



The Government's Response to the Health Select Committee Report 'NHS Next Stage Review'

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
March 2009



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ISBN: 9780101755825

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Introduction

1. The House of Commons Health Select Committee published its report on the NHS Next Stage Review on Tuesday 13th January 2009. This Command Paper sets out the Government's response to the conclusions and recommendations of that report.
2. *High Quality Care For All*, the final report of the NHS Next Stage Review, set out a vision of an NHS that gives patients and the public more choice, works in partnership and has the quality of care at the heart of everything it does. An NHS that delivers high quality care for all users of its services in all aspects, and that helps people to stay healthy.
3. We are grateful to the Health Select Committee for welcoming the manner in which the NHS Next Stage Review was conducted. At the heart of the Review were the local clinicians who engaged with their local communities and examined the best available clinical evidence to identify improvements to health and healthcare locally. Their work underpins the ambitious visions for health and healthcare that were published by Strategic Health Authorities in May and June of 2008.
4. *High Quality Care For All* provides the enabling framework to support the delivery of these ambitious local visions. We are grateful to the committee for concluding that there is much to commend in it, in particular its emphasis on quality and leadership. We are grateful too for the committee's welcoming of the key changes that will have an early and direct impact on patients, for example the provision of additional primary care services and establishment of a new right for patients to drugs and treatments recommended by NICE.
5. We are committed to implementing the commitments made in *High Quality Care For All* in partnership with the service. The Next Stage Review marks a new chapter in the relationship between the NHS and the centre, with the centre's role being to enable and support changes agreed locally by those best placed to ensure local services meet the needs and expectations of their users. Key to this is devolving power and decision-making as close to patients as possible while supporting and nurturing leadership and innovation across the service.

6. There is no doubting the ambition behind the Next Stage Review, it seeks to deliver nothing short of systematic change across the NHS to ensure that quality becomes the organising principle behind all that it does. Beyond the specific commitments made in *High Quality Care for All* and those agreed locally, its lasting legacy will be the development of a self-improving, locally-led system that places the needs and expectations of patients and the public at the heart of all that it does.
7. This document responds to each of the Committee's conclusions and recommendations in turn.

Key Issues

The significance of the Next Stage Review owes more to the manner in which it was conducted than to the proposals it makes. Many of its key recommendations, such as the need to improve quality of care, have been made before. However, the involvement of the Strategic Health Authorities is new, as is the extent of consultation with clinicians and patients, which we welcome. (Paragraph 54)

8. The NHS Next Stage Review has been a key step in a journey that has improving the quality of care at its heart. This journey began with the greatest investment in the history of the NHS, aimed at providing more doctors, more nurses and better facilities. Expansion in capacity and capabilities has been followed by a range of reforms to improve responsiveness, including the introduction of Foundation Trusts and Payment by Results, coupled with a strong focus on extending patient choice.
9. The NHS Next Stage Review marked the next stage in this journey, building on this greater capacity and responsiveness to systematically embed quality as the organising principle for all NHS services. For the first time, local clinicians, in discussion with patients, NHS staff and their local communities, have determined how quality can best be improved locally, rather than this being agreed in Whitehall or set out in national targets. The Government is grateful to the Committee for welcoming the way in which the Review was conducted.
10. The commitments made in *High Quality Care for All* are now being taken forward in partnership and co-production with the NHS, ensuring that the Review's open and consultative approach is embedded in the relationship between the NHS and the centre.
11. While many of the Review's key themes may not be new – all NHS reform has been aimed at improving quality of care – its recommendations are. *High Quality Care for All*, for the first time, *systematically* puts quality at the heart of all NHS services. In addition to the new Quality Framework that the Next Stage Review will deliver, *High Quality Care for All* sets out a range of new proposals that will have a significant impact on the quality of care

patients receive, for example the piloting of Personalised Health Budgets and of new forms of integrated care, and the introduction of Innovation Prizes and a new duty on SHAs to promote innovation.

There is much to commend in the Review, in particular the emphasis on quality and leadership. However, we are concerned about its implementation. This will largely be done by PCTs, but we doubt that most PCTs are currently capable of doing this task successfully. We have noted on numerous occasions, and the Government has accepted, that PCT commissioning is poor. In particular, PCTs lack analytical and planning skills and the quality of their management is very variable. This reflects on the whole of the NHS: as one witness told us, "the NHS does not afford PCT commissioning sufficient status". We consider this to be striking and depressing. (Paragraph 55)

12. We believe that the Committee is right to point to the importance of local commissioners and the key role of PCTs in delivering the ambitious improvements agreed locally through the Next Stage Review. It is right that local organisations who have the best understanding of local health needs take the lead on implementation. Improving the quality of local commissioning is an important and long-standing priority for the NHS.
13. The weaknesses in NHS commissioning pointed out by the Committee were previously identified through the Fitness for Purpose exercise (May 2006 – March 2007). A joint DH and Prime Minister's Delivery Unit review of commissioning capability in May 2007 highlighted similar challenges, and made a number of recommendations to ensure that all PCTs become more effective commissioners. They included:
 - Articulating a vision for what world class commissioning can achieve, telling a clear narrative to the NHS to embed understanding of the role of commissioning;
 - Setting out the organisational competencies that a world class commissioning organisation will need to demonstrate;
 - Developing a commissioning assurance system to hold commissioners to account and to reward performance and development;
 - Access to support and development tools and resources to help commissioners achieve world class commissioning.
14. The world class commissioning programme is the response to these recommendations. It is a ground-breaking and ambitious programme that takes best practice from this country, and from health systems around the world, to transform the way in which PCTs carry out commissioning. It will help PCTs deliver better services, which are more closely matched to local needs, resulting in better quality of care, improved health and well-being and a reduction in health inequalities across the community.

15. The programme is already creating a step-change in the way that the Department and the NHS, including commissioners themselves, view commissioning. A vision and organisational competencies for world class commissioning have been developed with the NHS and their partner organisations, and were published on 3 December 2007. The vision sets out the aims of world class commissioning, which are to improve life expectancy and reduce health inequalities – adding life to years and years to life. The eleven competencies describe the skills, knowledge, behaviour and processes of world class commissioning organisations, including knowledge management and data analysis skills, investment prioritisation and strategic planning skills, and the ability to commission collaboratively with clinicians, patients and the public, local authorities and other community partners.
16. PCTs development and performance against these eleven competencies are assessed as part of the annual commissioning assurance system, that was launched last year. As well as assessing the commissioning competencies, the assurance system also reviews PCT governance, including financial management, strategy and Board function. The third strand of commissioning assurance assesses how PCTs achieve improvement against local health outcomes, an approach which reflects the fact that world class commissioning is driven by health outcomes and focused on local priorities.
17. We have already seen an increase in the status of commissioning in the Department as well as the NHS as a result of the introduction of the world class commissioning programme. The NHS Operating Framework for 08/09 clearly highlighted world class commissioning as a priority, reflecting the importance of commissioning as a delivery mechanism. The 09/10 Operating Framework sets out the range of tools and enablers in place to ensure commissioners are at the forefront of efforts to systematically improve quality and focus on preventative care and health inequalities during 2009/10.
18. The establishment of Quality Observatories within each Strategic Health Authority, as set out in *High Quality Care for All*, will also play an important role in supporting PCTs to strengthen their commissioning capability. Although there will be no centrally prescribed model for what a Quality Observatory should look like, it is clear that SHAs collectively see the provision of expert advice and support to PCTs around the identification and use of quality indicators to support improved commissioning as a core function. In addition, the collation, analysis and publication of information on a set of regional quality indicators by Quality Observatories will enable both commissioners and providers to benchmark performance.

The Department argued that its World Class Commissioning programme will transform PCTs. While the programme has only been in place since July 2007, there are few signs yet that variations between PCTs in their commissioning capability have been addressed. The NHS purchasing/ commissioning function was introduced nearly 20 years ago and its management continues to be largely passive when active evidence-based contracting is required to improve the quality of patient care. Given the failure of successive reforms to enhance commissioning, implementation of the NSR may be slower and more uneven than the Government hopes. The Government must publish milestones for implementation of the NSR and monitor them rigorously. (Paragraph 56)

19. World class commissioning is an ambitious, challenging programme, the first of its type in the world. Each PCT's progress and development needs are assessed through an annual 'assurance' process. The first cycle of assurance is nearly complete. As part of this process PCTs have drafted five year strategic plans, and collected supporting evidence, including surveys from a range of partners. Each PCT undertook a panel review day between the PCT board and an expert external panel. The review day was about performance and development and each PCT received a report and ratings setting out their current commissioning capabilities and recommendations for development going forwards. PCTs received and published their final ratings and reports in February 2009.
20. Following the first year of the assurance system, we have received very positive feedback from the NHS and local government about the content and the process. We have undertaken an extensive evaluation of the system gathering a wider range of views. Overall, the impact was considered to be high, with nearly 90% of participants in the process agreeing that world class commissioning will lead to an improvement in commissioning capability and governance; and over 80% of respondents to a survey of PCT partners and stakeholders believing that it will have a marked improvement in PCT performance.
21. Alongside the commissioning assurance system, SHAs are leading the development of tools and resources to support PCTs as they move towards world class. On behalf of the SHAs, the Department of Health has put in place a board development framework to support PCTs to develop their board governance arrangements locally.

22. Following the introduction of the assurance system and development resources, we expect to see significant improvements in PCT commissioning capability, resulting in improvements in health and well-being outcomes. In this first year, the assurance process has helped PCTs identify a clear path to help them become world class organisations. Thereafter, we expect the pace of development in PCT commissioning capability to be impressive, with improvements in the commissioning competencies coming through in the next two to three years, with an effect on local health outcomes becoming visible in the next three to five years. The pace and ambition of commissioning capability development will support and encourage successful and consistent implementation of the Next Stage Review.
23. The world class commissioning programme will be further supported through the current proposals from the Care Quality Commission to include an element of this in the periodic review of each PCT. The assessment of PCTs made by the Care Quality Commission will be made against indicators devised or approved by the Secretary of State. The Commission's current proposition, on which they are consulting, will look at:
- the PCT's performance against national priorities as set out in the Operating Framework (including Vital Signs tiers 1 and 2, and existing commitments);
 - commissioning processes using information from the competencies and governance elements of world class commissioning assurance system;
 - Value for money, based on the Audit Commission's use of resources assessment.
24. The Co-operation and Competition Panel, an independent advisory body, has been established to support SHAs by providing advice on compliance with the overarching system rules. This includes investigating complaints about PCT procurement and contracting that cannot be resolved locally. It will play an important role in further ensuring quality around the commissioning of services.

The Department's other main proposal to improve commissioning is through better use of practice based commissioning. We heard that practice based commissioning had failed to engage doctors and PCTs in the commissioning of services. We are not convinced that the Next Stage Review will succeed in reinvigorating the scheme. Moreover, the role of practice based commissioning in relation to the planned World Class Commissioning by PCTs remains opaque and needs greater clarification. (Paragraph 57)

25. The Department is committed to strengthening Practice Based Commissioning (PBC) implementation. PBC puts clinical engagement at the heart of commissioning and allows groups of family doctors and community clinicians to develop better services for their local communities. There is widespread agreement that the PBC policy is the right one but that implementation has been patchy and not considered to be a high enough priority by some PCTs.

26. However we know that there is strong support for PBC amongst GP practices. The Department has been undertaking, on a quarterly basis since August 2007, an independent survey run by Ipsos MORI, of GP practice views towards PBC. Latest results published in December 2008 show that support for PBC amongst GP practices remains high at 62%, with a further 20% neutral. There are also other encouraging signs with the number of GP practices who have commissioned a service through PBC rising from 46% to 56%.
27. The Next Stage Review committed to redefining and reinvigorating PBC, positioning it firmly as providing the clinical leadership vital to the long term success of PCTs becoming world class commissioners. The Department of Health has been working with the NHS to take this forward and has:
- set out a compelling rationale for PBC in a vision document, published on 4th March. This sets out how PBC is an integral part of world class commissioning and fundamental to making commissioning more effective and improving health outcomes for individuals and communities; and providing clarity around the roles and responsibilities of PCTs and PBC groups in embedding PBC locally.
 - established a small, mainly clinical PBC Improvement Team which is visiting all regions in Spring 2009 to offer support locally in invigorating PBC. As part of this work, the team will collect and share examples of best practice and innovative solutions in order that we share leading edge activity across the country.
 - established a PBC Development Framework of pre-qualified organisations, quality assured and capable of providing capability development services for PBC. PCTs and practice based commissioners choosing to use the framework will have access to techniques, tools and templates which will help them strengthen and build on local support arrangements for PBC. The Framework was launched in December 2008. The Department is pump priming its use through a £1million budget shared across SHAs.
 - set out how PCTs will be held to account through the world class commissioning assurance process for the quality of their support for practice based commissioning, including the management support given to PBC groups and the quality and timeliness of data (e.g. on budgets, referrals and hospital activity).
28. PCTs are expected to provide the levels of managerial and analytical support necessary to allow practices to fully engage with PBC. The precise support necessary will vary from practice to practice. The 2009/10 NHS Operating Framework makes clear that PBC groups are entitled to improved information and management and financial support.

SHAs have an important role in managing the performance of PCTs. However, in recent inquiries we have heard evidence that the performance of SHAs in this area has been inadequate and we doubt SHAs' ability to manage effectively the performance of PCTs. We recommend that their work in this area be evaluated independently and rigorously. If SHAs are to manage performance effectively, they must improve their ability to gather and analyse data and to assess the strategic needs of their region. (Paragraph 58)

29. SHAs are directly accountable for managing the performance of PCTs and supporting their development under world class commissioning.
30. The Department is currently working with colleagues in the NHS and stakeholders to develop an assurance framework for SHAs for implementation during 2009-10. The assurance framework will include an external annual assessment of SHAs in their roles as 'system managers' of the NHS.

Department of Health documents have too often provided a long list of priorities without ranking them. It is unfortunate that the NSR repeats this bad habit. (Paragraph 59)

31. The goal of *High Quality Care for All* is to effect systematic change across the complex system that is the NHS. Implementation of the commitments it sets out will, as a totality, effect this systematic change. They are designed to be mutually reinforcing and enabling. For example, changes to education and training – such as career frameworks that link to emerging patient pathways and the development of Health Innovation and Education Clusters – are key to improving and embedding quality in the longer term. The greater focus on innovation, leadership and patient choice will help embed dynamism, self-improvement and responsiveness to patient needs and expectations more deeply across the service. All the commitments are key priorities for the Department.
32. The NHS Operating Framework for 2009-10 sets out NHS priorities for the next year and emphasises the importance of delivering the vision set out in *High Quality Care for All* as a totality.

The NSR provides little detail about how much it will cost to implement its proposals. Lord Darzi argues that PCTs will produce local strategies with details of costs by spring 2009, but it is unclear how much information about associated costs there will be. He also asserts that, by improving quality, costs will be saved over the long term. However, we are concerned that neither SHAs nor the Department have made clear where and how much will be saved. We recommend that the Department publish, as soon as possible, figures for each SHA region and for each PCT, identifying the cost of implementing the NSR. We also recommend that the Department quantify the savings that it expects to make from improving quality and indicate when the money will be saved. (Paragraph 60)

33. Implementing the commitments in the SHA Visions, and *High Quality Care for All*, is core business for the NHS. The NHS budget for England will have increased to over £100bn by 2009/10. The proposals will be funded from within that settlement.
34. All PCTs have produced five-year strategic plans detailing how they will invest to improve the health of their local populations, focusing on locally-driven health priorities. These plans will be the local levers for delivering the visions set out by the ten SHAs. Each PCT's strategic plan will be assessed as part of the annual commissioning assurance process, which was launched in 2008. Assessment will look at how well PCTs have been able to analyse local health needs and draw out from this context a set of focused health priorities, as well as their capability to develop and deliver measurable, practical and ambitious strategic initiatives to improve on those priority areas. PCTs must be able to demonstrate that they have costed these initiatives robustly, as well as how these costings fit within the overall financial management of the organisation.
35. Not only is the Next Stage Review package affordable, but critically, the NHS cannot afford not to take forward the national and local visions. Delivering on the ambitions in the Review by delivering an NHS that is focussed on prevention and on continually striving to improve quality and innovation will lead to an NHS better placed to deliver the best value for tax payers investment – and to meet the future challenges all health systems face.
36. Clinical practice and service design are constantly evolving and developing as innovations are invented and adopted locally. Prioritising the most effective treatments, reducing errors and waste and keeping people healthy and independent for as long as possible are all things that contribute not only to the quality of care, but also to a more efficient and productive health service. High quality and value for money are not competing alternatives; they are one and the same thing. Better care equals better value.

For example:

- Through the great efforts of the NHS to tackle healthcare associated infections in recent years, we estimate the NHS has already saved over £75 million in reduced bed days and drug costs, while improving outcomes for patients. These savings will rise as we continue to drive down infection rates.
- Significant savings have been made by reducing length of stay (over 20% since 2004), emergency bed days (more than 3 million fewer since 2004) and increasing day case rates (now at 73%).

- Our policy of supporting the NHS and its partners in shifting more services into the community and closer to people's homes is opening up new possibilities for commissioners and providers to meet the needs of local people responsively and efficiently. A number of local demonstration sites have shown how, across a range of clinical specialties, it is possible to use skills and facilities innovatively to bring services closer to home. The precise shape and mix of local services will, of course, vary according to a range of local circumstances including geography, but the possibilities and service models demonstrated by these and other examples of innovative practice can be used by commissioners and providers to better meet the needs of local people within the resources available to them.
- Improvements in procurement, coupled with technology, have not only delivered savings of hundreds of millions of pounds but can also help improve patient safety. For example, robotic medicine dispensing systems can cut not only costs but also dispensing errors. Bar codes and similar technologies can both improve efficiency and reduce errors when giving patients drugs, blood and other treatments.

Improving Quality in the NHS

Variations in the quality of care provided by the NHS have existed for a long time. Lord Darzi accepted that despite the doubling of NHS expenditure in real terms since 1997 and a number of reorganisations of NHS structures during that time, wide variations continue. The emphasis of policy for the last decade has been on access rather than improving the quality of care. We do not accept that this emphasis was sensible or that it was necessary to improve access before improving quality. We welcome the change to give more emphasis to quality. (Paragraph 85)

37. While the systematic embedding of quality as the NHS's organising principle may be new, the emphasis of policy over the last decade has been on improving quality of care. Access to services is a key aspect of the quality of care provided to patients. Shortened waiting times in A&E and from referral to treatment are key to both the quality and effectiveness of care and to the quality of patient experience. The unprecedented investment in capacity that underpins improved access has been key to building the conditions for further improvement in quality more widely.
38. Introduction of a wide range of measures aimed at improving quality of care – including Foundation Trusts, independent performance assessment and regulation of providers and Payment by Results – has gone hand in hand with measures to improve access across the NHS over the last decade.

39. *'A First Class Service'* published in July 1998 set out the Government's ambitions for providing high quality services in the NHS. It established a robust framework composed of three main elements, clear standards of service, dependable local delivery and monitored standards. The new National Institute for Clinical Evidence (as it was then known) and the National Service Frameworks (NSF) were between them assigned the standard setting role. Over the following years, a suite of NSFs was developed tackling major disease areas and client groups, extending across health and social care services.
40. The CHD National Service Framework offers an illustration of how this approach has delivered service improvements and of how the additional funding provided to the NHS has been used to improve outcomes.
41. The CHD NSF set out a series of quality standards aimed at ensuring services in England matched the best in the world. We had acknowledged problems in cardiac services at the turn of the century with long waiting times, low numbers of cardiologists and cardio-thoracic surgeons when compared with other countries, and relatively low rates of intervention. The NSF established a framework for action which, coupled with the additional resources made available to the NHS and the enthusiasm and commitment of NHS staff has yielded significant results. Cases of revascularization (Coronary Artery Bypass Grafts (CABGs) and Percutaneous Transluminal Coronary Angioplasties (PTCAs)) carried out in England almost doubled between 2000/01 and 2007/08. Over the same period, waiting times fell dramatically so that by March 2008 waits of over three months for a CABG had become a rarity.
42. Improved access, both in the form of availability of appropriate services and speed of provision are key facets of quality. This is borne out by various research studies (for example a Canadian study observed that waits of more than three months for CABG appeared to lead to significant decrease in physical and social functioning, both before and after surgery).
43. Surgical outcomes offer another measure of service quality. The UK now enjoys outcomes from cardiac interventions that match or exceed the best in the world in terms of post-operative mortality.
44. The independent regulatory system has also played a key role in ensuring quality improvement more widely. The Healthcare Commission has reported on the quality and safety of services provided by the NHS and the independent healthcare sector, and worked to improve services for patients and the public.

45. The Healthcare Commission's annual *State of Healthcare* report examines the state of healthcare in England and Wales. The 2008 report was published in December and makes clear that the focus has not been on access alone but a variety of dimensions of quality improvement. It concludes that 'the NHS as a whole is getting better at using and managing its resources, and that it is performing better against the wide range of national targets it has to deliver and the core standards it has to meet. Over the last few years, the NHS has made some dramatic progress.'
46. The Healthcare Commission has a statutory duty to assess the performance of NHS organisations and award annual performance ratings based on quality and the use of resources. The Commission's 2007/08 annual health check is a comprehensive assessment of performance in the NHS, covering 391 trusts in total. Overall, this independent verdict on the NHS showed significant improvement for the second year running, with more trusts getting an excellent rating, more trusts improving on the previous year's performance and fewer in the lowest category.
47. The Healthcare Commission, Commission for Social Care Inspection and Mental Health Act Commission will be replaced by the Care Quality Commission, which will take over responsibility for periodic reviews on 1 April 2009 and build upon the excellent work of the regulators that have gone before.
48. Improvements to a variety of dimensions of quality have also been noted by the Commonwealth Fund. A 2008 Commonwealth Fund report¹ on chronic conditions identified the UK as one of the highest performing health systems of those examined, concluding that the UK stands out as having the least waste and inefficiency, greatest access to primary care, low use of emergency services for conditions treatable in primary care and very good co-ordination of care.
49. In 2006, the Commonwealth Fund's wider overall assessment of health system performance based on quality² ranked the UK first in comparison with the US, New Zealand, Canada, Australia, and Germany. The UK ranked first on quality of care, right to care, co-ordinated care, efficiency and equity. The UK system had been ranked third in 2003 and 2004, and began improving in 2005/6 to first place, demonstrating the strength and scope of quality improvement over recent years.

In principle, like our witnesses, we also welcome the emphasis given in the NSR to seeking improvements in quality through better measurement and the provision of financial incentives for providing a high quality of care. However, we have some concerns:

¹ <http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2008/Nov/In-Chronic-Condition--Experiences-of-Patients-with-Complex-Health-Care-Needs--in-Eight-Countries--20.aspx>

² <http://www.commonwealthfund.org/Content/Surveys/2006/The-Commonwealth-Fund-2006--Health-Care-Quality-Survey.aspx>

- **The Department should not rely solely on the use of incentives to achieve improvements in quality; they should be part of a wider package of measures.**
50. *High Quality Care for All* set out seven aspects of the Quality Framework to support clinical teams in improving the quality of care locally, by:
- bringing clarity to quality – making it easy to access evidence about best practice by asking NICE to develop and kite-mark quality standards;
 - supporting clinicians to measure quality to support improvement;
 - requiring quality information to be published;
 - recognising and rewarding the delivery of high quality care;
 - recognising the role of clinicians as leaders and giving them the freedom to drive improvements in quality of care;
 - safeguarding basic standards through a new independent regulator, the Care Quality Commission; and
 - staying ahead by ensuring that innovation in medical advances and service design is fostered and promoted.
51. Implementation of the Quality Framework sits within a wider framework of policy as set out in *High Quality Care for All*, such as leadership for quality and freedom to focus on quality.
52. Financial incentives therefore represent a small part of a wider package of measures and are designed to reinforce other drivers and levers in the system. NHS colleagues have acknowledged and welcomed this approach.
- **There is a danger that by focusing incentives on a narrow range of clinical services, performance elsewhere might decline.**
53. *High Quality Care for All* is a response to the local visions agreed by each SHA. The framework it sets out is designed to enable and support the delivery of these visions. The visions were developed based on locally identified improvements to pathways of care running right through from birth to end of life. Each is predicated on taking a holistic patient-centred approach to clinical services. Delivering the local visions will ensure that the NHS is focussed on high quality care across the full range of its services.
54. The approach set out as part of the Quality Framework will allow improvement in the quality of care of a wide range of services by giving flexibility to commissioners and providers to focus on local priorities for quality improvement. Local discussion and agreement will help ensure that goals are achievable and do not cause inappropriate diversion of resource.

55. *High Quality Care for All* and *The Operating Framework for 2009/10* set no new national targets. The approach and requirements set out in *The Operating Framework for 2008/09* and in *Operational plans 2008/09 – 2010/11 (Implementing the 2008/09 Operating Framework)* *National Planning Guidance* and “vital signs” were a key milestone in creating an environment in which there is greater freedom for clinicians and managers to exercise their judgement and skill at a local level. World Class Commissioning gives PCTs greater freedom over the priorities they set where they have demonstrated that they are improving health outcomes.
56. The Department of Health will continue to have a role in ensuring that the NHS recognises and prepares for national clinical priorities. We will establish a National Quality Board to provide strategic oversight and leadership on quality.
- **The incentive scheme on which Advancing Quality is based is used in the United States, a very different health system to the NHS. Its effectiveness may not be replicable in the NHS and should be demonstrated by rigorous evaluation.**
57. The Advancing Quality scheme, in operation in NHS North West, is one of a number of existing quality schemes which have informed the development of the Quality Framework and the payment framework for Commissioning for Quality and Innovation (CQUIN) in particular. The CQUIN payment framework is intended to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion everywhere. It seeks to ensure contracts with providers include clear and agreed plans for achieving higher levels of quality by allowing PCTs to link a modest proportion of contract income to locally agreed goals.
58. The Department of Health intends to evaluate the impact of the CQUIN payment framework, and will ensure that the evaluation and future development of the framework are also informed by the independent evaluation of the Advancing Quality scheme, commissioned by NHS North West through the NHS Service Delivery and Organisation Research and Development Programme.
- **There is a lack of information about how extensive the PROMs incentive scheme will be; how much it will cost to implement; when it will be fully implemented; and whether it will provide value for money.**
59. The collection of PROMs for four elective procedures through the Standard NHS Contract for Acute Services will begin on 1st April 2009. The four elective procedures are Hip replacements, Knee replacements, Groin Hernia and Varicose Vein surgeries. The selection of these procedures was based on an extensive research programme, which first identified the most appropriate PROMs measures for each procedure before piloting them in the NHS.

60. Any increase in the mandated range of procedures and conditions would similarly be based on evidence of the usefulness, cost-effectiveness and acceptability to patients of PROMs in those contexts. Work is currently underway to identify and pilot suitable PROMs for a range of Long-term conditions. Any decisions on national implementation of PROMs in these areas would be contingent on the outcomes of the research. Beyond the set of PROMs used nationally, it is anticipated that there will be local innovation to develop, test and use PROMs in a broader range of clinical areas.
61. The cost of implementing PROMs for the four elective procedures will comprise the costs to Providers of administering a PROMs questionnaire and the costs of the services, which will support the collection, processing and analysis of PROMs questionnaires. The total workload across Providers of administering PROMs questionnaires has been estimated to be equivalent to 1,520 person days³. At the time of writing, a procurement process for the services that will support the implementation of PROMs is underway and so final cost estimates are unavailable. Drawing on evidence from the pilot study⁴ and accounting for practical considerations of a move from a pilot to a routine setting (increased information governance, for example), it is expected that implementation costs would represent less than 0.5% of the total spend on the four elective procedures each year.
62. The implementation of a PROMs scheme of this nature and scale is unprecedented and as such, there are limited examples of other similar schemes to compare it against to assess value for money. The pilot study demonstrated that there were variations in the outcomes experienced by patients across and within units. It is estimated that the benefits of identifying and then eliminating measured variations in quality are substantial and sufficiently large to ensure that the PROMs scheme offers value for money. In addition, there will be significant benefits resulting from the increased availability of information on the relative quality of interventions carried out in the NHS. The scheme, once implemented, will be subject to a process of independent review and evaluation in order to demonstrate its benefits.

³ See the Information Centre's Information Catalogue (search for PROMs at <http://www.icapp.nhs.uk/infocat/search.asp>)

⁴ The report of the pilot study is available from: <http://www.lshtm.ac.uk/hsru/research/PROMs-Report-12-Dec-07.pdf>

- **The timetable for implementing the initial set of PROMs by April 2009 is challenging. There is a lack of detail about how the PROMs results will be used by PCTs and SHAs to provide incentives to improve patient care.**

63. Support and information will be provided to Providers by the Department of Health to help them meet the April 2009 timetable for implementing PROMs. From the 1st April 2009, Providers of NHS-funded care will be required to begin collecting PROMs, as described above. In practice, this will mean Providers inviting patients undergoing one of the four elective procedures to complete a pre-operative PROMs questionnaire. Questionnaires and any supporting materials required for their return will be produced and distributed by contractors working on behalf of the Department of Health. At the time of writing a procurement process is in train which will conclude in advance of April 1st to ensure that arrangements are in place to support Providers to meet the PROMs timetable. In addition to providing questionnaires and supporting materials, the contractor will provide support and information to help Providers put in place processes for collecting PROMs. Detailed guidance on the PROMs scheme, which will include a section on how data can be used, will be published by the Department of Health in advance of 1st April.
64. PROMs represents one aspect of the commitment to support measurement for improvement. The seven aspects of the Quality Framework, set out above, will apply to these measurements in the same way they apply to other measurements, for example clinical teams will be able to benchmark themselves against each other, providers may publish them in their Quality Accounts, PCTs and providers might include them in CQUIN schemes.

For these reasons, while we strongly support the principle of using financial incentives to improve the quality of care, we recommend that the Department proceed with caution. Schemes such as Advancing Quality and PROMs which link the measurement of clinical process and patient outcomes must be piloted and evaluated rigorously before they are adopted by the wider NHS. (Paragraph 86)

65. The Department is committed to evidence-based policy making. *High Quality Care for All* committed the Department to commissioning a programme of independent evaluation to improve learning and ensure transparency and public accountability. It will be supported by an independent scientific co-ordinator and will be informed by ongoing evaluation of existing schemes and initiatives such as the Advancing Quality scheme in NHS North West.

Extending “choice” and “personalisation” in primary care

We welcome the provision of additional primary care services. There are strong arguments for increasing provision in under-doctored areas. However, this expansion in supply needs careful management and evaluation to determine whether it leads to better evidence-based medical interventions for patients and whether it reduces disparities in health care access and utilisation between different social classes. It should be recognised that the investment in primary care might increase demand for hospital care as deprived people get better access to care and referrals increase with more diagnostic tests. (Paragraph 128)

66. We are committed to growing and strengthening general practice by improving access to services, offering patients real choice, reducing variations in quality and giving general practice a more prominent role in tackling health inequalities.
67. Academic evidence demonstrates the importance of primary care in improving the health of the population,⁵ and suggests that one of the best ways to tackle health inequalities is to provide more primary care clinicians in areas with the greatest need. We welcome the Committee's recognition of the strong arguments for increasing provision in under-doctored areas. We have funded 112 new GP practices in the areas with the fewest GPs and practice nurses per head of population and the greatest health needs. The GP practices will help to address inequalities by providing easier access to primary care services and more choice for patients in the most deprived areas.
68. The evidence suggests that, rather than increase demand for secondary care; high quality primary care services can reduce pressures on hospital services. Additional investment in primary care allows PCTs to secure, among other benefits, increased access to services traditionally carried out in hospital. There are many examples of PCTs commissioning a range of new services based in primary care, including diagnostic services such as x-ray, ultrasound, echocardiography and MRI scans.
69. We are working with the NHS to support PCTs in evaluating the impact of primary care investment on local health outcomes and on demand for secondary care.

£100 million has been provided for extra capacity in areas of need. The allocation of this money should be determined by national criteria measuring deprivation. PCTs and SHAs should be required to use these criteria and locate facilities where access and utilisation is poorest. (Paragraph 129)

70. The resources for additional GP practices in areas of greatest need (which will increase to £120 million nationally by 2010/11) have been allocated based on criteria developed and agreed with the NHS. The 50 PCTs to

⁵ *The World Health Report. Primary Health Care Now More Than Ever* (World Health Organization, 2008).

receive this funding were identified using weighted indicators of local health need, deprivation and existing capacity. The three sets of criteria were: the number of whole-time equivalent GPs and practice nurses per 100,000 weighted population, health outcomes such as life expectancy, cancer and cardio-vascular mortality, and levels of patient satisfaction with access to GP services. We then asked the 50 PCTs which demonstrated the greatest need, when measured against these criteria, to work with the public and clinicians to identify the most appropriate locations for new GP practices and to agree what services should be provided to meet local needs.

The Government has proposed that there should be a GP-led health centre in each PCT. While some PCTs, particularly those which are “under-doctored” or with a high burden of disease, would undoubtedly benefit from providing more primary care services it is less clear how other PCTs would benefit. We are not convinced by the Department’s argument that all PCTs should have a GP-led health centre. Whether PCTs have such a centre should be a matter as a witness stated: “to be decided locally on a case-by-case basis using the best clinical evidence available together with a full assessment of the costs and the impact on patient access”. PCTs should not make their decisions on a whim, but national criteria should be set out for them to follow to ensure that benefits and costs of their decisions are known. (Paragraph 130)

We were disappointed that neither the Government nor witnesses representing doctors could tell us what criteria should be used to decide whether a PCT needed a GP-led health centre. (Paragraph 130)

71. There are two different issues:

- addressing the relative shortage of primary care capacity in some parts of the country; and
- addressing public concerns across the country about difficulties in accessing GP services at times when their local surgery is not open or when they are away from home.

72. To address the first issue we have provided additional money to the 50 most poorly served PCTs to commission 112 new GP practices so that those areas of the country with fewest GPs and greatest health needs will have more GPs and practice nurses, easier access to GP services and greater choice of GP practice.

73. To address the second issue, we have done two things. First, we have worked with the BMA to agree arrangements to encourage more GP surgeries to provide extra appointments at weekends or in the evening or early morning: over 70 per cent of GP practices are now providing this service for local patients. Second, we have asked every PCT to establish a GP-led health centre that is open from 8am to 8pm, seven days a week, and can be used by any member of the public (in addition to the local practice with which they are registered) to access GP services. These centres will be additional, they will not replace existing services.

74. Access to GP services was one of the strongest and most consistent concerns raised by the public as part of the NHS Next Stage Review. The annual GP Patient Surveys also show that patient dissatisfaction with their practice opening hours has increased: in 2007, it was 16% (which would equate to over six million people nationally); in 2008, it had risen to 18%. In 2008⁶, at least 10% of those questioned in every PCT were not satisfied with opening hours. Despite generally positive patient experience of being able to make fast GP appointments, the GP Patient Survey suggests some five million people (13% of patients) are unable to get GP appointments within 48 hours, an issue highlighted by the Healthcare Commission in its 2008 annual health check. There is no PCT which would fail to benefit from being able to provide additional flexibility in how people access GP services.
75. We asked the local NHS to work with the public and clinicians to identify the most appropriate location for this new service. These new primary care services will also increase patient choice in relation to GP services, in line with commitments given in the NHS Next Stage Review.
76. We have encouraged PCTs to consider whether and, if so, how to supplement these core services with additional services to allow greater co-location and integration between GP services and wider community-based services. It is, however, up to individual PCTs, working with the public and clinicians, to identify what additional services should be provided to meet local needs.

While polyclinics and GP-led health centres can bring benefits, we are disappointed that the Department is introducing them without prior pilots and evaluation. The evaluation of the first 5 polyclinics in London is yet to be designed making the collection of baseline data difficult if not impossible and “before and after” comparison of performance even more difficult. It is unclear how this evaluation, which will be commissioned in early 2009, will be used to inform the roll out of the programme. There is a risk that roll out will precede the results of the evaluation, which has the potential to waste taxpayers’ money and be grossly inefficient. The evidence that similar centres in Germany and the United States improve the quality of patient care and provide value for money is mixed. (Paragraph 131)

77. GP-led health centres as a model of provision are distinct from the ‘polyclinic’ programme that has been developed by the NHS in London following the Healthcare for London consultation, as one of the recommendations agreed by all London PCTs. As set out above, the core purpose of investment in GP-led health centres is to provide easily accessible GP services that can be used by any member of the public. There is widespread evidence across the country of demand for more flexible access to GP services.
78. The ‘polyclinic’ programme in London has been developed by the local NHS to address wider challenges facing public health and primary care in the

⁶ <http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/gp-patient-survey-2007-08>

capital. Polyclinics in London (which could be provided from a single site, or could be made up of a close network of local providers) are designed to bring together a range of both new and existing services in ways that provide integrated access to community-based services, such as diagnostic services, social care, well-being services, pharmacy, and some specialist services traditionally provided in hospitals. Every PCT in London has signed up to the core DH principles of the GP-led health centres, and each 'polyclinic' in London will, like GP-led health centres, provide GP and nurse appointments to registered and unregistered patients, from 8am to 8pm, seven days a week, every day of the year, in an easily accessible location, in addition to existing GP services in the area.

79. Although we have encouraged PCTs to consider including other community-based services in GP-led health centres, where this meets local needs, it is up to local PCTs to decide whether and, if so, on what scale to do so. The development of more integrated, community-based services is far from a new development. There are many long-standing examples across the country of GPs and other primary care providers working with the local NHS to give patients access to a broader range of integrated services in community settings. There has also been a growing trend of GPs coming together in larger groupings. Over a quarter of GP practices now have six or more GP partners, and 500 have nine or more GP partners.

GP-led health centres offer the potential for closer collaborative working between GPs, pharmacists and other clinicians. This should benefit patients by providing them with more integrated care. However, simply bringing health professionals under the same roof does not necessarily mean that they will work better or that they will start working together. The Department should give consideration to how closer integration will be achieved in practice. (Paragraph 132)

80. We agree that more integrated care is not necessarily achieved by co-location of services. That is why we have left it to the local NHS to decide how far to develop other services as part of GP-led health centres: the core feature of these services is that they offer any member of the public more flexible access to GP services from 8am to 8pm, seven days a week. To quote from the Next Stage Review vision for primary and community care –

"It is clear from the regional visions for health and healthcare developed as part of the NHS Next Stage Review that there is a shared ambition for developing a greater range of services in GP practices, in other community-based settings and in people's own homes.

"... The good primary and community care services of the future will not simply be more efficient and responsive versions of what we have now. They will have seized the opportunity to provide a much wider and more integrated range of services.

"We do not wish to create a national blueprint for how this is done. In some cases, as now, clinicians may decide to bring services together in single locations in order to support integration and provide a 'one-stop' point of access. In other cases, clinicians may choose to develop networks of services with strong ties to local GP practices (as described in the Royal College of General Practitioners' 'federated' model)."

The Department's decision to conduct trials of personal health budgets is welcome if it is done rigorously and policy makers wait for the results before large scale roll-out of the programme. (Paragraph 133)

81. We welcome the Committee's support for our approach of piloting personal health budgets before making a decision on national roll-out. We said in *Personal Health Budgets: First Steps* (published 28 January 2009) that we will develop a focused and rigorous evaluation, with support for pilots as part of a wider learning community. The Department will only promote the further take up of personal health budgets, and permit further use of healthcare direct payments, if the pilot programme proves their effectiveness.
82. We anticipate that the evaluation will examine:
- Patient, carer, and informal carer health, well-being and satisfaction – including their variation across different groups by condition and background;
 - Access to personal health budgets across different groups by condition and background;
 - Financial impact across the health and social care system, including demand growth, double running costs, the cost of support and brokerage, and value for money;
 - Impact on the provision of services that are covered by personal health budgets and those that are not;
 - Impact on staff in NHS and partner organisations, including skills development and training needs;
 - Innovation and responsiveness in the provider market, including NHS providers; and
 - Practical aspects of the implementation.

83. As we set out in *Personal Health Budgets: First Steps*, we are keen for the pilot programme to explore a range of different models of personal budget. The Department intends the pilot programme to explore each of the three models set out in *Personal Health Budgets: First Steps*, and by Lord Darzi in front of the Committee. The Department intends to build on the enthusiasm and innovation of PCTs and their partners, and the size of the pilot programme will depend on the quality of applications. We would welcome expressions of interest from a range of PCTs, and we are particularly interested in PCTs that are seeking to work with groups of people who are not traditionally well served by the NHS.
84. At present, we are not specifying what particular services or patient groups should be covered; rather we would encourage commissioners and clinicians to consider where personal health budgets could be used to meet people's health and well-being outcomes. Similarly, we will not prescribe in detail how personal health budgets can be used – though we have set a guiding principle that they can be used for any goods or services that are agreed as part of a care plan as likely to meet the individual's agreed health outcomes and which would be appropriate for the state to fund. Personal health budgets would be expected to meet patient's agreed needs in full, and people would not be permitted to 'top up' their personal health budgets from their own resources.

The NHS Constitution

85. The Constitution, its Handbook (the explanatory guide to the Constitution), the Government Response to Consultation, and a Statement of NHS Accountability were published on 21 January 2009 following extensive consultation on the draft Constitution (published 30 June 2008). The Department has clarified and strengthened the documents in several ways. In particular:
- The final Constitution sets out a new legal right to receive recommended vaccinations;
 - The proposed new right to choice has been expanded to include a right to information to help patients exercise their choices;
 - The Handbook to the Constitution has been substantially revised in order to make it more accessible, as well as to provide more information about routes for feedback, complaint and redress; and
 - The Department has produced a Statement of NHS Accountability.
86. The Government response to the consultation on the NHS Constitution sets out where other changes have been made to the draft Constitution, and reasons for those changes.

The draft NHS constitution is, according to the Department, the first time that the principles, values, rights and responsibilities of patients and staff in respect of the NHS have been set out in a single document. We have heard a number of concerns about the Constitution, in particular, that it should not include too many legal rights; we note the NHS Chief Executive's view that the constitution should not be a "lawyers' charter".

87. The NHS Constitution brings together, for the first time, the principles, values, rights and responsibilities that underpin the NHS. It is designed to renew and secure our commitment to the enduring principles of the NHS, making sure that the NHS continues to be relevant to the needs of patients, the public and staff in the 21st century.
88. The NHS Constitution should not be a "lawyers' charter" that might fuel litigation. The NHS Constitution sets out in one place the legal rights that patients and staff have in relation to NHS services. The vast majority of these rights already exist in law. The Constitution brings them together in one place to ensure that patients and the public are aware of them.
89. The only new rights included in the NHS Constitution are the right to make choices and to information to support those choices, the right to access to vaccines and the right to rational decision-making on local funding of drugs and treatments. These new rights will be created through regulations and directions, which are due to come into force from 1 April 2009.
90. The NHS Constitution should enable people to better understand their rights and responsibilities in relation to their healthcare. The NHS Constitution will not be enshrined in legislation but is instead a declaratory document. The Department believes this is the best way of avoiding a "lawyers' charter" – and this view was endorsed by the Constitutional Advisory Forum of leading stakeholders that we set up to oversee the consultation process.

We also heard concerns that the draft NHS Constitution included "an awful lot of rights and very few responsibilities". We recommend that the Department ensure that the Constitution gives sufficient emphasis to the responsibilities of patients and staff to the NHS.

91. The Department agrees that rights and responsibilities should go together in the NHS Constitution. Rights for patients and staff therefore sit alongside the responsibilities they have to help the NHS work effectively and to make good use of NHS resources.

92. The responsibilities for both patients and staff set out in the draft Constitution were supported by the results of public consultation. The Constitutional Advisory Forum commented that there was a balance to be struck between enforcing the responsibilities and not deterring people from the services they need. The responsibilities therefore only carry sanctions where appropriate (for example, not guaranteeing treatment within maximum waiting times when appointments are missed). The Constitutional Advisory Forum welcomed the responsibilities as set out in the draft Constitution and concluded that they did not need strengthening.
93. The Department intends to use a variety of means of communication over the coming months to help the NHS raise awareness and promote understanding of responsibilities among both staff and patients. The ambition is that the Constitution will form the basis of a new relationship between staff and patients at a local level – a relationship based on partnership, respect and shared commitment where everyone knows what they can expect from the NHS and what is expected from them.

On the other hand, there is a concern that the Constitution will fail to engage the public in a meaningful way because people will view it as “a lot of waffle” without rights to care and treatment that are legally enforceable.

94. The Constitutional Advisory Forum emphasised in their report that the reaction of patients, the public, staff and major stakeholders to the Constitution was overwhelmingly positive.
95. Every right contained in the NHS Constitution is either already underpinned by legislation or will be by 1 April 2009, and is therefore legally enforceable.
96. The Health Bill proposes that all NHS organisations, as well as third sector and independent organisations providing NHS care in England, should be legally required to have regard to the NHS Constitution in performing their NHS functions. This means that they will have to be able to demonstrate they have given proper consideration to the Constitution in their decisions and actions.
97. As the Constitutional Advisory Forum pointed out, the Constitution is not a central ‘initiative’ that can be imposed by the Department of Health. It needs to flow through everything the NHS does and become part of the life of the NHS. The Department plans to embed the Constitution in the NHS via a long-term plan covering a broad range of communications to help raise awareness and promote understanding of the Constitution among both staff and patients.
98. Communications will focus on staff in particular at the outset to ensure there is appropriate staff awareness of what the Constitution means both to themselves, and the patients and public they work in partnership with, enabling meaningful discussions with patients and public.

99. In addition, subject to Parliament's views, the Constitution will be reinforced by the following proposed obligations outlined in the Health Bill, which was introduced to Parliament on the 15 January 2009:

- That the Government carry out a full review of the Constitution at least every ten years;
- That the Government update the Handbook at least every three years;
- That the Secretary of State report every three years on the effect of the Constitution on patients, public and staff.

We welcome the establishment of a patient's right to drugs and treatments that have been recommended by NICE for use in the NHS. However, it is important that it is recognised that the commitment will not by itself end the post code lottery which determines access to drugs and treatments not on the NICE approved list.

100. The Constitution makes it explicit that everyone has a legal right to access drugs and treatments that have been recommended by NICE.

101. There will always be drugs that are licensed as safe to prescribe but that have not yet been appraised by NICE, or which don't have a licence, and it is right that PCTs should make the decision to fund them, taking account of local circumstances and individual cases.

102. To ensure that there is transparency and greater consistency in the way these decisions are made, the Constitution contains a new right to expect local decisions on the funding of drugs and treatments not recommended by NICE to be made rationally following a proper consideration of the evidence and for that decision to be explained. We published a clear set of principles on 21 January to inform PCT decisions on funding of drugs and treatments where there is no NICE guidance. This will mean that all PCTs can make their decisions based on the same set of underpinning principles. We have also published draft Directions to PCTs to ensure they are clear what their statutory responsibilities in this area are. We have commissioned detailed good practice guidance that will be published shortly, and will be establishing a dedicated programme of training and support for PCTs.

103. These measures, along with the improvements we are making in the timeliness of NICE appraisals, underline our commitment to address public concerns about a perceived 'postcode lottery' in access to drugs. They will mean that people can be very clear both what the NHS is offering them by way of access to drugs, and how those decisions are made.

Measures to improve the leadership and workforce of the NHS

We welcome the Department's increased focus on improving its workforce planning in the NHS. However, we note concerns that planning will be concentrated in the Department. In our recent report on Workforce Planning we recommended that SHAs have a key role in this area. The Department should ensure that regional NHS employers are given a role in identifying future workforce requirements. (Paragraph 157)

104. The Department of Health is committed to ensuring that workforce planning in the NHS is locally led and rooted in service improvement. The vast majority of workforce planning is owned and led locally by service providers who have responsibility for developing robust workforce plans. As outlined in *A High Quality Workforce*, commissioners have an assurance role to ensure that workforce plans are fit for purpose, sustainable and meet their commissioning plans. The SHAs will play a key role in ensuring a strategic approach to workforce development and will remain accountable for education commissioning. The SHAs will be supported by regional professional advisory bodies to help them do this. To support workforce assurance across the system, strengthened mechanisms are being put in place, including the development of key workforce competences and routines for commissioners and an improvement metrics framework for SHAs.
105. The development of Health Innovation & Education Clusters will create the opportunity for universities, NHS employers and industry to come together in local partnerships to deliver effective and responsive education linked to the latest developments in health and healthcare. They will also raise the quality of education and training by enabling SHAs to focus on commissioning while Trusts provide training programmes. Funding following the trainee will ensure that education providers are responsive to the needs of trainees.
106. In setting up national bodies such as the Centre of Excellence and Medical Education England (MEE), our aim is that local service providers and commissioners will be better informed and supported to plan their workforce and make key decisions around their education, deployment and development. Both the NHS and the Department of Health need access to the best strategic intelligence available to ensure that we get value for money from the significant investment that is made in the NHS workforce. Long term workforce planning is very complex and the workforce planning system needs to be able to access the best available data and information to properly plan and analyse risks. The introduction of a Centre of Excellence will help ensure there is a sound evidence base, provide greater strategic oversight and more effective risk management.

It is widely recognised that the quality of leadership in the NHS must improve and we welcome the Department's ambition to do this. However, we note the following concerns about its proposals:

- **There is undue reliance on new institutions such as the Leadership Council; we note that previous attempts to improve the quality of management and leadership in the NHS by introducing new institutions such as the NHS University have failed;**
- **The Department's approach is over-centralised; and**
- **The emphasis on medical leadership is important; however, we are concerned that at present many doctors are put off becoming senior managers. We therefore recommend that more training and support be given to those who wish to take on senior management responsibilities. (Paragraph 176)**

107. Far from taking a centralised approach to leadership development, we believe that leadership should happen at every level of the system and that leadership development should start at the level of the individual. All NHS staff have a responsibility to continuously learn, seek development and career opportunities, spot talent and support the development of others.

108. Employers play a crucial role at a local level in developing the leaders that we need in order to commission and provide high quality services. There is considerable evidence that many employers take this responsibility very seriously.

109. Strategic Health Authorities play a significant role at a regional level. They are responsible for ensuring that conditions are in place to improve talent and leadership development across organisational boundaries and that supply and demand at regional level are understood and action taken to address gaps. SHAs will also commission, and in some cases provide, development programmes for senior leaders where this is the most appropriate level in the system to do so.

110. Finally, at national level, our role is to create the right conditions and incentives, set standards and advocate improvement. The National Leadership Council will underpin and champion this work.

111. In developing the scope and purpose of the National Leadership Council we engaged with a wide range of diverse stakeholders, including clinicians and chief executives at every level of the system, and undertook an extensive consultation exercise.

112. The Council, chaired by the NHS Chief Executive, will work with existing commissioners and providers to champion leadership and to build a strong culture of leadership and leadership development across the NHS. We believe it will add value by gathering and analysing evidence on what works and ensuring that best practice is shared. It will not be responsible for delivering programmes but will have a role in ensuring that any programmes it commissions are of an acceptable standard and, if appropriate, accredited.
113. We are aware that there are already some highly effective leadership programmes which are being delivered at employer level and also at SHA level to improve leadership across the NHS. We expect the majority of leadership development work will therefore happen at employer and regional level.
114. Through the launch of *"Inspiring Leaders: Leadership for Quality – The Guidance for Talent and Leadership Plans"*, published in January 2009 after considerable engagement and co-production with stakeholders across the NHS, we have set out the responsibilities for talent development at all levels of the system with a strong emphasis on subsidiarity. The National Leadership Council will build on those responsibilities and only offer solutions and interventions where it is the most appropriate level in the system to do so.
115. We are committed to supporting more clinicians to play managerial roles, recognising that their expertise and frontline experience can really help drive quality improvement. There are many examples of clinicians who have become senior managers, both in the NHS and in the Department of Health. We do however accept that many doctors may be put off becoming senior managers.
116. We are exploring this further by working with four SHA regions to identify the barriers which clinicians can face in progressing to senior management positions in the NHS. We are analysing these findings to establish what we can all do at each level of the system to enable and facilitate action across the NHS, removing obstacles to help clinicians interested in leadership roles to realise their ambitions.

117. There are a number of commitments in *High Quality Care for All* which are aimed at ensuring that leadership development and support is given to doctors who wish to take on leadership roles. These start early by embedding leadership skills into undergraduate and postgraduate medical education and continue throughout the career paths of healthcare professionals. To support those doctors in training with a real interest in pursuing leadership development we are working with Post Graduate Deans from across the NHS to create Clinical Leadership Fellowships where Specialist Registrar level participants will undertake leadership and management work experience placements up to one year to further develop their leadership skills and experience. A new "Leadership for Quality" certificate will operate at three levels: Level one will be for staff in clinical and non-clinical teams with an interest in becoming future leaders; Level two will be for leaders of team and service lines and Level three will be for senior directors.

It is unfortunate that the NSR does not place more emphasis on the importance of recruiting and developing better managers. Over many years this Committee has heard concerns about the quality of management in the NHS which witnesses to this inquiry echoed. Some managers lack the analytical skills or motivation to handle and interpret the wide range of performance and routine administrative data, such as HES, that they have to deal with. With the introduction of PROMs and other quality related measures this issue is becoming ever more important. We therefore recommend that the Department address the issue of weak management skills in this area with urgency. Senior NHS management, clinical and non-clinical, should acquire analytical skills which will enable them to understand the products of expensive and increased investment in clinical and cost effectiveness data. This should be a central component of their annual appraisals, and in the case of clinicians, linked to their systems of performance related pay (Clinical Excellence Awards). The pay and promotion prospects of managers should be linked to their skills, in particular their ability to analyse and use data. (Paragraph 177)

118. "Inspiring Leaders: leadership for quality", the Guidance for NHS Talent and Leadership Planning, is designed to support SHAs in identifying, developing and recruiting the best leadership talent across their regions. It requires SHAs to examine both leadership capacity and capability through a structured approach looking at demand and supply, identifying the gaps and implementing strategies to address these. At its core the guidance is about creating deep and diverse talent pools from which we will draw our next generation of NHS leaders. The anticipated outcome of this more systemised approach to Talent and Leadership planning is creating a situation where organisations at all levels become spoilt for choice when recruiting leaders.

119. We anticipate that leadership development programmes at all levels of the system will emphasise analytical skills where appropriate to do so. For example, in developing our commissioners of the future a strong emphasis is placed on the World Class Commissioning competencies which include a range of analytical skills. In addition we are examining how Service Line Management (including analytical skills) will be embedded into development programmes such as the Leadership for Quality Certificate.

120. The Clinical Excellence Awards (CEA) scheme is currently under review and we will examine how leadership and managerial skills can best be reflected in the criteria for awarding CEAs.

The National Training Programme has attracted graduates of great ability. They should be encouraged to take appropriate academic qualifications and be given sustained career support to ensure that their talent is exploited to the full throughout their careers. (Paragraph 178)

121. The award winning NHS Management Training Schemes are run by the NHS Institute for Innovation and Improvement on behalf of the Department of Health. The new National Leadership Council (NLC) will have a dedicated workstream covering Emerging Leaders, including the Management Training Schemes. The NLC will review the schemes to identify improvements, this will include consideration of the academic qualifications offered, strengthening the Alumni and providing ongoing career support.



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ISBN 978-0-10-175582-5



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