

From the Office of Sir David Nicholson KCB CBE
Chief Executive of the NHS in England



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| <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 Monitor Care Quality Commission Local Government Association</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 ref: 14795</p> <p>10 September 2010</p> |
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Dear Colleague

EQUITY AND EXCELLENCE: LIBERATING THE NHS – MANAGING THE TRANSITION

1) INTRODUCTION

I last wrote to you on 13 July to set out the initial steps that we need to take to prepare for the transition to the new health and social care system proposed in the White Paper, *Equity and Excellence: Liberating the NHS*. This letter provides further detail about our approach and the role we all need to play as leaders and as leadership teams in the coming weeks and months.

Since July, I have had discussions all across the country, with NHS chief executives, and with leaders in primary care and local government. It has been an energising and uplifting experience. I have been hugely impressed by your enthusiasm for the critical tasks at hand and appreciative of the complexity of the challenges you are facing with such professionalism and dedication.

It is clear that there is a thirst for as much information as we can provide about the detail of the reforms heralded in *Equity and Excellence*. This letter is the second of what I intend to be an ongoing series of communications. It does not provide all of the detail of the proposed new system, nor can it at this stage.

Equity and Excellence sets out the Government's overarching proposals for the NHS and consultation on the implementation and some of the detail of those proposals continues to be developed. Many of the proposals require primary legislation and so are subject to the approval of Parliament. A Health Bill is to be introduced in this Parliamentary session. Until decisions have been taken following the outcome of the consultation and the legislative provisions have been introduced and enacted, those proposals may be subject to change. It is important, therefore, that we do not take binding actions that pre-judge the outcome of this process.

However, given the likely timeframe for implementation it is also important that we continue to think through the changes, to work in line with the principles of *Equity and Excellence*, to engage with our staff and our local partners, especially in local government, and to take preparatory steps. We also have a long-standing commitment to reduce management costs in the NHS, and so it is vital that we begin the work now to support people as good employers should and to sustain talent and capability through the changes ahead.

2) OUR DIALOGUE SO FAR

In my meetings with NHS and local government leaders across the country since July, I have emphasised a number of points of real importance.

Firstly, **it is vital that we grasp the opportunities** presented by the White Paper proposals. These opportunities are clear: most importantly, the opportunity to **improve the quality of patient care and health outcomes**. This is our core purpose and the reforms in the White Paper are all aimed at supporting that goal.

They are aimed at truly empowering our patients with more choice, better information and more control over their care; putting GPs in control of the commissioning decisions that influence the quality and productivity of care; enabling our providers to innovate to meet the needs of patients, and developing a first class Public Health Service. We must embrace these opportunities and encourage the leading edge, as well as working to mitigate risks through transition.

Secondly, as managers **we should have real confidence in our ability to deliver**. We have a very strong recent track record of delivering whatever is required of us, whether it be sustained financial turnaround, improvements in quality and access, or reforms to create a more dynamic system. We should be rightly proud of our achievements. The White Paper provides a new set of opportunities and challenges, but we should not be daunted by that and should retain focus on our core purpose.

Thirdly, the key task for us all is to deliver high quality care within the resources available whilst making the transition to the new system. There is significant work in designing the new system, on which we want your full participation, but **we must not allow that to distract us from the major operational challenges** we continue to face. These will also be challenging times for the whole system as we seek unprecedented quality and productivity improvements. So it is vital that we continue to focus on delivery, particularly as winter approaches.

Finally, we can only succeed, both in supporting the design of a new system and in continuing to deliver, by **working in partnership**. This will mean NHS organisations working more effectively together, with their staff, and more closely with colleagues in local government, the proposed new public health service and the independent sector. And it will mean seeking genuine partnerships rather than competing for leadership space.

I have reflected in depth on our conversations and what you told me. There are a few areas which I think need particular attention locally:

- The proposed changes to Local Authorities and the creation of the Public Health Service, which must remain connected with the changes to the NHS;
- The proposed changes to the provider system, where I think the extent of the changes and the freedoms and opportunities to innovate are particularly significant;
- The work on patient empowerment through choice and information, which we must not overlook as we take forward the architectural changes;
- Our ongoing work on improving care pathways, where we need to understand how this work would be taken forward in the new system.

We also discussed the decisions that each one of us needs to take about our roles in the transition. I would encourage all of you to take time for yourself to work through these issues, and support your teams to do the same.

I know that it is a time of personal and professional uncertainty for many of you around the country and I admire and appreciate your dedication and professionalism in those circumstances. It underlines to me the excellence of the public service managers we are lucky to have.

3) CURRENT PERFORMANCE

Maintaining a strong grip on current performance is central to the success of the transition process. The NHS has responded positively to the revisions to the 2010/11 Operating Framework. Overall, performance across finance and many key indicators of high quality care is stable or improving. But this is not a time to rest on our laurels. We need to keep a particularly firm grip on quality and finance during this period of transition. There are four broad issues to focus on in particular:

- The quality and productivity challenge remains of central importance. We must continue to develop and implement QIPP plans across the country with absolute focus;
- Emergency activity continues to rise, above plan in many places. A number of organisations are also behind plan on their cost improvement programmes. These issues need urgent attention, with organisations working together to deliver their shared commitments, to ensure that all health economies meet their financial responsibilities and duties throughout the year;
- As ever, this time of year is crucial in planning for emergency preparedness and the coming winter, and that planning needs our full attention now in

order to manage those pressures and risks as successfully as we have in recent years. It is particularly important that organisations work together with local government partners on developing proposals for reablement to support people to live at home;

- We are now measuring access to elective care in different ways, tracking median referral to treatment waiting times and focussing on those organisations with exceptionally long waiters. Performance is stable overall albeit with significant local variation. 18 weeks remains a constitutional commitment and it remains commissioners' responsibility to ensure that commitment is met.

4) DESIGN RULES

During our recent discussions, I set out the importance of developing a consistent set of design rules to guide the transition to the proposed new vision set out in *Equity and Excellence*. Building on our conversations, I think these can be summarised as:

1. Delivering **high quality care and improving health outcomes** for our patients within the available resources whilst taking preparatory steps towards **transition to the new system** is our central priority. This remains the central responsibility for current boards and of any new organisations as they are formed through the transition period. No one should drop any of their current roles and accountabilities, unless these are formally transferred, handed over, or have been agreed to stop;
2. At every level, clinical and managerial leaders and leadership teams in the NHS, from both primary and secondary care, should **work together across organisations** and with local government, guided by the principles of *Equity and Excellence*, to support the design of the proposed new arrangements. Nationally, I have begun this by asking those on the Top Leaders Programme, together with existing and new clinical leaders to work on solutions to key challenges within the change programme. Strategic Health Authorities should ensure the same happens regionally and locally, working with local government;
3. We will only do at national level what needs to be done at national level, leaving the **maximum possible opportunities for flexible local implementation** and innovation by GPs, providers and local government;
4. **Strategic Health Authorities will hold the ring** regionally on the transition process and on balancing differing interests in implementing the new system. The SHA's role should include overseeing consideration of the regional shift of functions required to create the proposed new Public Health Service, with Regional Directors of Public Health leading on the detailed design proposals locally. The challenge for local government is to engage at this level to ensure the best possible outcomes from the transition;

5. **Authority and accountability will be inextricably and transparently linked** at every stage of the transition. This encompasses both accountability within the system, which will not be reduced, but also to local patients and communities. Engagement with local authorities will be critically important about the proposed Health and Wellbeing Boards and future Public Health Service;
6. In designing the new system **the test for us will be what provides the best quality and outcomes for our patients and the best value for our communities**, not the preferences of sectional interest groups within or outside the system. To this end, patients' views will be centrally important in creating the new arrangements;
7. We will not wait for all of the elements of the new system to be in place before seeking to **provide more information to the public on quality and outcomes and further support patients in making informed choices** about their care. We should make tangible progress towards realising the principles in *Equity and Excellence* as far as possible, whilst not pre-empting consultations or legislation;
8. **Running costs need to start and remain low in the new system** in line with the reductions already planned. This will require lean solutions, shared capacity and focussing of management effort on the areas of highest priority;
9. We would want to enable **new organisations, and particularly GP consortia, to have the maximum possible choice of how they operate** and who works for them. It is important that GP practices be given time and space to develop their plans to form commissioning consortia. PCTs should provide support for this process and empower consortia to take on new responsibilities quickly when they are ready to do so, but it is important that solutions develop from the bottom up and are not imposed from above. GP commissioners should have the freedom to arrange themselves as they see fit to best meet the needs of their local populations;
10. We want to **support current employees of SHAs and PCTs through the change**, to treat them well and, where it is the right thing to do, support them in moving into new roles, minimising the cost and complexity and ensuring we retain essential talent and capability through the transition. Those creating new organisations and individuals in the change process will need to be provided with **developmental support to enable them to undertake their future roles**, and we must appreciate the value of their skills and experience.

5) LEADERSHIP AND GOVERNANCE

My letter in July set out the establishment of national leads for commissioning and provision, and the start of a process to split commissioning from provision at national and regional level, whilst maintaining a bridging function during the transition period. We need to continue to re-focus our leadership and governance systems to prepare for the changes ahead, whilst ensuring we do not pre-empt the outcomes of the consultation process or the proposed changes which are subject to Parliamentary approval.

Nationally, Ian Dalton (for provision development) and Dame Barbara Hakin (for commissioning development) have begun their work, with David Flory, Jim Easton and I co-ordinating their work with national priorities, QIPP and the transition programme within the Department of Health.

To mirror these arrangements, we have now identified leads at regional level for commissioning development, provider development and the bridging function. The bridging function will be vital to manage the risks in the system today, to make the best arrangements for our people and capacity through the transition and to coordinate the development of the system of tomorrow. Therefore, the NHS Management Board will maintain the bridge nationally and SHA Chief Executives will personally lead the bridging function and leadership of transition at the regional level. Regional leads will form part of the national transition process and will account to SHA Chief Executives. A list of the regional leads is annexed to this letter.

We will now create dedicated groups at national level to oversee commissioning and provision, bringing together national and regional leads into a Commissioning Development Board and Provider Development Board.

In addition, Ian Dalton will create a national reference group for the provider side work to advise on implementation and policy issues. Mike Deegan (Chief Executive of Central Manchester University Hospitals FT) has agreed to chair this group, which will include key figures from the NHS chief executive community who will offer the benefit of their experience and expertise.

It is essential that we respect and treat our staff fairly through the transition period ahead, and that we constantly keep under review the availability of senior leadership talent in mission critical roles. Sir Neil McKay will set up a group, with director leads in each SHA region, to support the regional bridges in those aims. As part of that work, he is leading the work to create a national HR framework for those affected directly by change, working closely with the DH, ALBs, the NHS and Trade Unions to achieve this. Sir Neil wrote to SHA and ALB Chief Executives in August outlining his early thinking and approach. Clare Chapman, Director General for Workforce, will continue to lead on national workforce policy and on the changes to education and training which are a crucial element of the wider transition.

The NHS Medical Director, Professor Sir Bruce Keogh, and Chief Nursing Officer, Dame Christine Beasley, will lead on clinical engagement, working with the SHA Medical Directors and Directors of Nursing. This leadership should include not just NHS organisations but also those professional organisations such as the Royal Colleges and Specialist Associations which are key to improving clinical quality across the NHS.

We are also clear that there is a need to undertake national, regional and local work, with the same level of focus and energy as the work already in hand on commissioning and provision, to drive patient empowerment and the public availability of information on quality, and this will be led by Christine Connelly nationally.

NHS communications professionals will have a vital role throughout the transition in supporting and engaging their staff and organisations and in presenting the opportunities of the reforms to their patients and communities.

We will re-focus the work of the National Leadership Council so that it plays a central role in ensuring we have the capacity and capability to manage the transition and design the future system. We will create new dedicated workstreams on Commissioning and Provision, and we will continue to use the Clinical Leadership programme to develop leadership across all of the key professions.

The National Quality Board will play a major part in guiding the transition and advising on the design of the new system architecture. The NQB will support NICE on the creation of the new Quality Standards that will be at the heart of the new commissioning system, and advise on improving integration between health and social care. Most importantly, the NQB will advise on how to maintain and improve quality and safety during the transition period. Earlier in the year, the NQB published its Review of Early Warning Systems in the NHS, and I urge you to refer to this report as you take your organisation through what will be challenging times. I have asked the NQB to re-visit this work and to consider how these systems will need to adapt in light of the changes set out in *Equity and Excellence*.

We will continue to work with the national Equality and Diversity Council, which includes leaders from all regions of the NHS, to ensure that we maintain our focus on improving equality and diversity across the NHS and that the transition process does not distract us from this important task. The Council is leading the development of an 'Equality Delivery System' which will facilitate improved performance across the system and support the implementation of the Equality Act.

Finally, we have learned from previous changes within the NHS, that the role played by chairs and non-executives and the effective continuation of good board governance is vital. We are therefore progressing the appropriate changes in regulations to provide the flexibility for a PCT chair or NED to serve on more than one PCT board. More details on changes to non-executive appointments is set out in the "frequently asked questions" attached to this letter.

6) TRANSITION PLANNING

These actions aim to align and adapt our governance at national and regional level to support the transition. Their purpose is to create the new national arrangements and to support you in creating the new system locally. The significant reduction in management costs, linked to the major proposed changes in commissioning responsibilities set out in the White Paper, will require careful and proactive management. We will need to ensure continuity of capability and provide opportunity for new commissioners, where they wish it, to make use of current capacity in their new arrangements with minimum transaction costs. To this end:

- Each SHA will work with local health and social care economies to develop coherent plans, building where possible on existing sub-regional arrangements, for shared commissioning capacity and capability, with leadership and accountability arrangements that can be secured through the transition period;
- These plans should demonstrate how we will deliver improved quality and outcomes within the available resources and how other critical functions (including for example emergency planning and child protection) can be sustained through the transition. Similarly, the plans should ensure that the commissioner and provider separation is carried through to local level;
- We will look at how such arrangements can be linked with and supported by the HR framework, particularly in terms of the proposed pooling arrangements for emerging vacancies and wider programmes for leadership and talent management.

Nationally, we need to understand overall progress on implementation so that we can spot and resolve risks and issues, support development needs and ensure that the overall timetable will be met. We will do this by requesting information about progress in local implementation through integrated QIPP and reform plans at regional level. Ian Dalton and Dame Barbara Hakin are working with colleagues from the service to identify what information we should collect. We will set out a first cut of this in October and begin collecting it from November.

In measuring progress this way I want to be clear that this is not a race to have the first or the most GP consortia established, or to rush through unsustainable solutions on the provider side. For commissioning, this is not about dragooning GPs into administrative boundaries that they do not feel any allegiance with. It is certainly not about replicating current structures with some new players involved. The proposals represent a fundamental change, not just in structure, but in culture and ways of working.

For provision, it is not just about completing the Foundation Trust pipeline, but about a transformation in the quality and productivity of provider services and the

opening up of provision to new entrants. For both commissioning and provision there is a need to establish new relationships with patients, staff and communities, particularly through the proposed new role for Local Authorities.

So the picture we need to assemble about progress needs to cover not just the new organisations coming into being, but also measure engagement, development activity and the linkage between the new commissioning landscape and operational and QIPP delivery. You should start thinking about these issues and how you would implement and measure them now.

7) CURRENT ACTIONS

The table below sets out the broad areas leaders and leadership teams should be focussing on at each level of the system over the coming weeks:

| Key current responsibilities for NHS leaders | |
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| All leaders | <ul style="list-style-type: none"> • Maintaining a clear focus on the delivery of high quality care within the available resources while planning for the transition • Leading engagement on the White Paper proposals and getting involved with the ongoing national consultations • Make time to think through your future career options and to make decisions about this, and support your teams to do the same |
| Providers | <ul style="list-style-type: none"> • Continuing to develop and implement QIPP plans, working closely with local commissioners • Working as appropriate to achieve Foundation Trust status and to complete the Transforming Community Services work • Engaging on the new system of provider regulation and preparing for the transition to this system • Joining up with other providers and commissioners to ensure care pathways and clinical networks are sustained and developed |
| Commissioners | <ul style="list-style-type: none"> • Continuing to develop and implement QIPP plans, working closely with local providers • Leading local engagement on the future commissioning system • Working with SHAs on plans to sustain capacity and capability during the transition • Supporting the proposals to create GP consortia by giving freedom to the leading edge within existing powers, linking consortia development with QIPP planning, and ensuring robust accountability arrangements for the transition period |
| Strategic Health Authorities | <ul style="list-style-type: none"> • Leading on the White Paper engagement process at regional level • Overseeing the transition process at regional level, including the changes within their own organisations, in local government and public health, and the transition planning process • Working with commissioners on plans to sustain capacity and capability during the transition |
| Department of Health | <ul style="list-style-type: none"> • Leading on the White Paper consultation and engagement processes at national level |

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| | <ul style="list-style-type: none">• Developing future consultations on choice, education and training, the information strategy, social care, and leading the development of proposals for the Public Health Service nationally• Overseeing the policy and legislative processes leading up to the introduction of the Health Bill• Developing the overall transition path and the planning process, leading to the publication of the 2011/12 NHS Operating Framework |
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8) TIMELINES AND FREQUENTLY ASKED QUESTIONS

We continue to work through the details of the change and two updated timelines are enclosed, showing the period up to April 2011 and the period up to April 2014. I should stress once again that many of these proposals and timings are subject to the consultation and legislative processes and are therefore not set in stone. Also enclosed are responses to the most common questions raised during our recent discussions.

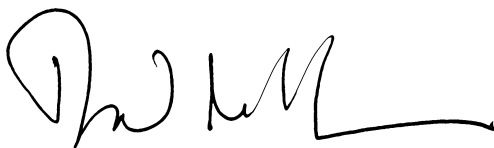
9) CONCLUSION

Equity and Excellence sets out radical proposals for changing our health and social care system, and the leadership challenge in delivering those changes while continuing to deliver high quality care for our patients is very significant. I have been encouraged by our recent discussions. There is clearly energy and enthusiasm across the system to make these changes happen, albeit alongside some questions and concerns about the details of implementation. I urge you to get involved with the ongoing national consultation processes which seek to answer those questions, as well as engaging and preparing for the transition locally.

Finally, I want to stress once again the importance of strong leadership at this time. Our staff look to us for direction during periods of change, and our behaviour will set the tone. We must show energy, seek out opportunities, work across organisations, and communicate effectively within our own staff and organisations if we are to succeed in the coming period.

Our track record speaks for itself. I have every faith we can meet this challenge.

Yours faithfully,



Sir David Nicholson KCB CBE
NHS Chief Executive