

NHS Future Forum

Summary report on proposed
changes to the NHS

Professor Steve Field – Chairman

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Letter to the Prime Minister, Deputy Prime Minister and the Secretary of State for Health

Dear Prime Minister, Deputy Prime Minister and Secretary of State,



The NHS has always been there for me. It has taken care of me and my family whenever we have needed it. It has been a huge privilege to work as a doctor in the NHS for my entire career. I know that its core principles and values are as important now as they were when it was launched. They have become part of the fabric of our society, binding together the people and communities that it serves and the staff that work for it.

It has, therefore, been a great responsibility to lead this process. As I have listened over the last eight weeks I have done so with the opening words of the NHS Constitution at the forefront of my mind. The powerful opening statement constantly reminded me of the seriousness of the task we were set and, more fundamentally, of what the NHS is striving to achieve every single day:

“The NHS belongs to the people. It is there to improve our health and wellbeing, 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 to the end of our lives. 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 need, when care and compassion are what matters most”.

The level of the engagement we have seen in just eight weeks has been staggering and highlights how important the future of the NHS is to staff, patients, citizens and all those organisations that care about its success. Over 6,700 people have attended listening events with members of the NHS Future Forum, 3,000 comments have been posted on the website, over 25,000 people have emailed us and 600 people have taken the time to complete a questionnaire. I am clear that the reason people have been so willing to enter into a meaningful, constructive and insightful dialogue with us and with each other is not because they don't believe the NHS needs to change but because they want any changes to be the right ones and to feel ownership of them.

Based on what I have heard, my messages to you are:

- The Government's stated aim of making improvement in quality and healthcare outcomes the primary purpose of all NHS funded care is universally supported. However, during our listening, we heard genuine and deep seated concerns from NHS staff, patients and the public which must be addressed if the reforms are to be progressed. If the substantial changes we propose are accepted by Government, then I believe that the resulting framework will place the NHS in a strong position to meet this objective and tackle the pressing challenges in the years ahead;
- It is right that GPs should take responsibility for the health of their local populations and the financial and quality consequences of their clinical decisions through a comprehensive system of commissioning consortia. But, they cannot and should not do this on their own and must be required to obtain all relevant multi-professional advice to inform commissioning decisions and the redesign of patient pathways;
- Services must change in order to meet the needs of local populations. This will require difficult decisions, especially about the location of some services and hospitals. These decisions will need to be sensitively handled but must be clinically-led;
- The place of competition should be as a tool for supporting choice, promoting integration and improving quality. It should never be pursued as an end in itself. Monitor's role in relation to 'promoting' competition should be significantly diluted;
- The declaration of 'no decision about me, without me' must be hard-wired into every part of the system – from the legislation through to each and every encounter between a patient and a healthcare professional;
- There has been too much focus on different parts of the system – GPs, hospitals, public health – and insufficient attention to how they all join up to provide the integrated care that patients need;
- Because the NHS 'belongs to the people' there must be transparency about how public money is spent and how and why decisions are made and the outcomes being achieved at every level of the system; and
- The education and training of the healthcare workforce is the foundation on which the NHS is built and the single most important thing in raising standards of care. More time is needed to get this right - the effects of mistakes made now will be felt for a generation.

Everybody agrees that while the NHS has improved over the past ten years, it can't stand still. The NHS must address the challenges that lie ahead. It must continuously

be looking for new ways to improve patient safety and to drive up quality and value in a very difficult financial climate, to ensure its future sustainability.

There will be rising demand as a result of an ageing population. Many of these people will live long, healthy and productive lives. But, increasing numbers of them will suffer from conditions such as arthritis, chronic heart and lung disease and dementia that will affect the quality of their lives and place significant demands on their families, carers and the health and social care system. A greater proportion of NHS funding will need to be targeted at the increasing numbers of frail older people. The NHS must also meet the costs of sophisticated but expensive new drugs and technologies. It must tackle unacceptable variations in quality, keep pace with public expectations and raise these expectations where they are simply too low. Meeting all these challenges requires constant evolution and adaptation.

As a jobbing GP, I've experienced first hand how healthcare is changing. I know that some of my patients are alive now because of new treatments that have been introduced into our NHS in the years since I qualified.

For example, children who are born with cystic fibrosis, the serious lung disease with multiple chronic complications including diabetes are now less likely to die in childhood but, because of advances in medicine, may live into their forties, fifties, or older. The breakthroughs in their treatment occurred because children cared for by the NHS took part in research studies. Advances which increase life expectancy and quality of life will cost more if ongoing treatment is required into adulthood, unless a cure is found.

My patients are living longer, with many of my older patients coping with a number of conditions at the same time, but still living full and active lives. We have seen operations which were once pioneering, like coronary stents and angioplasties become commonplace, while drugs such as statins and new cancer treatments have transformed people's lives. Safer surgical techniques and better anaesthetic mean it's now safe to offer treatment to people who would previously have been seen as too frail.

How I interact with my patients has also changed. My consultations are longer because patients' problems are more complex and they often have many physical, psychological and social problems all at the same time. These days, my patients rightly want the same information, choices and convenience in healthcare as in other areas of their busy lives and, above all else, want to have more control.

I am optimistic about the future of healthcare in this country. Every week I read the results of a clinical trial or hear of a new medical advance with the prospects of a new cure or opportunities to transform many of my patients' lives for the better. But, these advances and new opportunities will cost money. Various reports tell us that we need to spend three or four per cent more per year just to keep pace with the new things we can do for our patients. And, in this time of large fiscal deficits and tight control of public spending, we can't keep asking the taxpayer to pay more and

more. Instead, clinicians are going to have to make some difficult decisions on how we spend the money more effectively and importantly how not to spend money on treatments that don't work.

I have been a doctor in the NHS since 1982 and seen the NHS improve over those years. But, I believe the current model of care cannot be sustained in the future. The NHS of today is mostly about the provision of episodic treatment of illnesses such as cancer and cardiovascular disease. Priority has been on acute hospitals and providing effective interventions and treatments for people affected by those life threatening conditions.

I believe that the NHS must change. It must reassess the old model of hospital based care. A high priority now needs to be given to meeting the needs of the increasing numbers of older people. As people get older, they will require more support from both the NHS and social care to enable them to live independently in the community for as long as possible.

The NHS will need to move from focusing on treating people when they are acutely ill to focusing on prevention and supporting self-care as well. We will need to move resources away from hospitals so that we can provide more care in the community and in people's homes. Many patients and healthcare staff have told us that priority should be given to enabling more people to have their wishes granted to die at home rather than in hospital. To provide this choice for people at the end of life will require an integrated approach in health and social care with greater involvement of the third sector, including the hospice movement. Moving to the new model will require a much more comprehensive approach that improves the coordination of services for patients and their relatives.

In primary care we need to continue to improve access to services, reduce variations in their quality and provide additional services that help to keep people out of hospital. GPs, their primary care teams, social care professionals and specialists must work much more closely together as part of extended teams to ensure that the care provided is effectively co-ordinated. Better information systems and the development of more integrated electronic care records will be a major enabling factor for this.

To give clinicians like myself the headroom to offer our patients the very best care that we can, we are going to have to decide where to disinvest, how to become more efficient, where to root-out waste and target our limited budgets on where we can do the most good for the money spent. We need to do this not to reduce what the NHS does but to take advantage of new opportunities for healthier and longer lives that previous generations would never have thought possible. And, we need to do this in partnership with the patients and citizens we are there to serve.

If we are going to seize these opportunities there must be change. But any change must be carefully guided by the enduring values of the NHS, as set out in our NHS

Constitution, and a relentless focus on purpose – the provision of high quality care and improved outcomes for patients.

It was encouraging to read in last year's White Paper that the Government made clear that it would build on Lord Darzi's review of the NHS and "establish improvement in quality and healthcare outcomes as the primary purpose of all NHS funded care". The important definition of quality that his report set out (safety, effectiveness and patient experience) has been incorporated into the Health and Social Care Bill. The Government has since set out a powerful new accountability framework for the NHS, called *the NHS Outcomes Framework*, which is designed to focus the whole system from top to bottom on the outcomes achieved for patients. These are important and positive steps forward.

So if there is agreement about the principles and the need for change, what has gone wrong? At best, the Health and Social Care Bill has received lacklustre support from many staff groups, open hostility from others and has been lambasted in much of the press. This opposition was not merely political – it stemmed from genuine fear and anxiety that the reforms would not deliver the improvements that we all want. This fear and mistrust was expressed by many patients and staff that we met. Many told us that they feared for their own job prospects, others because they feared that their NHS was about to be broken up and in their words 'privatised'.

Some of this fear was misplaced and the result of a failure by the Government to clearly explain how the structural and technical details of the Bill would help the NHS improve today and tomorrow. Undoubtedly, the debate has focused too heavily on the means, without a clear enough link to the ends – the provision of high quality care and improved outcomes for patients.

However, in other areas we found people's concerns to be justified. Whilst there was never any intention to introduce a market in the style of the utilities sector into healthcare, the Bill contained insufficient safeguards against cherry-picking and was not sufficiently clear that competition would only exist when it served the interests of patients not profit. In other areas, whilst NHS staff supported the general thrust of the reforms, they were anxious that the deadlines would force them to take on responsibilities before they had the skills or capacity to undertake them in a way that would improve patient care. And, in a few areas, such as the proposals for education and workforce training, there were genuine concerns that there was simply not enough evidence or detail to justify such radical change where the consequences of failure are so significant and long lasting.

So, in taking forward our task, we have done one simple thing: we have taken the key building blocks of the reform programme and looked at them through the lens of whether they will help or hinder the delivery of high quality care and improved outcomes for patients. Where we have identified weaknesses in the legislative framework or broader policy, we have recommended changes. Where there has been failure to explain, we have sought to provide clarifications about the purpose as well as the mechanisms in the Bill. Where there has been genuine anxiety and

mistrust, we are recommending safeguards for the avoidance of doubt. And, where the case for change has yet to be proven, we have recommended that further work be carried out. At all times, the pursuit of high quality care and improved outcomes for patients has guided us in our recommendations and must be the guiding principle for any change, whether at a national or local level.

It was right to pause and reflect. It has, however, been a destabilising period for the NHS and an unsettling time for staff and for patients. It is time for the pause to end. I believe that the advice and recommendations we present in this report, if acted upon, will help the NHS to move forward and refocus its efforts on delivering excellence in patient care and building the NHS of the future. The core recommendations of the full NHS Future Forum are:

- **The enduring values of the NHS and the rights of patients and citizens as set out in the NHS Constitution are universally supported and should be protected and promoted at all times.** The Bill should be amended to place a new duty on the NHS Commissioning Board and commissioning consortia to actively promote the NHS Constitution. In addition, Monitor, the Care Quality Commission, the NHS Commissioning Board and commissioning consortia should all set out how they are meeting their duty to have regard to the NHS Constitution in their annual reports.
- **The NHS should be freed from day-to-day political interference but the Secretary of State must remain ultimately accountable for the National Health Service.** The Bill should be amended to make this clear.
- **Patients and carers want to be equal partners with healthcare professionals in discussions and decisions about their health and care. Citizens want their involvement in decisions about the design of their local health services to be genuine, authentic and meaningful. There can be no place for tokenism or paternalism.** The declaration of ‘no decision about me, without me’ must become a reality, supported by stronger and clearer duties of involvement written into the Bill focused on the principles of shared decision-making.
- **Because the NHS ‘belongs to the people’ there must be transparency about how public money is spent and how and why decisions are made.** The Bill should require commissioning consortia to have a governing body that meets in public with effective independent representation to protect against conflicts of interest. Members of the governing body should abide by the Nolan principles of public life. All commissioners and significant providers of NHS-funded services, including NHS Foundation Trusts, should be required, as a minimum, to publish board papers and minutes and hold their board meetings in public. Foundation Trust governors must be given appropriate training and support to oversee their Trust’s performance – until governors have the necessary skills and capability to take on this role effectively, Monitor’s compliance role should continue.

- **GPs, specialist doctors, nurses, allied health professionals and all other health and care professionals state that there must be effective multi-professional involvement in the design and commissioning of services working in partnership with managers.** Arrangements for multi-professional involvement in the design and commissioning of services are needed at every level of the system. The Bill should require commissioning consortia to obtain all relevant multi-professional advice to inform commissioning decisions and the authorisation and annual assessment process should be used to assure this. In support of this, there should be a strong role for clinical and professional networks in the new system and multi-speciality clinical senates should be established to provide strategic advice to local commissioning consortia, health and wellbeing boards and the NHS Commissioning Board.
- **Managers have a critical role to play in working with and supporting clinicians and clinical leaders.** Experienced managers must be retained in order to ensure a smooth transition and support clinical leaders in tackling the financial challenges facing the NHS.
- **There should be a comprehensive system of commissioning consortia but they should only take on their full range of responsibilities when they can demonstrate that they have the right skills, capacity and capability to do so.** The assessment of the skills, capacity and capability of commissioning consortia must be placed at the heart of authorisation and annual assessment process. Where commissioning consortia are not ready, the NHS Commissioning Board should commission on their behalf but provide all necessary support to enable the transfer of power to take place as soon as possible.
- **Patients want to have real choice and control over their care that extends well beyond just choice of provider.** Building on the NHS Constitution, the Secretary of State should, following full public consultation, give a ‘choice mandate’ to the NHS Commissioning Board setting out the parameters for choice and competition in all parts of the service. A Citizens Panel, as part of Healthwatch England, should report to Parliament on how well the mandate has been implemented and further work should be done to give citizens a new ‘Right to Challenge’ poor quality services and lack of choice.
- **Competition should be used as a tool for supporting choice, promoting integration and improving quality and must never be pursued as an end in itself.** Monitor’s role in relation to competition should be significantly diluted in the Bill. Its primary duty to ‘promote’ competition should be removed and the Bill should be amended to require Monitor to support choice, collaboration and integration.
- **Private providers should not be allowed to ‘cherry pick’ patients and the Government should not seek to increase the role of the private sector as an end in itself.** Additional safeguards should be brought forward.

- **The duties placed on the Secretary of State, the NHS Commissioning Board and commissioning consortia to reduce health inequalities are welcome. These now need to be translated into practical action.** The Mandate for the NHS Commissioning Board, the outcomes frameworks for the NHS, public health and social care, commissioning plans and other system levers and incentives must all be used to help reduce health inequalities and improve the health of the most vulnerable.
- **Local government and NHS staff see huge potential in health and wellbeing boards becoming the generators of health and social care integration and in ensuring the needs of local populations and vulnerable people are met.** The legislation should strengthen the role and influence of health and wellbeing boards in this respect, giving them stronger powers to require commissioners of both local NHS and social care services to account if their commissioning plans are not in line with the joint health and wellbeing strategy.
- **Better integration of commissioning across health and social care should be the ambition for all local areas.** To support the system to make progress towards this, the boundaries of local commissioning consortia should not normally cross those of local authorities, with any departure needing to be clearly justified. The Government and the NHS Commissioning Board should enable a set of joint commissioning demonstration sites between health, social care and public health and evaluate their effectiveness.
- **Most NHS staff are unfamiliar with the Government's proposed changes to the education and training of the healthcare workforce. Those who are aware feel that much more time is needed to work through the detail.** The ultimate aim should be to have a multi-disciplinary and inter-professional system driven by employers. The roles of the postgraduate medical deaneries must be preserved and an interim home within the NHS found urgently. The professional development of all staff providing NHS funded services is critical to the delivery of safe, high quality care but is not being taken seriously enough. The National Quality Board should urgently examine how the situation can be improved and the constitutional pledge to 'provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed' be honoured.
- **Improving the public's health is everyone's business but should be supported by independent, expert public health advice at every level of the system.** In order to ensure a coherent system-wide approach to improving and protecting the public's health, all local authorities, health and social care bodies (including NHS funded providers) must cooperate. At a national level, to ensure the provision of independent scientific advice to the public and the Government is not compromised we advise against establishing Public Health England fully within the Department of Health.

- **Clinical leaders, managers and all those who care about the success of the NHS agree that quality, safety and meeting the financial challenge must take primacy and the pace of transition should reflect this.** To ensure focused leadership for quality, safety and the financial challenge, the NHS Commissioning Board should be established as soon as possible.

I would like to thank the thousands of individuals and organisations that have made their contribution to the work of the NHS Future Forum, and to the 44 members of the Forum itself. Without their genuine commitment and serious hard work, it would not have been possible to write this report.

It is now time to move on but the active listening must continue – the NHS Future Forum stands ready to help listen and to advise.

*Yours,
Steve Field*

Professor Steve Field CBE FRCGP FRCP

The NHS Future Forum

– our role and how we listened

Introduction

On 6 April, the Government announced that it would take advantage of a natural break in the legislative timetable to “pause, listen and reflect” on modernisation plans and bring about improvements to the Health and Social Care Bill where necessary.

An eight-week NHS Listening Exercise was announced. The objective was not to repeat the formal public consultations which had already taken place, but to reflect on the areas which had prompted the most heated discussion and debate and bring forward improvements to the legislation where necessary. The four core themes of the NHS Listening Exercise were:

- Choice and competition
- Clinical advice and leadership
- Patient involvement and public accountability
- Education and training

The NHS Future Forum

The NHS Future Forum was established as an independent advisory panel to drive engagement around the listening exercise, listen to people’s concerns, report back on what we heard and offer advice to the Prime Minister, Deputy Prime Minister and the Secretary of State for Health on how the Government’s modernisation plans for the NHS might be improved.

The Forum, chaired by Professor Steve Field immediate past Chairman of the Royal College of GPs, brings together 45 individuals from a diverse range of backgrounds including frontline clinicians, healthcare managers and representatives from the voluntary sector, local government and patient bodies amongst others.

As a Forum we divided ourselves into four working groups to tackle each of the core themes and committed to undertake an intensive period of listening and reflection. Each of these groups was led by a workstream lead:

- **Sir Stephen Bubb**, lead for Choice and Competition (Chief Executive of the Association of Chief Executives of Voluntary Organisations)
- **Dr Kathy McLean**, lead for Clinical Advice and Leadership (Medical Director of NHS East Midlands)

- **Julie Moore**, lead for Education and Training (Chief Executive of University Hospitals Birmingham)
- **Geoff Alltimes**, lead for Patient Involvement and Public Accountability (Chief Executive of Hammersmith and Fulham Borough Council)

The timescales for the listening period were tight and challenging with many of us working full-time, including many as practising clinicians. However, we worked as a group to maximise the engagement opportunities presented to us. We also mobilised existing networks, events and used new ways of engagement such as webchats and blogs to reach key audiences.

We came together as a whole at regular intervals to share and cross-reference key themes coming out of the exercise and worked together to develop our recommendations.

- **Lord Victor Adebowale**, Chief Executive, Turning Point
- **Dr Charles Alessi**, Senior GP Partner, The Churchill Practice
- **Geoff Alltimes**, Chief Executive, London Borough of Hammersmith and Fulham
- **Dr Frank Atherton**, President, Association of Directors of Public Health
- **Vicky Bailey**, Chief Operating Officer, Principia, Partners in Health, Nottingham
- **Sally Brearley**, Patient representative
- **Sheila Bremner**, Chief Executive, Mid Essex Primary Care Trust
- **Dr Simon Brown**, Huntington GP Consortia pathfinder lead
- **Sir Stephen Bubb**, Chief Executive, Association of Chief Executives of Voluntary Organisations
- **Professor Hilary Chapman**, Chief Nurse, Sheffield Teaching Hospitals
- **Ratna Dutt**, Chief Executive, Race Equality Foundation
- **Moira Gibb**, Chief Executive, London Borough of Camden
- **Mark Goldring**, Chief Executive, Mencap
- **Paul Farmer**, Chief Executive, Mind
- **Mr Derek Fawcett**, Consultant Urological Surgeon, Royal Berkshire NHS Foundation Trust
- **Professor David Fish**, Managing Director, UCLPartners
- **Peter Hay**, Strategic Director, Adults and Communities, Birmingham City Council; and Vice President, Association of Directors of Adult Social Services
- **Thomas Hughes-Hallett**, Chief Executive, Marie Curie Cancer Care
- **Prof. David Kerr**, Professor of Cancer Medicine, Oxford University
- **Joanna Killian**, Chief Executive, Essex County Council
- **Clare Leon-Villapalos**, Intensive Care Nurse, Imperial College Healthcare NHS Trust
- **Dr Paul Lelliott**, Consultant Psychiatrist, Oxleas NHS Foundation Trust
- **Chris Long**, Chief Executive, Hull PCT
- **Malcolm Lowe-Lauri**, Chief Executive, University Hospitals of Leicester NHS Trust
- **Bill McCarthy**, Chief Executive, Yorkshire and Humber Strategic Health Authority
- **Claire Marshall**, Head of Professions, Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- **Anthony McKeever**, Chief Executive, Bexley Care Trust
- **Dr Kathy McLean**, Medical Director, NHS East Midlands
- **Julie Moore**, Chief Executive, University Hospitals Birmingham NHS Foundation Trust
- **Dr Peter Nightingale**, President, Royal College of Anaesthetists
- **Mr Dermot O’Riordan**, Medical Director and Consultant Surgeon, West Suffolk Hospital NHS Trust
- **Dr Niti Pall**, Practising GP, Smethwick; Chair and Clinical Lead, West Midlands Third Wave pathfinder consortia
- **Tom Riordan**, Chief Executive, Leeds City Council
- **Cllr. David Rogers**, Chair, Local Government Association Community Health and Wellbeing Board
- **Duncan Selbie**, Chief Executive, Brighton & Sussex University Hospitals Trust
- **Mr Matthew Shaw**, Orthopaedic Surgeon and Co-founder, Remedy UK
- **Ash Soni**, Pharmacist, Lambeth; and Chair, Lambeth Professional Executive Committee
- **Professor Jimmy Steele**, Head of School and Professor of Oral Health Services Research, Newcastle University
- **Professor Terence Stephenson**, President, Royal College of Paediatrics and Child Health
- **Jeremy Taylor**, Chief Executive, National Voices
- **Professor Sir John Tooke**, Vice-Provost, University College London
- **Dr Robert Varnam**, Practising GP, Manchester
- **Gill Walton**, Director of Midwifery, Portsmouth Hospitals NHS Trust
- **Mr Francis Wells**, Consultant Cardiothoracic Surgeon, Papworth Hospital NHS Foundation Trust

NHS Future Forum Members



How we listened

Face to face listening – we met with a large number of people face to face to hear firsthand views, concerns and solutions of patients, the public, NHS staff and stakeholders. In total, we met with over 6,700 people in a series of over 200 listening events and meetings. These meetings and events included:

- **Meetings and events with over 250 national stakeholder organisations** - through proactive engagement, a number of national stakeholders offered to host or revise existing agendas to accommodate listening events with their members and representatives in order to feed their views into the listening exercise. These organisations included patient groups, professional bodies and unions, third sector groups, as well as local government, regulators and the independent sector.
- **Regional listening events and meetings** - Strategic Health Authorities (SHAs) across the country supported the listening exercise by encouraging staff, communities and stakeholders at regional and local levels to share their views online. Furthermore, the SHAs used several hundred events and meetings to engage people in the exercise. We attended a number of these meetings across the country and the themes from the meetings were collated regionally and then shared with the Forum.
- **Patient and public engagement** – members of Local Involvement Networks (LINKs) were invited to two national listening events with the Forum to feed in views from their communities. Furthermore, regional representatives from patient organisations, the third sector and LINKs were invited to a series of nine regional events hosted by Regional Voices. Over 100 patients and patient representatives with long-term conditions were also invited to a national patient event hosted by Rethink.

Online engagement

People were encouraged to share their views with the NHS Future Forum in a number of ways including:

- **Webchats** – we took part in a series of webchats with the public through the Department of Health modernisation site, the Guardian site and the British Medical Association site.
- **Comments via the modernisation website** – members of the public and stakeholders were invited to leave comments either publicly or privately via the modernisation website. More than 3,000 comments were received through the website.

- **NHS Future Forum inbox** – members of the public and stakeholders were also invited to email comments and viewpoints via a dedicated inbox if they preferred, which were shared with the Forum. Over 25,000 emails were received and 600 people took the time to complete a questionnaire. It is important to point out that a large proportion of these emails were generated by campaign groups and that as a result, many of them contained similar wording. Nonetheless, our approach is that if an individual sees fit to take part in such campaigns, their email is fully considered.
- **Social networks** - many of us also made use of social network routes such as Twitter to promote ways to get involved.

The NHS Future Forum is very grateful to the thousands of people who took the time to talk to us and to submit their views.

The NHS Constitution

As the NHS Future Forum listened across each of the four core themes of the Listening Exercise, the importance and relevance of the NHS Constitution became increasingly apparent. Indeed, its seven key principles have helped guide the writing of this report and our recommendations:

1. The NHS provides a comprehensive service, available to all
2. Access to NHS services is based on clinical need, not an individual's ability to pay
3. The NHS aspires to the highest standards of excellence and professionalism in the provision of high quality care that is safe, effective and focussed on the patient experience
4. NHS services must reflect the needs and preferences of patients, their families and their carers
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
6. The NHS is committed to providing best value for taxpayers' money and the most cost effective, fair and sustainable use of finite resources
7. The NHS is accountable to the public, communities and patients that it serves

The Forum is united in its support for the enduring values of the NHS and the rights of patients and citizens set out in the NHS Constitution. However, we believe that awareness amongst patients and the public of their rights is low so we are calling for the Health and Social Care Bill to be amended to include new duties on the NHS Commissioning Board and commissioning consortia to actively promote and raise awareness of the NHS Constitution and the rights it enshrines.

Furthermore, we recommend that the NHS Commissioning Board, commissioning consortia, Monitor and the Care Quality Commission should all set out how they are meeting their duty to have regard to the NHS Constitution in exercising their functions in their annual reports.

Patient confidence and trust in their care and in the health professionals looking after them is an essential element of good healthcare. The Listening Exercise revealed that the NHS is associated with very positive attributes by the public and staff – affection, trust, integrity and strong pride in the institution of the NHS.

Everyone involved in our listening has agreed that the values of the NHS must endure and the NHS must continue to be a national institution of which patients, the public and staff alike are proud. Knowing that every aspect of care is underpinned by the enduring values of the NHS is important to patients and the public in all their interactions with the health service. We therefore feel that an important part of this sense of pride involves being clear with patients and the public about when they are receiving NHS funded care regardless of whether it is being provided by a large teaching hospital, GP surgery, pharmacy, third sector organisation or independent provider.

Integration and collaboration

One of the ways the NHS can deliver care that upholds the principles and values of the NHS Constitution is increased integration of care around the needs of the patient. This was a core theme in many of our discussions.

The Government's proposals for the NHS have attracted many claims that they will create fragmentation and undermine integration of services around the needs of patients and individuals. What is also clear is that services under the existing system are currently highly fragmented across the NHS, public health and social care; and within the NHS, between primary, secondary and tertiary care. Regardless of whether our discussions were focussed on the issue of public accountability and patient involvement, competition and choice or clinical advice and leadership, concerns around integration came up time and time again. The importance of collaboration and integration between different care sectors and care settings are, therefore, strong themes in each of the separate workstream reports and important recommendations for strengthening collaboration and integration are put forward.

There are already examples of successful integration of health and social care at different levels in the NHS. While there are many examples in local communities of multidisciplinary teams working together to meet the needs of individual patients and carers, there are also examples of integrated services at a larger scale for example in stroke care in London, diabetes in Bolton and in the care of older people in Torbay. We have learnt that it doesn't always need a merger of services to deliver better care but providers working together, for example, in networks to coordinate around the needs of patients.

However, legislating or dictating for collaboration and integration can only take us so far. Formal structures are all too often presented as an excuse for fragmented care. The reality is that the provision of integrated services around the needs of patients occurs when the right values and behaviours are allowed to prevail and there is the will to do something different. We need to move beyond arguing for integration to making it happen, whilst exploring the barriers. We would therefore expect to see the NHS Commissioning Board actively supporting the commissioning of integrated packages of care building on the ideas that many organisations, including the King's Fund and the Nuffield Trust, have presented as part of the Listening Exercise.

We have seen that many local areas across the country are pressing ahead with strengthened partnership arrangements. More than four in every five upper-tier local authorities in England are early implementers for Government's proposed health and wellbeing boards. This demonstrates enthusiasm from councils and their NHS partners to work together to improve health and care outcomes for local communities. These early implementers have told us they see this as an opportunity to overcome historical blocks to innovation, building better services that are joined up around the needs of local people and communities, to address health inequalities and to tackle the wider determinants of health. There appears to be a growing

consensus that health and wellbeing boards have the potential to provide an opportunity for local partners to work with communities and to deliver real benefits in a way that they haven't been able to achieve under previous arrangements.

We have also heard of many examples of commissioning consortia pathfinders testing out the new commissioning arrangements and demonstrating how clinical leadership of commissioning can improve care, reduce waste and deliver better outcomes and value. Many pathfinders have highlighted the benefits of stronger collaboration, be that between primary and secondary care, or local partnership working with local authorities, but also the importance of engagement with patients and the public. Bassetlaw Commissioning Organisation is working in partnership with its local NHS Foundation Trust to improve acute care processes and discharge system to improve patient care. Integrated Care Commissioning, a pathfinder in South Birmingham, is setting up partnerships with local authority and third sector organisations to deliver new services for patients. Others are looking at referral management through peer review. What is clear is that they are all focused on really making a difference for their patients.

Collaboration is essential for effective clinical networks and the delivery of high quality education, training and research. It is also the most clinically and cost effective way of delivering high quality care for those children and adults with co-morbidities and long-term conditions. In short, collaboration is essential for the delivery of high quality health and care in the future NHS.

The public's health

Much of what we heard emphasised the importance of new approaches to care that help keep people well and promote wellbeing.

The Government's commitment to put the public's health centre stage has been applauded by those we have heard from. This is not only the right thing to do from the point of view of helping people to live longer, healthier and active lives but is critical to ensuring the future sustainability of the NHS as a tax funded system. The NHS is currently spending between five and six per cent of its total annual budget on the disease consequences of obesity and this continues to grow¹. In 2009/10 there were around 1.1 million alcohol related hospital admissions, an increase of 12 per cent compared with 2008/09². And in 2006/07 treating smoking related illness was estimated to have costs the NHS £2.7 billion³.

The need for a strengthened public health system at local and national level is clear. A coherent, system-wide approach to looking after the public's health in which all health and social care bodies (including NHS funded providers) cooperate in efforts to protect health, respond to public health incidents and help people to take control of their own health is needed. The system will also need to work on a new approach to promoting health and wellbeing that supports individuals in taking responsibility for their own health and making healthy choices

At a local level, the move of public health services into local authorities is widely supported. We also heard from patients, carers, managers and health professionals that the public's health has got to be everyone's business.

Those clinicians leading commissioning consortia and local NHS providers all have a fundamental role to play. Health and wellbeing boards need to become the focal point for ensuring the health needs of local populations are met. To support the desired focus on population health, local commissioning consortia must be responsible for a defined geographical area, and while co-terminosity should not be an absolute requirement, we advise that boundaries should not normally cross those of local authorities, with any departure needing to be clearly justified.

The Director of Public Health will play a critical role in supporting the preparation of the joint strategic needs assessment and the joint health and wellbeing strategy. Although they will be a key part of the corporate decision making process they must still maintain their ability to provide independent advice through their statutory annual public health report.

¹ The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006-07 NHS cost Scarborough et al. (2011) Journal of Public Health

² Alcohol-attributable fractions for England – alcohol-attributable deaths and hospital admissions Jones et al. (2011) North West Public Health Observatory

³ Estimating the cost of smoking to the NHS in England and the impact of declining prevalence Callum et al. (2010) Health Economics, Policy and Law

At a national level, we heard about the value of a strong, integrated public health service encompassing the three domains of public health: health protection, health improvement and health services. But, we also heard strong concerns from the public health community that the organisational form should not compromise the ability to provide independent scientific advice to the public and the Government. We are not convinced that the current proposals to place Public Health England fully within the Department of Health will achieve the necessary level of independence and, with that, public trust and confidence. We therefore recommend against this.

Regardless of the final organisational form of Public Health England, it will be vital for it to work closely with the NHS Commissioning Board in order to effectively deliver against all three domains of public health.

The Government's focus on inclusion health and reducing health inequalities has also been warmly welcomed. The duties the Bill already places on the Secretary of State, the NHS Commissioning Board and commissioning consortia will all need translating into practical action through the mandate, the outcomes frameworks for the NHS, public health and social care, commissioning plans and other system levers in order to reduce health inequalities and improve the health of the most vulnerable.

The four core themes of the NHS

Listening Exercise

Choice and Competition

Choice and competition has probably been the most controversial area of the Forum's work and has prompted very strong views. For some, the Government's proposals represent an attack on the core values of the NHS. For others, they are the only means of ensuring that the NHS can be protected and sustained into the future. It is unfortunate that much of the public debate has become polarised around these positions and the Choice and Competition group sought to move beyond these extremes to hear what people's views were about the impact that choice and competition would have in the NHS.

Whilst there were a wide variety of discussions, there were some themes that came up time and time again: *What does choice actually mean in the NHS? Where and when should competition be applied in the NHS? What role should the private sector have in the NHS?*

In looking at what choice in the NHS means, the Forum is clear that, in line with the NHS Constitution, choice must be more than just choice of provider. Several of the responses we received through the website commented that people were more worried about the quality and safety of local services than being able to choose where to go.

It is absolutely right that people should have the confidence that their local services are safe. But, we are clear that choice can help support better quality and more integration between health and social care. It is also true that choice of where to go is not always relevant, for example in an emergency the paramedics will not normally be able to ask you where you want to go. However, that should not mean that someone should not have choice around their treatment. There is a strong link here with the report on Patient Involvement and Public Accountability as more choice is part of the shared-decision making ethos.

There are parts of the system that are offering people choice now, but more needs to be done to deliver real choice. We therefore recommend that there should be a clearer choice offer, set out in a 'choice mandate' as a core part of the overall mandate that the Health and Social Care Bill says the Secretary of State should give to the NHS Commissioning Board. All players in the system should then be held to account for delivering this offer. We also recommend a stronger push to offer personal health budgets where these are appropriate.

Perhaps the most commonly discussed issue was what the practical implications of the Bill were for competition in the NHS. There was a great deal of confusion about

where and when it would be applied, and fears that competition could block attempts to integrate care around the patient, and that Monitor would apply competition law to promote competition above patient care. Competition already exists in the health service, and the Forum is convinced that it has a place in enabling choice and improving quality. But, it will not be appropriate everywhere. The current policy is not clear enough about this. We have heard many people saying that competition and integration are opposing forces. We believe this is a false dichotomy. Integrated care is vital, and competition can and should be used by commissioners as a powerful tool to drive this for patients.

There need to be changes to the current plans to put stronger safeguards in place against the misuse of competition. And, there must be much greater clarity on where competition would be applied. Most importantly, the Bill should be changed to be very clear that Monitor's primary duty is not to promote competition, but to ensure the best care for patients. As part of this, they must support the delivery of integrated care.

The report also recommends that there should this institutional duty on Monitor to "promote" competition is replaced with a new right for patients – the right to challenge commissioners at local level where they feel that choice does not exist and where they feel that services are not good enough. Further policy work is needed to ensure this right to challenge will lead to real change, driven by patients and citizens.

The Forum heard real concerns about the involvement of the private sector and whether the NHS was being privatised. It is clear that people are genuinely worried that policies such as 'Any Qualified Provider' will allow the private sector to get involved in large parts of the NHS. This fear overlooks the fact that charities and the voluntary sector will also be able to take advantage of 'Any Qualified Provider' and it could allow smaller local organisations to offer services that truly reflect their communities' needs. There needs to be a way of enabling new, innovative services that will offer what the patient needs. But, the Forum is very clear that the NHS should not be 'privatised'.

People were worried that the private sector will come in and cherry-pick profitable, low risk patients, leaving the complex and expensive patients to NHS services. This could potentially mean that the NHS organisation could find that some clinical services became unviable. It is clear that more needs to be done to ensure that cherry-picking does not undermine the quality of services that patients have access to locally.

As the full report on Choice and Competition concludes, if competition is used effectively and properly regulated, we do not believe it threatens the fundamental principle of an NHS that is universal and free at point of delivery. The reverse may well be true; that it helps protect that into the future. The recommendations from this workstream are intended to help move the debate from whether or not competition works to how best to maximise the benefits whilst minimising the risks.

Read the full report of the choice and competition group at www.dh.gov.uk/nhsfutureforum

Patient Involvement and Public Accountability

The Forum heard that there were three things people wanted to see in relation to the theme of Patient Involvement and Public Accountability:

- integrated care for patients and communities designed around their needs;
- the voice of patients and the public hard-wired into every level of the health system, including the voices of children, vulnerable adults, carers and those who are often excluded; and
- effective systems of accountability and governance to ensure that the highest quality, most seamless care is delivered.

In terms of integration, we repeatedly heard from people who had found themselves having to adapt to the specifications of the services caring for them, rather than the services adapting to their needs. The boundaries between health services, social services and public health services are irrelevant to them – they want the care they need in a place convenient to them, often at home, when they need it. Delivering this aspiration has to be the ambition for every local area. We therefore recommend that incentives need to be aligned across health and social care, with joint outcomes and financial mechanisms to drive this.

Health and wellbeing boards will play a critical role in making this joint-working a reality. But, the boundaries of commissioning consortia and local authorities need to support integration, not hinder or complicate it. We therefore recommend that the boundaries of local commissioning consortia should not normally cross those of local authorities, with any departure needing to be clearly justified.

We are also clear that there should be prominent examples of where real joint-commissioning of integrated services is happening. We therefore recommend that the Government and NHS Commissioning Board should enable a set of demonstration sites on the same model as pathfinder consortia and early implementer health and wellbeing boards. These need to be evaluated so that others areas can learn from them.

The Forum heard consistently that ‘patient involvement’ has too broad a spectrum of meaning – from merely informing to active partnership in decisions. We are firmly in the latter camp – we believe that shared decision making should be the norm, and that the declaration of ‘no decision about me, without me’ must permeate the culture throughout the health and care system. To support a culture of shared decision-making to become a reality, we believe it is important to start at the top, with the legislative framework. We therefore recommend that the definition of ‘patient involvement’ in relation to the duty ‘to involve’ and duty ‘to promote patient involvement’ is made stronger and clearer in the Bill.

We also heard how patient and public involvement in the design of care pathways and strategic commissioning decisions at every level was critical for people. Health and wellbeing boards must have a key role to play in promoting this locally. We also recommend that there should be independent representation on commissioning consortia governing bodies with specific responsibility for ensuring that their 'duty to involve' is effectively fulfilled.

The Forum also heard concerns about whether the new system would have the appropriate accountability mechanisms at local and national levels, and sufficient safeguards against conflicts of interest. Although many welcomed the concept of the health and wellbeing board, they were also disappointed at the lack of power given to these boards to drive cooperation and integration of services at a local level and in the interests of local populations.

We firmly believe in the potential of health and wellbeing boards and have outlined our vision that they are the focal point for local decision making about the commissioning of health and care services, through joint development of their health and wellbeing strategies. To ensure the strategies are delivered, we recommend that health and wellbeing boards' role should be strengthened. They should agree commissioning plans, be able to refer concerns about commissioning consortia's commissioning plans to the NHS Commissioning Board and contribute to their annual assessment.

There must be transparency and openness wherever taxpayers' money is being spent, and all accountable individuals should abide by the Nolan principles for conduct in public life. Commissioning consortia should not be given total freedom to determine their own governance arrangements – we recommend that they must at a minimum have a governing body, with independent membership, which holds meetings in public and consults publicly on commissioning plans. These safeguards will help secure the best outcomes for communities and help guard against any conflicts of interest.

Finally, at a national level, there needs to be absolute clarity that the Secretary of State for Health is ultimately accountable to Parliament for a comprehensive health service – a responsibility against which he should annually report. This is too fundamental a principle on which to allow any ambiguity.

Read the full report of the patient involvement and public accountability group at www.dh.gov.uk/nhsfutureforum

Clinical Advice and Leadership

The most common concern that the Forum heard on this theme was that GPs leading commissioning decisions as part of commissioning consortia would not involve others with a contribution to make to improving health and care services. Some groups felt the solution was to have a seat on the governing bodies of commissioning consortia to represent other professional groups.

The Clinical Advice and Leadership report says that there must be genuine multi-professional involvement and leadership at all levels in the system. We call for strengthened duties on commissioning consortia to secure multi-professional input to the commissioning process and for the authorisation and annual assessment process to be used to assure this. Assessment of the skills, capacity and capability of commissioning consortia should be placed at the heart of the authorisation and annual assessment process. Where commissioning consortia cannot demonstrate readiness to take on their new responsibilities they should not be allowed to do so.

Multi-professional involvement and leadership should be visibly strengthened at all levels in the system. There should be a strong role for clinical and professional networks in the new system and multi-speciality 'clinical senates' should be established to provide advice to local commissioning consortia, health and wellbeing boards and the NHS Commissioning Board and to provide a forum for cross specialty collaboration, strategic advice and innovation. The Clinical Advice and Leadership report also calls for multi-professional involvement to be embedded within the NHS Commissioning Board and for independent public health advice and expertise to be present at every level of the system.

Continuing professional development (CPD) is essential to enable NHS staff to continually improve and leadership development is needed support those taking on new roles and responsibilities. We heard concerns about the huge variation in the provision of CPD across the NHS and how the professional development of all staff providing NHS funded services is critical to the delivery of safe, high quality care. We recommend that the National Quality Board should examine how the situation can be improved and the constitutional pledge to 'provide all staff with personal development and access to appropriate training for their jobs' be honoured.

Evidence based commissioning is a crucial part of effective clinical advice and leadership. People wanted to see better information systems and better data about outcomes. We, therefore, highlight the importance of information systems and flows to enable seamless, integrated patient care. The report recommends that commissioners should require improved collection and use of data about outcomes of care to enable patient choice and service improvement. Support for research and innovation is also important for evidence based commissioning and practice so the report recommends that commissioning consortia should have a duty to promote research and innovation and the use of research evidence in the NHS.

Read the full report of the clinical and advice and leadership group at www.dh.gov.uk/nhsfutureforum

Education and Training

This workstream was unusual in that education and training was not included in the Bill. Changes had been proposed to the arrangements for education and training commissioning as a consequence of the proposed abolition of Strategic Health Authorities. The NHS Listening Exercise came on the heels of a three month consultation on the Government's White Paper "*Liberating the NHS: Developing the healthcare workforce.*"

During the listening exercise, and in line with the bulk of the consultation responses, we found broad support for the objectives and design of the proposed system alongside concern to ensure maintenance of high quality training responsive to patients' needs. Patients need to have confidence that services and skilled professionals will be available when and where they are needed.

On the other hand, what emerged as one of the most widely voiced criticisms of the proposed changes was a deeply felt concern at the risks to healthcare education and training in England posed by the fast pace of change.

Education and training is the foundation of the NHS. Without well trained and motivated staff we will not have the elements necessary for a world-class NHS. Without investment in continuing professional development for all staff, the current workforce cannot be equipped to face future technological and care delivery developments. Moreover, UK-based clinical education and training enjoys a world class reputation and is a valuable contributor to the UK economy.

The effects of mistakes made now in the planning for the education and training of healthcare professionals will jeopardise this and will have long-term effects. One of our main recommendations therefore is to take sufficient time to ensure an orderly and safe transition to the new arrangements for planning and commissioning education and training.

However, two elements do need to be addressed quickly. We recommend that the proposed Health Education England, which has been almost universally welcomed, needs to be operational as soon as possible to provide focus and leadership while the rest of the education and training architecture is planned.

Next, where plans for the new local education and training boards cannot be in place by the time the SHAs are abolished, the workforce functions related to educational commissioning and workforce planning and the post graduate medical deaneries should be transferred to a host organisation until the new organisation is functioning

We met consistent resistance to transferring the workforce planning functions out of the NHS family and so we recommend finding an NHS home for the Local Education and Training Boards. Finally, there needs to be a substantial transition period for moving to a levy-based funding regime.

Read the full report of the education and training group at www.dh.gov.uk/nhsfutureforum

Getting the pace of change right

Throughout the Listening Exercise we heard concerns about the pace of change. Some people felt that the changes were proceeding too quickly, with others concerned that the pace of change was not fast enough. We need to strike the right balance and the transition timetable should, at all times, be guided by the philosophy that patients must be treated safely, be given the highest quality care possible and treated with dignity and respect. In short, the pace of change should be determined by what is in the best interests of quality and safety and therefore the best interests of patients.

The principle of 'assumed liberty' espoused in the White Paper is the right one and the Government should hold true to this vision. For the period of the transition the principle of 'earned autonomy' should prevail.

More specifically, we recommend that:

- the NHS Commissioning Board should be established as soon as possible to ensure focused leadership for improving quality and safety as well as meeting the financial challenge during the transition;
- those commissioning consortia that have demonstrated they are ready to take control of budgets and the commissioning process should be allowed to do so from April 2013. Where commissioning consortia are not ready, the NHS Commissioning Board should commission services on their behalf but provide all necessary support to enable the transfer of power to take place as swiftly as possible;
- all areas should have shadow health and wellbeing boards as soon as possible in order to support the building of strong local relationships and to get to grips with understanding the health and care needs of local populations to inform emerging joint health and wellbeing strategies;
- Healthwatch England should be established as soon as possible in order to provide focussed leadership for putting patients at the heart of local reforms;
- changes to the system of education and training must not be rushed. However, Health Education England should become operational as soon as possible to provide focus and leadership while the rest of the education and training architecture is planned. The roles of the postgraduate medical Deaneries must be preserved and an interim home within the NHS found urgently as a consequence of the planned abolition of Strategic Health Authorities;

- all NHS Trusts should continue to work towards achieving Foundation Trust status by 2014 as authorisation is about clinical and financial sustainability. However, 2014 should not be an absolute cut-off date in the Bill. Until NHS Foundation Trust governors have been equipped with the right skills and capability to effectively hold their boards to account, Monitor should continue to have an ongoing compliance role;
- the implementation of Any Qualified Provider should be guided by the principles set out in the Choice Mandate we have proposed and driven by patients;

Overall, the Department of Health should move swiftly to setting out a new transition timetable to provide clarity for all staff.