

<p>TO: All Chief Executives in NHS Trusts in England All Chief Executives in NHS Foundation Trusts in England All Chief Executives in Primary Care Trusts in England All Chief Executives in Strategic Health Authorities in England</p> <p>CC: All Chairs of NHS organisations in England All Chief Executives of Arm's Length Bodies in England All Chief Executives of Local Authorities in England Chief Executives of independent sector partners Leads for pathfinder consortia</p>	<p>Richmond House 79 Whitehall London SW1A 2NS Tel: 020 7210 5142 Fax: 020 7210 5409 david.nicholson@dh.gsi.gov.uk</p> <p>Gateway reference: 15966</p> <p>13 April 2011</p>
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Dear Colleague,

EQUITY AND EXCELLENCE: LIBERATING THE NHS - MANAGING THE TRANSITION

1) Introduction

The end of one financial year and the start of the next is a good time to take stock of what we have achieved together and our shared task ahead. I thought, therefore, that it would be timely to write to you with the latest in my series of transition letters, which covers:

- Delivery in 2010/11;
- Delivery in 2011/12 and beyond;
- Progress on transition, and
- Engagement over the coming weeks and months.

It will not have escaped your attention that the NHS has been the subject of considerable debate in Parliament and the media. My message to you is simple: whilst we cannot help but be interested in these debates, especially when they potentially affect our own futures, we must not allow ourselves to be diverted from our core purpose and responsibilities in the year ahead.

In taking forward decisions this year, you need to ask yourself two questions:

- Will it improve care for my patients?
- Will it improve value for taxpayers?

If the answer to both is 'yes', then it's the right thing to do. If anyone is in doubt as to the core responsibilities for which they will be held to account this year, then they need look no further than the *NHS Operating Framework for 2011/12*.

2) Delivery in 2010/11

On 24 March, David Flory's latest quarterly report on NHS performance published data for the third quarter of the year. That report, and the provisional data for the end of the year, shows that the NHS had another very strong year last year, making further improvements for our patients:

- Referral to treatment waiting times remain low and at levels promised under the NHS Constitution;
- Patients with symptoms of cancer continue to see a specialist quickly;
- MRSA and *C.difficile* are at the lowest level since records began, and
- At an aggregate level, financial management remains strong. In line with the plans, we are forecasting a surplus in PCTs, SHAs and NHS Trusts of £1.4bn.

The NHS and all its staff should be proud of these excellent achievements for patients. This progress was made in spite of an exceptionally cold winter putting considerable pressure on the service and our staff.

Nevertheless, I have no doubt we can do more together for our patients. The quarter three results also showed slight deterioration in some areas, notably access in A&E departments, ambulance response times and referral to treatment waits. These were affected by the severe winter weather to some extent, but we must strive to improve them next year.

In addition, the NHS Staff Survey results, published on 16 March 2011, showed that the commitment to staff experience and engagement is holding up well. Continuing to support staff over this coming year will be critical to delivering the changes to make services more responsive to patients.

3) Delivery in 2011/12 and beyond

Financial context

The overall financial environment ahead is difficult but manageable. We have a financial settlement that ranks with the best in the public sector, but is still very tight by historical standards. Last year, we had already begun to adjust to much slower growth in recurrent funding.

Our ability to maintain and improve patient care whilst living within our means is critically dependent on meeting the quality and productivity challenge. As leaders of the NHS, we must not be diverted from meeting the all important challenge to release up to £20bn of recurring quality and productivity savings by 2015.

We must also recognise the financial pressure on our partners in local government. This is why the Government has made an additional £1bn p.a. of grant funding available for social care by 2014/15, which will be allocated through the local government Formula Grant. In addition, the NHS Operating Framework sets out two funding streams that PCTs have been allocated to support adult social care services. This joint investment is designed to support the integration of services around patients and service users and we will need to be able to account for the expenditure and the results it achieves.

Planning for the years ahead

Even with the more challenging financial climate ahead, the integrated plans for investment and quality improvement across the NHS are well advanced and contracts between providers and commissioners are mostly signed. This is a testament to effective partnership working across local health systems. In the small number of places where agreements are yet to be reached locally, I am expecting all chief executives and boards to work together positively so that contracts can be signed quickly.

Together with the NHS leadership team at the Department of Health, I am currently visiting each region of the NHS as part of a programme of assurance visits to probe each region's plans and progress with transition. We have been deeply impressed by the commitment to improving services and the positive way in which people are approaching the transition in each region we have visited so far.

One of the most striking themes that has emerged is that planning tends to focus on the year ahead and, in many cases, planning horizons need to be extended to the three years beyond.

We need shared ownership of the four-year QIPP agenda from all key players in the system, current and future. By this I mean SHAs, PCTs, the emerging PCT clusters and GP-led commissioning consortia, their local government partners, and the full range of provider organisations. In each locality, those organisations will only succeed in meeting the quality and productivity challenge together, not apart. The combination of clinical engagement in commissioning and democratic accountability is now an essential part of how we will achieve both efficiency and improving outcomes.

I am also expecting chief executives and boards to pay particular attention to the deliverability of their planning assumptions. It is not credible to close gaps with unrealistic balancing figures for cost improvement programmes or demand

management schemes. These plans must be robust to avoid the risks of financial deterioration or passing legacy debts to successor organisations.

As the costs of drugs, new technologies and treating more patients rise in the years ahead, we know there will be increased pressure on the paybill. We are responding to this with a range of interventions, such as the national pay freeze for staff paid over £21,000; more productive ways of working; reducing sickness absence by focusing on staff health and well being; and reducing agency and management consultancy. Where significant staffing changes occur, we expect plans to be agreed with medical and nursing directors, as well as workforce and finance directors, to assure the resilience of quality and safety.

Quality and performance challenges

Good performance is being maintained across the three broad domains in the operating framework of improving quality, managing within resources and reforming the NHS. There are six specific areas on which we need particular focus in the year ahead: A&E access and quality; ambulance responsiveness; referral to treatment waits; provision of single sex accommodation; emergency preparedness; and tackling the small number of financial deficits that remain.

On 1 April, a new set of clinical quality indicators for A&E were launched. The aim here has been to broaden the measurement of quality to a range of indicators covering the timeliness and effectiveness of treatment, and the overall patient experience. Systematically measuring quality in order to drive benchmarking and improvement is the essence of the approach to quality improvement set out in *High Quality Care for All*. In the early part of this year, we need to concentrate on improving the data quality across the five clinical quality indicators and subsequently to aim for continuous improvement across all five.

Similarly, we have issued a new range of quality indicators for ambulance services. It is disappointing that ambulance response times slowed marginally in 2010/11 from the previous year, notwithstanding the severe weather conditions. There were tremendous efforts in the latter part of 2010/11 to recover the aggregate position and we must continue that recent trend of improved performance into 2011/12 and widen it to include the new indicators.

On referral to treatment waits, I want to reiterate the message of my last letter on the importance of continuing to meet the waiting times standards as set out in the NHS Constitution and the NHS contract. Timeliness of diagnosis and treatment is what patients expect and remains essential to providing high quality care. The most recent data shows that the NHS continued to meet these standards overall, but by a smaller margin than in the last two years. We cannot allow waiting times to increase, nor can we allow distortion of clinical priorities.

Also from 1 April, there has been the expectation that all providers of NHS funded care should be able to declare that they are compliant with the national definition of single sex accommodation. Where there are breaches, this should be a matter of concern and attention for provider boards, and their commissioners will invoke contractual sanctions on behalf of their patients.

There has been much good work across the NHS, with regional leadership from SHA Emergency Preparedness leads, to ensure that the NHS is resilient to potential emergencies and surges in demand. I want to reinforce that this crucial work must be part of boards' mainstream business. Emergency preparedness plans should be robust, up-to-date and reviewed and refreshed regularly, with clear leadership and accountability at board level. This is particularly important in the run up to the Olympics.

Whilst the overall financial performance of the NHS remains strong, there are still a small number of organisations in deficit. 2011/12 is the critical year to implement sustainable solutions so that successor organisations do not inherit actual debts or underlying financial problems. This will be a crucial test of success by the end of the year.

In summary, all of the expectations for delivery in 2011/12 and beyond are set out in the current Operating Framework. My expectation, based on our track record, is for success. We cannot allow ourselves any excuse, external or otherwise, to fail our patients and communities.

4) Progress on transition

Last week, the Secretary of State set out the intention to use a natural break in the passage of the Health and Social Care Bill to pause, listen, reflect and improve the Government's plans. That is a very important process, of which I will say more below, but I want to stress very firmly that we need to continue to take reasonable steps to prepare for implementation and maintain momentum on the ground. Those who are leading the change at local level, particularly pathfinder consortia, should be at the heart of the engagement process.

This is particularly important because recent progress on the transition has been strong. Many thousands of GPs, nurses, other clinicians and support staff are already actively involved in consortia pathfinders, now covering 88% of the population and proceeding ahead of schedule. 90% of local authorities, together with GP consortia pathfinders and other partners, have signed up to be early implementers of Health and Wellbeing Boards. And all remaining NHS Trusts have now agreed plans with local commissioners for achieving Foundation Trust status. This critical work needs to continue and to inform the engagement exercise, but we must also bear in mind that the outcomes of that exercise may lead to changes to some aspects of the Bill.

We have also made good progress on the changes necessary to sustain capacity during the transition. PCT clusters are now established across the country with senior appointments either completed or being finalised. All clusters will be fully established by 1 June 2011 and we are working with clusters and SHAs to develop a shared operating model for clusters by June. In addition, we recently published guidance to support assignment of staff to emerging consortia, a process which is critical to building capacity.

The National Quality Board has also recently published the first part of its guidance on maintaining quality and safety during the transition and it is important that boards press on with the changes recommended in this report. It also remains essential that NHS boards maintain progress on equality and demonstrate compliance with the Equality Act. The Equality Delivery System, designed by NHS leaders on the Equality and Diversity Council, provides the framework which will enable boards to demonstrate leadership on this issue.

For planning purposes, and subject to the results of the listening exercise and the passage of the Bill, the proposed timeline for completing the key elements of the transition at local level remains unchanged. So, GP consortia would take control of commissioning from April 2013 following authorisation by the NHS Commissioning Board. Health and Wellbeing Boards would also take on their full statutory powers and PCTs would be abolished by April 2013. And we continue to aim for completion of the Foundation Trust pipeline by April 2014.

However, because of the pause in the legislative process and again subject to the results of the listening exercise and the passage of the Bill, all of the statutory changes which were due to take place in April 2012 will take place no earlier than July 2012. That includes:

- The abolition of Strategic Health Authorities;
- The assumption of its full statutory powers by the NHS Commissioning Board;
- The assumption of their full powers by the NHS Trust Development Authority, Health Education England and Public Health England;
- The first phase of taking on its new powers by Monitor, and
- The establishment of HealthWatch England and other changes to Arm's Length Bodies.

The creation of shadow bodies and the appointment of senior staff to these organisations will also be delayed to allow time for the engagement process to take place.

These changes are of course very significant for the organisations concerned and their staff. We are working through the full implications of the changes on a case by case basis and will provide further advice in due course on any further developments. In the meantime, it is important that we continue to support our staff through what will no doubt be a difficult and uncertain period for many.

5) Engagement and the NHS Future Forum

While the overall timing and core pillars of the transition remain broadly in place, the new engagement exercise gives us a real and important opportunity to shape the details of what the new system looks like and how it operates. Co-production and clinical engagement are at the heart of successfully managing change, so it is critical that we take this opportunity to engage with the public, staff and stakeholders at national and local level.

We have chosen to focus the engagement exercise on four areas where there has been particular debate. These are:

- **Choice and competition**, where we need to engage further with patients and the public to understand their priorities for introducing choice, and to understand how competition can best be used as a tool for improving care;
- **Patient involvement and public accountability**, where our priority is to test our plans for the new organisations and structures to ensure that public accountability is sufficiently strong and that patient involvement runs through the new system. This has been a particular concern with respect to GP-led consortia so we need pathfinders to drive engagement on this issue;
- **Clinical advice and leadership**, where we must ensure that clinicians are in the driving seat in our new organisations and that integrated working between primary and secondary care and between commissioners and providers is strengthened not undermined in the new system, and
- **Education and training**, where there is an opportunity for further engagement to test the ideas coming out of the recently completed consultation on 'Developing the Healthcare Workforce' and to stimulate further debate on how we move forward and manage transition.

These are very significant issues and the engagement process may result in changes to how we proceed in implementation, whilst the principles of the modernisation remain

clear. That is why it is important to make the process effective, engaging with as wide a range of people as possible. Our ambition is to hold engagement events in every health economy as part of this process and we will need your help and support in achieving this.

To inform the engagement process, we will be issuing further detail on our emerging plans for discussion and debate. So we plan to publish more information on how the authorisation of consortia might take place, on how the NHS Commissioning Board might be organised, and on how we might measure progress and reward consortia for improving outcomes.

The engagement process will be overseen by a new independent advisory group, the NHS Future Forum. This group brings together a wide range of clinicians and other staff and will be chaired by Professor Steve Field. The group will report back on its initial findings around the end of May in order to inform amendments to the Health and Social Care Bill. You can find out more details about the group and the engagement process at <http://healthandcare.dh.gov.uk>.

The initial phase of engagement over the next eight weeks will focus particularly on improving the legislation that will underpin the new system. However, the work can and should continue beyond this initial period and look more widely at how policy meets the principles of the White Paper, at plans for implementation, and at the way we go about change itself. So I see this not as a one-off exercise, but as the start of a new phase of implementation where we work even more closely with partners, stakeholders and staff to build understanding and appetite for change and improvement.

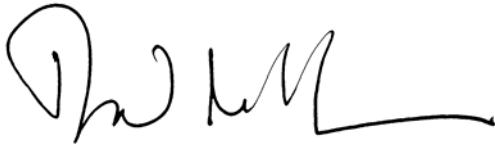
As part of this broader engagement work, I have asked Sir Bruce Keogh, the NHS Medical Director, and the national clinical directors to begin longer term work to strengthen our multi-professional clinical networks and to engage with the networks to understand how best to improve outcomes for patients. There is a central role for networks in the new system as the place where clinicians from different sectors come together to improve the quality of care across integrated pathways. So I want to put these networks at the heart of our efforts to renew and strengthen engagement.

6) Conclusions

I know that to some the message to press on with implementation while significantly increasing our levels of engagement on our plans may seem paradoxical. I don't believe that it is. Engagement, learning and adaptation should always be at the heart of effective implementation: good engagement is central to making change happen, it is not an alternative to change. That is why it is particularly important that the current engagement process does not prove to be a one-off exercise, it needs instead to form part of our approach for the duration of the transition.

The scale and breadth of what we need to deliver over the coming period remains as challenging as ever. Maintaining momentum for transition and driving deeper engagement are important goals, but focussing on delivery in order to improve quality for our patients and value for taxpayers must always be our over-riding priority. Clinicians, managers and other staff all have a critical role to play in this. It is the issue on which we will rightly be held to account, and as leaders it is the issue on which we must continue to focus above all in the weeks and months ahead.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'D Nicholson', with a long horizontal flourish extending to the right.

Sir David Nicholson KCB CBE
NHS Chief Executive