on record.

However, there are key areas where we need a renewed focus this year:

- Eliminating mixed-sex accommodation. Patients have told us that the ongoing use of mixed-sex accommodation is unacceptable. From 2010/11, financial penalties will be applied to those hospitals where single-sex facilities are not provided

- In the wake of a significant rise in the number of cases of measles in 2008, increasing the vaccination rate of children with the measles, mumps and rubella (MMR) vaccine

- Reducing rates of teenage pregnancy, which had fallen to the lowest level in 20 years in 2006 but have started climbing again
The performance of maternity services is a touchstone of whether we are delivering quality based on patient safety, effectiveness of care and patient experience.

The Healthcare Commission reviewed maternity services in 2007/08 and raised concerns about quality and capacity. They also published a number of investigations into maternity services in individual local trusts, which have had a high media profile.

Their findings show that the vast majority of mothers still rate their maternity care, and particularly their care during labour and birth, as good or better, but there is more we need to do to respond to what patients say they want.

There has been a renewed focus on improving maternity services this year, with more midwives and an extra £330 million over three years. We are working to expand choice around type of care, improved access to services and continuity of midwifery care and support. Chief Nursing Officer Dame Christine Beasley is leading the work on improving maternity services.

Part of the answer lies in spreading the benefits of innovation as well as linking resources locally to improvements that respond to what parents are telling us they want for themselves and their babies.
Supporting prevention

The Change4Life programme has given the NHS a big push at local level to work with local organisations to drive health improvement and prevention activities and messages.

Rising levels of obesity in the UK mean that 90 per cent of today’s children will be overweight and at risk from serious diseases by 2050, costing the NHS an estimated £50 billion. We know that tackling childhood obesity is difficult and cannot be done in isolation. The Change4Life programme has the backing of thousands of organisations and charities working with the NHS.

*High Quality Care for All* highlighted that while the NHS is great at treating people who are sick, we are not always good at helping people to make the right choices about staying healthy, such as diet and exercise. We routinely miss prevention opportunities that could reduce the risk of people falling ill in the future.

PCTs, in particular, should use our focus on innovation to share and spread creative approaches to commissioning health promotion and prevention, and to support local partners to do the same, to deliver a more joined-up approach.

Improving care for people with long-term conditions

Long-term conditions are the other end of the story on prevention. We need to revolutionise the treatment of people with long-term conditions. It is a complex issue to get right but I saw many good examples in the service this year.

Breaking down barriers between health and social care and focusing on integration opportunities is a key way forward. The integrated health and social care team I visited at Liverpool PCT is using its shared pool of expertise to offer personalised care, speeding up diagnosis and getting appropriate care and supports in place so more patients can be looked after at home. The team was starting to make a big impact on hospital admission rates for its patients, effectively stopping a cycle of readmissions for a number of them.

Empowering patients to manage their conditions better and lead more independent lives is at the heart of what we are trying to achieve on quality.

In June 2009, the Green Paper on reform of adult care and support will be published, setting out long-term reforms to provide tailored support, help to stay healthy, help to find and gain access to high-quality care, standardised portable assessment and support for informal carers.
Top-ups and improving access to drugs

Responding to what patients and the public want from the health service at the very end of their lives is an issue where the NHS still has much work to do to reflect the choices patients have told us they want.

Decisions by the National Institute for Health and Clinical Excellence (NICE) to deny terminally ill patients access to a range of cancer drugs to prolong their lives triggered one of the most difficult debates in my time in the service.

At the heart of this debate was the value which society places on extending the lives of people with life-threatening diseases.

Professor Mike Richards’ review of whether patients should be allowed to pay to “top up” their basic NHS treatment is to be commended for its thoughtful and compassionate approach.

The NHS should not stand in the way of patients paying privately for treatment with expensive cancer drugs. Professor Richards also recommended that NICE speed up its processes to approve these cancer drugs for NHS use once they are licensed. His recommendations have been widely praised by the NHS, patients and all political parties.

As well as NICE speeding up its processes, PCTs need to act fairly and take a consistent approach to applications by individual patients for payment of non-approved drugs on an “exceptional” basis. The Richards Review found inconsistencies and variations across PCTs. The NHS Constitution has been explicit in setting out what patients have a right to expect in this area, reflecting what the public and patients have told us they value.
Focus on learning disabilities

I have had a particular interest throughout my career in services for people with learning disabilities, and was horrified this year by a series of events highlighting poor care, neglect and problems of access to general acute services. If both primary care and hospitals can organise their services around the needs of people with learning disabilities, the chances are that services will get much better overall. It is one of the key litmus tests of a fair and personalised NHS that is committed to tackling health inequalities.

“the outbreak of swine flu is a crucial test of our approach to emergency planning and our resilience as a system”

Emergency planning: swine flu and winter pressures

While the outbreak of swine flu reminds us of the importance of the urgent care system, it is also a crucial test of our approach to emergency planning and our resilience as a system. It is precisely at times like these that the public relies on our comfort and care, and reaps the benefits of a sustainable and integrated system.

The impact of one of the coldest winters in a decade tested our resilience at the start of this year, particularly in terms of ambulance services. Maintaining public confidence means being able to manage these extra pressures without compromising patient safety.

The outbreak of swine flu makes it more important than ever that we have robust winter plans in place. All organisations need to stress-test their plans and Strategic Health Authorities (SHAs) need to do the same with their regional systems.

Our flu planning has paid off in the early stages of this outbreak but we need to remain vigilant. SHA North East Chief Executive Ian Dalton is leading the NHS flu planning effort to ensure that we can continue to deliver high quality care.
Improving patient experience, staff satisfaction and engagement

What patients told us

GP Patient Survey 2008

<table>
<thead>
<tr>
<th>Key findings</th>
<th>2007 (%)</th>
<th>2008 (%)</th>
</tr>
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<tbody>
<tr>
<td>Satisfaction with their ability to get through to their practice on the phone</td>
<td>86</td>
<td>87</td>
</tr>
<tr>
<td>Reported they tried and were able to get an appointment with a GP in 48 hours</td>
<td>86</td>
<td>87</td>
</tr>
<tr>
<td>Wanted to book ahead for an appointment and could</td>
<td>75</td>
<td>77</td>
</tr>
<tr>
<td>Could get an appointment with a particular GP even if they had to wait longer</td>
<td>88</td>
<td>88</td>
</tr>
<tr>
<td>Satisfied with GP’s current opening hours</td>
<td>84</td>
<td>82</td>
</tr>
</tbody>
</table>

2008 Survey of Patients in NHS Hospitals in England: Care Quality Commission

The survey asked 72,000 people who stayed at least one night in a hospital during summer 2008 about their experience. The survey’s key finding is that, compared with the previous year’s survey, more patients rated their hospitals’ wards and bathrooms as “very clean” and more noticed doctors and nurses washing their hands between patients.

<table>
<thead>
<tr>
<th>Other key findings</th>
<th>2007 (%)</th>
<th>2008 (%)</th>
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<tbody>
<tr>
<td>Rating overall care as “excellent”, “very good” or “good” – up 1%</td>
<td>92</td>
<td>93</td>
</tr>
<tr>
<td>Rating care as “excellent” – up 5% since the first survey in 2002</td>
<td>42</td>
<td>43</td>
</tr>
<tr>
<td>“Always” treated with respect and dignity – up 1%</td>
<td>78</td>
<td>79</td>
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The survey also highlighted a number of areas where the NHS needs to improve further, including eliminating mixed-sex accommodation, improving the quality of hospital food and involving patients in decisions about their care.
What the public told us

On 28 January 2009, the British Social Attitudes Survey reported that the public are more satisfied with the NHS now than at any time since 1984, when the survey first reported, and that those who the NHS has treated recently are the most satisfied.

The report concluded: “It is hard to resist the conclusion that massively increased NHS spending over the last seven years, enabling (the service) to increase its staffing considerably and ... reduce waiting times to their lowest since the inception of the NHS, must have played a significant part in boosting satisfaction.”

What NHS staff told us

NHS Staff Survey 2008

The NHS Staff Survey is the biggest staff survey in the world.

On job satisfaction, the survey found that:

- job satisfaction jumped from 3.41 last year to 3.47 on a scale of 1 (low) to 5 (high), higher than the previous highest score of 3.44 in 2005
- 90 per cent of staff felt that their role makes a difference to patients
- 85 per cent of staff felt valued by their work colleagues
Reforming the system

The NHS made history this year, delivering its promise of free choice of the location of hospital care. This is a significant development in the journey of the NHS from a ‘one size fits all’ service to one that is responsive to the needs of individual patients. These advances are driven by the changing wants and needs of our communities. This is reflected in the fact that the NHS Constitution provides a new right to make choices about your NHS care, and a right to information to support these choices.

There are also more high quality providers for patients to choose from. This year, half of all NHS acute and mental health trusts have achieved foundation trust status, freeing them from Whitehall control and giving patients and local communities a bigger say in shaping local health services.

The creation of the Competition and Co-operation Panel will ensure that new providers, whether NHS, foundation trust or private, are being utilised for the greatest patient benefit. The panel will advise SHAs, who will ensure that competition and co-operation – two powerful levers – are used effectively to benefit patients and communities, rather than becoming ends in themselves.

We revamped Practice Based Commissioning over the year in response to concerns by clinicians and PCTs that we were not maximising the potential of these arrangements to drive local improvements in patient care.

All of the extra capacity and reforms that have been put in place over recent years are now bound together by the first NHS Constitution, which makes clear that we are a system that must work together for the benefit of patients. We must continue to reform that system, with more foundation trusts and Practice Based Commissioning, but we must always be clear that it is reform with a purpose – better patient care for all.
Broadmoor Hospital

In January, a visit to Broadmoor Hospital in Berkshire highlighted the breadth of work being done with patients suffering from severe mental illness and personality disorders, where a whole system of healthcare, from primary to tertiary, is managed.

Broadmoor’s Dangerous and Severe Personality Disorder service has a national and international reputation. The Paddock Centre is a new 70-bed unit that assesses and treats patients using a cognitive behaviour therapy model. The service is a joint initiative between the NHS, the Home Office and the Prison Service.

Broadmoor, like most high-security services, faces particular challenges in managing risk. When something goes wrong, it tends to hit the headlines. Touring the site highlighted the impact of the age of some parts of the estate on plans to improve care.

The staff I met were ready to take on the challenge of providing high quality care and bringing the basic reforms and entitlements enjoyed by the majority of NHS patients to patients with severe mental illness.

I will visit the other two high-security hospitals, Rampton and Ashworth, over the summer.

Summary of our performance on key indicators

<table>
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<tr>
<th>Key indicators</th>
<th>Target</th>
<th>Summary of our performance</th>
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<tbody>
<tr>
<td>18 weeks</td>
<td>• no patient to wait more than 18 weeks from referral to treatment unless there is a clinical reason or they want to wait longer</td>
<td>• the NHS has delivered 18 weeks since August 2008. NHS waiting times are now at the lowest levels on record</td>
</tr>
<tr>
<td>MRSA</td>
<td>• maintain annual number of MRSA infections at less than half the number in 2003/04</td>
<td>• MRSA: 62% reduction on 2003/04 baseline, to December 2008. Met 50% target in September 2008</td>
</tr>
<tr>
<td></td>
<td>• 30% reduction in C. difficile by 2011, compared with 2007/08 baseline</td>
<td>• C. difficile: 33% reduction to December 2008, meeting three-year target in one year</td>
</tr>
<tr>
<td>Key indicators</td>
<td>Target</td>
<td>Summary of our performance</td>
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<td>---------------------------------------</td>
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</tr>
<tr>
<td>GP extended opening hours</td>
<td>• 50% of GPs providing extended opening hours, including evenings and weekends, by December 2008</td>
<td>• over 70% of GP practices offering extended opening hours at January 2009; met 50% target by December 2008</td>
</tr>
<tr>
<td>Cancer treatment waiting times</td>
<td>• two-week maximum wait from referral to first outpatient appointment for all urgent suspected cancer referrals&lt;br&gt;• maximum wait of one month from diagnosis to treatment of all cancers&lt;br&gt;• maximum wait of two months from urgent referral to treatment of all cancers&lt;br&gt;From 1 January 2009, the NHS has set new standards aimed at making our cancer services among the best in the world by 2012. These new standards will change the measurement of this target.</td>
<td>• met&lt;br&gt;• met&lt;br&gt;• met</td>
</tr>
<tr>
<td>Four-hour waits in A &amp; E</td>
<td>• a four-hour maximum wait in A &amp; E</td>
<td>• met. The NHS fell under 98% standard by 0.5% in quarter 3</td>
</tr>
<tr>
<td>Dentistry</td>
<td>• improve access to dentistry</td>
<td>• small improvement in the number of people seeing an NHS dentist in quarter 3. PCTs will commission extra services in 2009/10 to further improve access</td>
</tr>
<tr>
<td>Create a financial reserve</td>
<td>• plan for appropriate and reasonable levels of surplus</td>
<td>• the NHS is heading for a projected reserve of £1.7 billion this year</td>
</tr>
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</table>

Looking back over the year 19
3. The NHS journey

The journey of the NHS from a top-down industrialised service to a system that can wrap services around the individual needs of patients and local communities is a fascinating one.

It’s been a long journey with many complicated parts and we needed a coherent story to connect the different stages and reforms together and clearly define the direction we are taking.

The NHS story

Starting with the NHS Plan in 2000, there have been three phases to the journey: the first about increasing investment and capacity; the second about reform levers to expand choice and contestability, such as Payment by Results and foundation trusts; and the third about pulling together that extra capacity and those reform levers to focus on improving quality for our patients.

The third phase has been shaped by Lord Darzi’s Next Stage Review, which has given us the shared ambition of making quality the organising principle of the NHS. The Next Stage Review involved 60,000 staff, clinicians, patients and members of the public. It’s the biggest engagement process in the history of the service, and it is through that process that people told us that quality is what they want us to focus on.

“we needed a coherent story to clearly define the direction we are taking”
Quality and evidence

The Next Stage Review has given us a shared definition of quality – spanning the three elements of safety, effectiveness of care and patient experience. Previously, there had been many definitions of quality in the system, and because of that we had struggled to get an absolute focus on how to take quality forward.

Achieving this vision of quality requires a radical transformation across the entire system. Change on this scale, in a system as large and complex as the NHS, has not been achieved before.

A key reason the Next Stage Review has been so well received in the service is that it is based on evidence of what works. The next step was to look at evidence of large-scale change in different industries and countries to find out what has worked and not worked.

The evidence shows some key things, including that:

- quality is systemic
- leadership that looks out to patients and communities, not up to the centre, has the best chance of success
- organisations that focus on poor performance tend to be poor performers, while those that focus on the leading edge, innovation and risk taking tend to be more successful

It became clear we could not deliver the transformational vision we promised in the Next Stage Review simply by performance managing a raft of policies from Whitehall. Everyone involved in the NHS has a part to play. The key is to release the tremendous energy of frontline staff.

The evidence clearly shows that improvements in quality are led and delivered by teams of health professionals and supporting staff, working together as part of a system.
North East leads the way on cardiac care

The Cardiothoracic Centre at Freeman Hospital in Newcastle is rolling out angioplasties (balloon treatments for narrowed coronary arteries) for patients across the region.

The North East is the first region to achieve this. On a recent visit, it was clear that the specialist clinicians at the Centre have been supported to take an innovative approach to new technologies and treatments and that the local system has been comprehensively redesigned to expand access to this procedure, which the evidence shows can save patients’ lives.

The four principles

Learning from industries and countries where large-scale change has been successfully implemented, we developed four principles to describe the way we aim to do business in the NHS in 2009/10 and beyond. Crucially, the Department of Health has signed up to the four principles and they are starting to underpin the way the NHS and Department of Health are working.

1. Co-production

Co-production means that all parts of the system need to continue to work together on shaping and implementing change. This sounds like management jargon, but what it means in essence is engaging people across the system to work together to make change happen. This approach is what made the Next Stage Review process so successful, and it has informed the World Class Commissioning programme and the development of the Operating Framework.

“all parts of the system need to continue to work together on shaping and implementing change”
The Operating Framework 2009/10

In October and November last year, Lord Darzi, NHS Director General of Finance and Performance David Flory and I toured the 10 regions to discuss their local visions. For the first time, we gave the service the opportunity to inform the content and shape of the Operating Framework, as it was effectively the implementation strategy for *High Quality Care for All*. It was critical that the Operating Framework supported implementation of the local visions, and giving the service the opportunity to shape the content gave us the best chance of achieving this.

Measuring quality

Our approach to measuring quality was co-produced using the benefits of e-communications. I wrote out what I thought was the story for how we were going to measure quality and emailed it to 60 people in the Department of Health and the NHS, giving them four days to respond and engage to make it better.

For the first 36 hours there was total silence. Then the first comments trickled in and I responded and asked a few more questions. After four days we had 80 contributions generated by genuine dialogue, which we turned into a letter to the NHS setting out what we were going to do to measure quality.

2. Subsidiarity

This means ensuring that decisions are taken at the right level of the system, which means as close to the patient as possible. It means an enabling role for the centre, with more power and responsibility lying with patients and clinicians. And it means looking ‘out, not up’ wherever possible.

My role

Key to this is understanding what role each level of the service plays. As NHS Chief Executive, there is a temptation for me to get involved in a raft of issues in the system. What I have had to do is stand back and consider what it is that my role is uniquely placed to do. And that is to focus on the health of the system, how it is led, how it is aligned around quality, and how we can make further improvements to the processes and levers to get this right. It is tempting to dive in and try to micro-manage issues in the service, but that is not what my role is best placed to do in seeking to improve quality for patients.
Practice Based Commissioning (PBC)

One of the best examples of subsidiarity in action in the system is Practice Based Commissioning. Its purpose is to structure the system around clinicians, giving them the support and information they need to plan and purchase services that respond directly to the choices and needs of their patients and local communities. There is a huge incentive to innovate because savings made by redesigning services, such as moving services out of hospital and into the community, can be put back into improving patient care locally.

3. System alignment

Achieving complex cultural changes, such as making quality our organising principle, requires all the different parts of the system to pull in the same direction and work with partners, in particular through Local Area Agreements (LAAs).

Mid Staffordshire NHS Foundation Trust

The events at Stafford Hospital have been a stark reminder of what happens when the system does not work together for the benefit of patients. Both the Healthcare Commission and the two independent reviews found not only management and board failings but poor communication between the Trust, patients, the public and other parts of the local health economy. Locally and within the system there needs to be a clear understanding of where the Trust is heading and at what speed, as Professor George Alberti underlined in his report.

Aligning the system for quality

The Secretary of State has asked the National Quality Board, in the wake of events at Stafford Hospital, to look at how national systems are picking up and responding to warning signs and whether different processes are aligned.

The National Quality Board is the only place in the system that brings together representatives of the key national regulatory bodies – the Care Quality Commission, Monitor, NICE and the National Patient Safety Agency – with key statutory and professional bodies, patient advocacy groups and the clinical leadership of the system.

The Board has a unique role in the system to align and agree quality goals for the NHS. Key priorities this year include overseeing the work to improve quality indicators and NICE’s work on setting priorities for clinical standards. In the autumn, the Board will produce an annual report looking at the state of quality in England and comparing our performance with that of other countries and systems.
4. Clinical ownership and leadership

This principle was crucial to the success of the Next Stage Review process and must be maintained during implementation. If we get it right, the quality agenda has great potential to mobilise and empower clinicians across the system. And, conversely, we will get nowhere without clinicians on board. So clinical leadership needs to be part of everything we do.

Promoting clinical leadership

Dr Mark Goldman, Chief Executive of Heart of England NHS Foundation Trust, is leading the National Leadership Council’s workstream on clinical leadership.

He says: “Promoting clinical leadership is a key ambition which I have been asked to lead. My sense is that the timing is right. It arrives at a point when the NHS is moving forwards from the ‘push’ of performance to the more enlightened ‘pull’ of patient quality and safety. Managers and clinicians at last feel at ease on the subject material if not yet the language. Aligned ambition across professional and managerial groups is the only way to deliver for the future.

“Even in its infancy, it feels like a movement. It has more than the ministerial thumbprint upon it. It has heart and soul, it is about people and what they need to deliver the most complex and important public service at the most complex and important time since the inception of the NHS.”

Lord Darzi and David Nicholson with clinicians at Queen Victoria Hospital NHS Foundation Trust in East Grinstead
The roadshow tour

Lord Darzi and I took the opportunity to highlight the four principles during our regional tour in October and November. The roadshows were a key opportunity to focus on what different parts of the system were doing to support implementation of the regional visions. There is an incredible breadth of ambition in the 10 regional visions. The roadshows started at NHS South East with Chief Executive Candy Morris setting out their regional vision. We visited a virtual ward at Crawley Hospital which has integrated intermediate care. Other visits during the tour demonstrated excellence in healthcare delivery, like improving stroke care at Leicester and supporting young mothers and their babies at a community-based centre run by Liverpool Women’s Hospital.

Achieving cultural change

The Next Stage Review and the 10 regional visions have provided us with the strategy to make quality the organising principle of the NHS. High Quality Care for All has also set out a range of processes and levers to get us there.

But strategies and processes alone are not sufficient to drive the degree of change we are seeking. The third area we identified that the NHS should focus on is tackling the behaviours and cultures in the system that stand in the way of moving forward on quality.

Innovation is an example of the sort of cultural change we need to achieve if we are to give ourselves the best chance of success. It is in the interests of both patients and taxpayers that we move away from a culture that is reluctant to adopt innovations invented in other parts of the system to one where NHS organisations promote and embrace innovation across the system. Tackling the behaviours and ways of thinking in the NHS that stand in the way of achieving quality will be a key focus over this next year.

“strategies and processes alone are not sufficient to drive the degree of change we are seeking”
NHS Management Board ways of thinking

Changing the way a system thinks and behaves starts at the top. The NHS Management Board looked at the behaviours and ways of thinking it needed to change to support the strategy and processes on quality. Here are three examples:

<table>
<thead>
<tr>
<th>Values and quality</th>
<th>Now: We care about quality but our focus is on resources and narrow quality metrics</th>
<th>To: I focus on cost, quality and value for money and do not think about one without the other, because every point wasted is someone’s lost opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>Now: We have long-term visions but the short-term focus takes all our energy</td>
<td>To: I will improve lives for every individual today and work consistently towards a long-term vision</td>
</tr>
<tr>
<td>Innovation</td>
<td>Now: We want to improve but innovation is risky and failure will be punished</td>
<td>To: I will be recognised for success and want to learn from failures as well as success in my restless pursuit of change and improvement through innovation</td>
</tr>
</tbody>
</table>

The NHS Management Board and the National Institute for Innovation and Improvement have identified activities and processes that form part of a toolkit to support change. They include setting out a consistent and compelling story for staff about what we are trying to do, as well as building the capabilities and skills of the NHS leadership to deliver the vision in a new way, which is work the National Leadership Council is taking forward. Changing behaviours and ways of thinking has started with the work of the NHS Management Board and piloting of the new SHA Assurance Framework process.

We want to encourage the leadership of the NHS to spend time and energy understanding the evidence of what has worked and to share their experiences of what has worked.

We have made available some of the tools and evidence we have been using and would encourage NHS Chief Executives to use this resource, which is available at www.institute.nhs.uk/chiefexecutivecommunity
4. Focusing on priorities

The role of the NHS Chief Executive is to create the right conditions for the NHS to deliver high quality care for patients today and to work to create the architecture, capabilities and culture to deliver better health for tomorrow. Understanding how that role is best placed to drive improvements for patients is an example of subsidiarity.

My diary is reviewed every six months to ensure that my activities are aligned with the key strategic priorities I need to focus on. Through this process, I identified four strategic priorities for the year – driving quality improvements, strengthening leadership, promoting innovation and, with the NHS Constitution, revisiting what matters to patients and staff and, through that process, agreeing a consistency of purpose for the NHS.

Putting quality at the heart of all we do

On a visit to the Torbay Care Trust in Devon, the staff described how they got started on their journey to becoming an integrated health and social care organisation. Their mantra is “Mrs Smith”. When the local trust sat down with the council to find a solution to improving care for their older population, they started by imagining a patient called Mrs Smith, and plotted her journey through the health and social care system. By understanding the entirety of that journey and the impact on her safety, her quality of care and her experience of the system, they found a consistency of purpose. Staff said that then drove the integration of adult health and social care locally as the optimum way, based on their evidence, to improve quality for their patients.

Focusing on the entirety of the journey through the system is what quality is all about. Torbay’s approach bears out the wider evidence that quality is systemic.
Patient safety. The first dimension of quality must be that we do no harm to patients. This means ensuring that the environment is safe and clean, and reducing avoidable harm such as excessive drug errors and rates of HCAIs.

Patient experience. Quality of care includes quality of caring. This means how personal care is – the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patients’ satisfaction with their own experiences.

Effectiveness of care. This means understanding success rates from different treatments for different conditions. Assessing this will include clinical measures such as mortality or survival rates, complication rates and measures of clinical improvement. Just as important is the effectiveness of care from the patient’s own perspective, which will be measured through patient-report outcomes measures (PROMS). Examples include improvement in pain-free movement after a joint replacement, or returning to work after treatment for depression. Clinical effectiveness may also extend to people’s wellbeing and ability to live independent lives.

“Focusing on the entirety of that journey through the system is what quality is all about”

Quality care cannot be provided by the heroic efforts of individual clinicians and support staff alone, or even by highly effective teams or organisations. Quality relies on all parts of the system working together. Without that system-wide approach, a patient can easily be let down when the efforts of one part of the system are undone by the shortcomings of another.

We asked staff what they needed to lift their performance on quality, both in their teams and as part of the wider system. And the answer was clear. They wanted good quality information about evidence-based treatments, access to information about how they and their teams are performing so that they can build on strengths and areas for improvement, and time and space to focus on learning and applying good practice.

It has been fantastic working with NHS Medical Director Professor Sir Bruce Keogh and his team, and with Sir Ian Carruthers (South West), Sir Neil McKay (East of England) and Mike Farrar (North West), in developing the architecture and incentives for taking quality forward.
Taking quality forward

We have been working with clinicians and staff across the system to develop a range of quality indicators so that NHS organisations can measure quality of care. In the past, there has been no consistent methodology or terminology. We consulted on a list of more than 400 potential indicators to produce an assured quality indicator menu. The aim is to give everyone, from individual clinical teams to SHA regions, a menu of existing indicators in the NHS by which they can measure their work. NICE is developing a set of quality standards to enable the service to be clear about what high quality care looks like. The National Quality Board is overseeing that process.

The work on the indicator menu means that service providers can start publishing Quality Accounts this year. These are a form of annual report to their patients and local communities setting out their approach and performance on quality.

The Commissioning for Quality and Innovation Scheme (CQUIN) is being put in place to reward organisations that focus on quality improvements and innovation in commissioning discussions and decisions. CQUIN is developing as a collaborative process between SHAs, PCTs and providers, sharing information on what works and developing ways of encouraging improvement.

At regional level, SHAs have started to establish quality observatories and appoint medical directors to oversee clinical leadership.

The new health and social care regulator, the Care Quality Commission (CQC), and NICE will be key to developing a consistent national approach to regulation and standards. The CQC is independently validating performance on quality, while NICE is selecting the best available standards for the new Quality Standards. This will be invaluable in defining what success looks like, releasing the time and energy of frontline staff to focus on improving quality of care.

“we need to be able to demonstrate what world class quality is and have the systems in place to measure it”

Former NHS West Midlands Chief Executive Cynthia Bower is leading the new Care Quality Commission
At national level, the National Quality Board has been established to provide strategic oversight and leadership on quality, with a strong focus on system alignment.

I am proud of what we have been able to achieve in this area, but there is much yet to do. To make it a reality, we need to be able to demonstrate what world class quality is and have the systems in place to measure it.

“leadership focused on the needs of local communities and patients has more chance of success”

Building world class leadership

We are lucky to have great leaders throughout the NHS. But if we are to achieve our vision on quality, we need to embrace more leaders from all levels in the service and from a wider range of backgrounds.

The evidence of what has worked to achieve “world best” in other countries and industries shows that leadership focused on the needs of local communities and patients has more chance of success than leadership focused on patrolling the boundaries of individual organisations or looking up to the centre.

This is a radically different way of looking at leadership in the NHS.

Fostering and developing leadership that recognises the importance of high quality care and how to achieve it is central to our expectations for the future. The ad hoc approach to leadership development across the NHS hasn’t been able to deliver the quality or quantity of leaders that we have needed.

We have made progress with the diversity of leadership in the NHS. There are more women, more people from black and minority ethnic communities and more clinicians involved than there were five to 10 years ago, but we still need more. There is a huge pool of untapped talent which we need to focus on.
My leadership journey

My own journey through the NHS began back in the early 1980s. After graduating from the National Management Training Scheme I worked in mental health services, mainly in Yorkshire, where I was involved in implementing the policy of closing the old asylums and developing services in the community. The lesson I learned from that period in my career was that it was possible to deliver big changes in the NHS if managers could harness the support of patients and their relatives.

Then I moved to Doncaster, where I was appointed as the Chief Executive of Doncaster Royal Infirmary – one of the first wave of NHS trusts to break free from Whitehall control. The period I spent leading that organisation taught me the power of engaging clinicians to mobilise support for making change. I recognised that once clinicians and staff were engaged in change, there was nothing stopping us from making real improvements to patient care.

And the third part of my career, which saw me as Regional Director in Trent and Chief Executive of Birmingham and the Black Country, and London, taught me the value of the system that underpins the NHS. Delivering change on a grand scale can only be achieved if all parts of the system are pointing in the right direction.

Leading the way

We have developed a new approach to leadership in the NHS. What the new Leadership Framework reinforces is that leadership is everyone’s business. It starts with the individual taking responsibility for their development and their line manager and organisation providing the support and development they need. At regional level, there need to be the right planning and conditions for leadership development to flourish. And at national level, our role is to advocate for leadership and to create the conditions for a strong leadership culture to grow. The work of the National Leadership Council, set up early in 2009, will take this forward.

What we need to guard against in the current economic climate is managers going one way, focusing on costs, and clinicians another way, focusing on quality. It’s essential that we keep both these groups together and united in a common purpose. The National Leadership Council will play a key role in reinforcing that linking quality and productivity together is the key focus going forward.
Five priority areas of the National Leadership Council

The Council has identified five priority areas that it will focus on, each led by a Champion (pictured).

**Strengthening clinical leadership**
*Dr Mark Goldman,*
Chief Executive,
Heart of England
NHS Foundation Trust

**Board development**
*Elizabeth Buggins,*
Chair,
NHS West Midlands

**Top leaders**
*Dr Barbara Hakin,*
Chief Executive,
NHS East Midlands

**Inclusion**
*Prem Singh,*
Chief Executive,
NHS Derby City

**Emerging leaders**
*Julian Hartley,*
Chief Executive,
Blackpool, Fylde and Wyre Hospitals
NHS Trust

Thanks to NHS Director General of Workforce, Clare Chapman, and the team who worked with us on setting up the Council.
Innovation

From the discovery of penicillin to the invention of the disposable hypodermic needle and the portable defibrillator, the UK has been at the forefront of health innovation. What staff told us during the Next Stage Review is that the NHS is world class at invention but poor at spreading and adopting good practices, products and effective treatments.

We held a series of innovation masterclasses through the year to showcase innovation in the regions. At the Sheffield event, Professor Wendy Tindale from Devices4Dignity used an innovation process map of the Yorkshire and Humber region to illustrate the complex set of relationships and processes, and sheer number of organisations, that are involved. The process map highlighted how daunting that journey can be.

We have not made it easy for innovation to flourish in the NHS. Yet putting innovation at the centre of what we do on a day-to-day basis is the key to driving sustained improvements in quality across the system and unlocking productivity gains.

Through the work of the Next Stage Review, we recognised the need to develop a coherent vision on innovation, invest in its development across the system and foster a leadership culture that supports innovation and risk taking. A key part of this involves recognising and rewarding innovators, and sharing and improving access to information, which Director General of Commissioning and System Management, Mark Britnell, and his team have worked on through the year.

In May 2009, we launched:

- **the Regional Innovation Fund** – £220 million over five years to support frontline staff to turn their best ideas into practice, managed by the SHAs

- **Innovation Challenge Prizes** – £20 million to reward breakthroughs in the biggest healthcare challenges, from childhood obesity to dementia. The challenges will be set every year. Five £1 million prizes are being launched in 2009, the biggest prizes ever awarded by the NHS

- **the Innovation Expo** – bringing together the world’s leading thinkers and doers, the Expo on 18–19 June is designed to inspire staff and raise the profile of the NHS as an innovation leader in the UK

- **NHS Evidence** – a new web-based one-stop shop for up-to-date clinical and non-clinical information, to support the work of health and social care staff. Go to www.evidence.nhs.uk

- **SHAs’ legal duty to promote innovation** – to raise the profile of innovation, promote collaboration, and support the spread and adoption of the best ideas across the system

“putting **innovation at the centre of what we do** is the key to driving sustained improvements in quality”
Academic Health Science Centres

UK research has played a key role in transforming healthcare, both here and globally. While the UK has featured among the top nations in the world in ratings lists for research and development, it has not enjoyed the same reputation for “bench to bedside” – bringing the benefits of that research to patients, and quickly. The role of Academic Health Science Centres is to bring together world-class research, education and patient care, with the aim of speeding up access to new and better-quality treatments and approaches. This year we announced the first five Academic Health Science Centres in the UK, flagship centres with the potential to benefit not only the NHS but to take their work across the globe:

- Cambridge University Health Partners
- Imperial College
- King’s Health Partners
- Manchester Academic Health Science Centre
- University College London Partners

Improving TB care at Imperial College London

In March 2009, on a visit to the St Mary’s Hospital campus of Imperial College with NHS London Chief Executive Ruth Carnell, Professor Ajit Lalvani demonstrated a new blood test for TB that he and his team have devised. The test makes it possible to accurately identify people who are carrying the TB infection but who have not yet gone on to develop the disease. This test has been heralded as the greatest advance in the diagnosis of TB in over a century. It’s an example of the benefits of bringing researchers and frontline care together to both improve the diagnosis and treatment of TB patients locally and to improve TB care worldwide.
Showcasing innovation in the regions

The Innovation Masterclass events in March showcased innovation in the regions. Innovation is not just about big scientific inventions – it is about identifying, adopting and spreading good practice, products and effective treatments, and evaluating their success.

At the Birmingham event, we heard about the nutritional toolkit, devised by Derbyshire County PCT, that helps people with learning disabilities to identify what they want to eat at mealtimes. The project started when staff recognised that they were making the food choices for their patients, so they started supplementing printed menus with pictures of food. As the project progressed, one of the inpatients became involved in researching the pictures. This became a food alphabet and toolkit, which is being used in the region to encourage healthy choices and to empower patients. It has won a number of innovation prizes.

At the Sheffield event, we saw how the design of a smaller, portable kidney dialysis machine offered the potential for patients to live more independent lives, and even to go on holidays without the relentless routine of having to come into the system for dialysis.

Both of the above are examples of innovation driving improvements in quality and of the system seeking to fit around the lives of patients.
Introducing Health Innovation and Education Clusters (HIECs)

These partnerships bring together healthcare providers, higher education and industry at regional level in order to drive innovation and accelerate delivery of the benefits of innovation and research to patients. They are also designed to raise the quality and co-ordination of healthcare education and training. Applications for the first round of clusters will be sought later this year.

David Nicholson meets Jenny and her two children taking part in the Carnegie programme

Tackling childhood obesity in Rotherham

There are already good examples in the system of the style of partnership working that the HIECs are designed to take forward.

Tackling childhood obesity is difficult to do in isolation. The work being done jointly by the Carnegie Weight Management Programme, Leeds Metropolitan University and NHS Rotherham is demonstrating the benefits of bringing together education, research and service provision.

Lord Darzi and I visited the Carnegie programme in September, meeting with families from Rotherham taking part in a programme for children aged eight to 17. They praised the integrated approach, which involves education, physical activity and research, saying that the programme had literally changed their lives. By focusing on families working as a team, and having local families supporting each other and changing their daily routines together, that intake of 38 children had lost over 100 kilograms between them.
The NHS Constitution

“The NHS belongs to the people. It is there to improve our health, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.”

I never fail to be moved by the preamble to the NHS Constitution because it brings together what the NHS is about and gives real meaning to the work I do, and have done, for more than 30 years.

Two years ago, amid all the reform and technical changes working their way through the system, the NHS was in danger of losing sight of its direction and purpose.

The NHS Constitution has changed all that. Put together by patients, the public and staff, it encapsulates the values of those who work in the service and those who use it.

The work of the Constitutional Advisory Forum meant that the final document was representative of a rich breadth of views. Thanks also to the SHA Chairs who put a huge amount of effort into leading the consultation process regionally and locally.
NHS East of England Chair, Keith Pearson

“We engaged all 125,000 staff in the East of England in the consultation through a personal email with direct links to the Constitution documents. Our media campaign resulted in more than 1 million opportunities for people to read coverage of the consultation. And we have made good use of low-cost, innovative engagement methods such as blogs, websites and online surveys. The blog created at NHS East of England has received almost 5,000 hits.”

The NHS Constitution does four key things:

• it pulls our rights and responsibilities together in one place. By doing this we provide patients and staff with clarity and clout

• it sets out two new rights – choice, which includes access to information to make an informed choice, and the right to NICE-approved drugs

• it sets out that every organisation providing services to the NHS must pay due regard to the Constitution. This includes the independent and private sectors, the regulators etc

• it sets the foundations for the NHS for the next 10 years and beyond

I have heard many times that people in the service really wanted consistency of purpose. In my view, this is the first step in getting that consistency of purpose. It brings together in one place what we are trying to achieve as we move forward.

We all now have a responsibility to give the NHS Constitution life and make it work.
5. Challenges ahead

We have a unique opportunity and a serious responsibility now to invest the growth of the next two years in plans that will benefit patients over the next five to 10 years. Our best chance lies in focusing on improving quality and productivity, linked together by innovation driving sustained improvements across the system.

Opportunities: quality, innovation, productivity

While the NHS has had a good year, can we say we have done our best when 25 per cent of patients in hospital beds don’t need to be there and could be looked after by NHS staff at home? When someone with a breast lump living in one location can get their tests and care in one place at a time convenient to them, while someone in another location spends months going from appointment to appointment in different places?

These are the sorts of challenge that our focus on quality gives us the best chance of tackling. When the NHS leadership team set out on the journey on quality, we committed to using the best evidence to shape our approach. The evidence has convinced us that our best chance lies in linking quality and productivity using innovation to drive sustained improvements across the system.

As many industries have done, the NHS needs to recognise that improving quality and value for money go hand in hand. The evidence from the United States, for instance, shows that the best-performing hospitals also have the lowest costs.
“the NHS needs to recognise that **improving quality** and value for money go hand in hand”

Innovation is the key to driving this objective, by prioritising the most effective treatments across the system and reducing waste and errors. Getting it right for patients the first time means not only better care but also better value for money, as it avoids costly follow-up treatment.

Our work this year to reduce HCAIs not only saved patients’ lives but also saved the NHS £75 million.

Innovation is the way we achieve sustained improvements across the system and unlock productivity gains. It presents a unique opportunity for clinicians and managers to address long-standing problems and accelerate the pace of new developments.

Former NHS Yorkshire and Humber Chief Executive Margaret Edwards is leading a new NHS Productivity Unit so that we have access to the best evidence and advice as we move forward.

It is important that what we do locally on productivity gains is aligned with what matters for patients, and is not just done for the sake of making gains.

“It is important that what we do locally on productivity gains is aligned with what matters for patients“
Our finances

The NHS has enjoyed a remarkable period of growth since 1997, and we have repaid the faith taxpayers and the Government have placed in us by significantly improving services for patients and restoring staff morale and public confidence in the NHS.

The Government’s vote of confidence continued this year, with a total of 11 per cent growth over the next two years which will be locked in on a recurring basis, and the facility to draw down £800 million of the NHS surplus.

The NHS has a great track record on delivering efficiency savings. This year we asked PCTs and Trusts to explore a range of opportunities, such as making better use of the existing NHS estate and using shared services in back-office operations.

“we unlock efficiency gains by using commissioning to build more efficient pathways”

Over the year, Director General of NHS Finance, Performance and Operations, David Flory, led work on redesigning the national tariff. We are using the new tariff to reward and drive both better quality and better efficiency by reducing unit costs and moving towards pricing based on best practice, and we want to deliver further gains by developing the tariff into non-acute services.

World class commissioning is delivering more strategic and long-term planning of local health services. We have strong levers in place to unlock efficiency gains by using commissioning to build more efficient pathways and reduce investment in services that don’t deliver on quality and value for money. But we need to drive more value from commissioning, including looking at more pooling of resources.
NHS Shared Business Services

In November, I visited the Indian operations of NHS Shared Business Services (NHS SBS). We spoke about the role of their work in the bigger story about achieving efficiency gains to free up resources to improve frontline services for patients.

NHS SBS has more than 100 trusts on its books, has achieved operational efficiencies of up to 30 per cent for some of those trusts, and has delivered more than £40 million in savings this year.

Trusts still retaining in-house corporate services need to be clear that the decision to retain them represents better value for money than outsourcing them to NHS SBS or other shared service or outsourcing solutions.
The National Programme for IT (NPfIT)

A key challenge in getting more value from commissioning is to make better use of the incredible breadth of information held in the NHS. Commissioners need access to the best evidence and information so that they can design clinical pathways based on what works and what delivers excellence.

The desire to provide that access and better tools for organising this information in order to improve quality lies at the heart of NPfIT.

NPfIT has delivered some impressive benefits. We are the only G8 country to have fully implemented a digital imaging and scanning system, and Choose and Book is routinely offering patients a choice of hospital and appointment when they are referred by their GP.

“We are the only G8 country to have **fully implemented** a digital imaging and scanning system”

Christine Connelly joining the Department in September as the first Chief Information Officer for Health was the right opportunity to review the programme and sharpen our focus on the deployment of the hospital-based systems.
Our role in the downturn

The state of the economy has sharpened the focus on how we are going to go further in seeking improvements in quality and productivity.

But we must not let the “how to’s” cloud the fundamental role that the NHS needs to play to care and support people, and to drive economic growth and recovery. The NHS does this in four ways:

• We provide comprehensive access to care, free at the point of need. The NHS will continue to be there when people need it most

• We are the country’s largest employer and a major investor. Our investment is central to industries in the wider economy, such as construction and pharmaceuticals

• We drive innovation, with a significant impact on leading-edge science and innovation across the wider economy

• We are committed to driving efficiencies, and are in better shape to respond to the challenge of driving further improvements in productivity

We have put in place measures to respond to some of the specific effects of the recession, including improving access to primary care services and investing in mental health services to address depression and anxiety. Also, we are:

• doubling investment in apprenticeships, with 5,000 new posts across health and social care

• investing more than £7 billion for new and upgraded NHS facilities in 2009/10, with more than 31,000 jobs linked to that investment

• increasing our use of Local Employment Partnerships to help tackle long-term unemployment

“The state of the economy has sharpened the focus on how we are going to go further in seeking improvements in quality and productivity”
The year ahead

Getting in shape for the future

We have benefited this year from the stability of no structural re-organisation, a key commitment of the Secretary of State. As we take the quality agenda forward, we need to check that the roles of different parts of the system are working to support that agenda.

London, for instance, has made good progress this year working on local arrangements designed to strengthen commissioning.

In addition, the SHA Assurance Process will ensure that we understand the role of the SHAs in supporting quality and can make the most of that role. NHS South Central, led by Chief Executive Jim Easton, is piloting the assurance process and the lessons we learn will benefit every SHA as we move forward.

“We have benefited this year from the stability of no structural re-organisation”
Comprehensive Spending Review

Looking ahead to the next Spending Review, we need to be planning for a much tighter financial environment than we have had in recent years. We need to start that work in earnest now.

We know that NHS investment will grow by 11 per cent over the next two years. That growth will be locked in on a recurring basis, so we have a real opportunity to prepare for harder times.

After those two years, we must be prepared for a range of scenarios, including the possibility that investment will be frozen for a time. We should also plan on the assumption that we will need to release unprecedented levels of efficiency savings between 2011 and 2014 – between £15 billion and £20 billion across the service over the three years. This is so that we can deal with changing demographics, the implementation of the regional visions and cost pressures in the system. That level of productivity gain can only be realised through the kind of quality improvements and advances in innovation described earlier in this report.

We have a unique opportunity and a serious responsibility now to invest the growth of the next two years in plans that will benefit patients over the next five to ten years.

I am the first to acknowledge that the system was built during a period of growth. Payment by Results, foundation trusts and National Service Frameworks are all things that have been built in an era of increasing growth and capacity.

We need to look at the system reform levers we have put in place and test them to see if they are robust and strong enough to take us through a recession. This is the prudent thing to do and will form part of our preparation for the Operating Framework 2010/11. At the centre, we need to think carefully about what we are going to do in policy terms and make sure that this connects with improving quality and value for money.
We should all be proud of what the NHS has achieved for patients this year. It’s the culmination of two years of hard work. We delivered what we said we would.

At the same time, we have made tremendous progress in this third phase of the NHS reform story, mobilising clinicians and managers around a shared vision of improving quality and developing plans and processes for taking quality forward.

We have set the bar high with our ambitions on quality. And as we seek to move forward with implementing these plans, the threat of pandemic flu and the consequences of low growth flag riskier times ahead.

We have a choice. We can sit back and wait for things to be done to us. Or we can seize the opportunity we have with our plans for quality.

The global evidence shows us that our best chance lies with a relentless focus on quality and value for money, linked together by innovation driving sustained improvements across the system.

The NHS is well placed but there is absolutely no room for complacency. We must accelerate the pace of reform. It is time now to go further and faster.

“We have set the bar high with our ambitions on quality”
I have four challenges for the NHS leadership over the coming year:

- Focus on driving quality up and costs down
- Accelerate the pace of reform, particularly by expanding choice
- Continue to look out, not up. Focus on working with clinicians, local partners, patients and the public, and on being accountable to them
- Support clinicians and managers to work together with a shared purpose

And I have four challenges for us at the centre:

- Connect policy developments with driving quality up and costs down
- Maintain consistency of purpose
- Remain committed to no new national targets
- Remain committed to no structural reorganisation of the NHS

“The NHS is well placed but there is absolutely no room for complacency. We must accelerate the pace of reform. It is time now to go further and faster”

It is a fantastic management challenge and an opportunity for all NHS staff to make significant improvements in quality for patients over the coming years.

David Nicholson
NHS Chief Executive
The NHS leadership team 2008/09

During the year, I finalised the make-up of the NHS leadership team, which brings together a fantastic group of people from both within and outside the NHS to give leadership and direction on key areas of policy and performance.

I was delighted to welcome Christine Connelly as the first Chief Information Officer for Health.

I would like to thank the NHS Management Team for their support and hard work this year.
What a fantastic celebration of the first 60 years of the NHS. Here are just some of the ways we celebrated.