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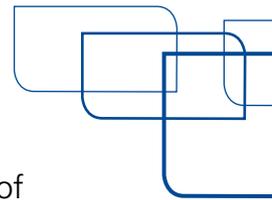


NHS Next Stage Review Leading Local Change

May 2008

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Leading local change



Over the month ahead, every region of the NHS¹ will publish its strategic vision for improving health and healthcare over the next decade. These locally-developed visions are an expression of the dedication, enthusiasm and commitment of clinicians to improving the quality of care for patients.

I have heard the collective desire to improve quality of care for patients and the recognition that this can mean changing the way that we work or how our services fit together. This is not unique to our NHS – throughout the world, healthcare is changing. We are constantly finding new and better treatments and better ways to deliver care that meet patients' rising expectations.

Summary

I was asked by the Prime Minister and Secretary of State for Health to lead the NHS Next Stage Review. As part of my Review, I committed to examining how clinical decision-making could be put at the heart of change in the NHS. Since July last year, I have been engaging widely with patients, the public, NHS staff, Local Authorities and third sector partners so that together we can chart a way forward.

Put simply, world-class quality of care is a moving target – what was high quality in 1948 or 1998 is often not regarded that way in 2008. High quality care cannot be achieved through one last heave, but only by recognising the need to accept, embrace and lead change. Standing still won't meet the expectations of our patients, the ambitions of our staff or the interests of the public. Such an approach would frustrate staff,

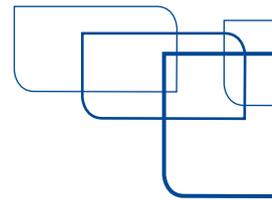
¹ Except London, which published its report through a separate process in July 2007

work against the interests of patients, and is necessarily doomed to failure.

This document sets out how, where necessary, the NHS can change through the leadership of clinicians and the support of patients and the communities in which they live. It makes five pledges, which PCTs should have regard to, demonstrating our commitment to delivering the most effective change possible:

1. **Change will always be to the benefit of patients.** This means that they will improve the quality of care that patients receive – whether in terms of clinical outcomes, experience, or safety.
2. **Change will be clinically driven.** We will ensure that change is to the benefit of patients by making sure that it is always led by clinicians and based on the best available clinical evidence.
3. **All change will be locally-led.** Meeting the challenge of being a universal service means the NHS must meet the different needs of everyone. Universal is not the same as uniform. Different places have different and changing needs – and local needs are best met by local solutions.
4. **You will be involved.** The local NHS will involve patients, carers, the public and other key partners. Those affected by proposed changes will have the chance to have their say and offer their contribution. NHS organisations will work openly and collaboratively.
5. **You will see the difference first.** Existing services will not be withdrawn until new and better services are available to patients so they can see the difference.

This new approach will ensure that the right changes happen for the right reasons, based on what is clinically best for patients. The process of change we have put in place will ensure that these pledges are acted on, with frontline clinicians as their guardians.



I will publish my final report next month. It will not be a grand plan or a national blueprint. It will instead respond to the challenges set by clinicians and other health and social care professionals in each NHS region and set out how we can enable nationally what the NHS aspires to locally. Together, we can make world-class quality of care a reality for all.

Professor the Lord Darzi of Denham KBE,
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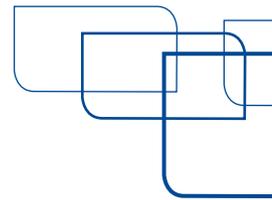
Changing for the better

The past decade has seen unprecedented investment in the NHS. The service has almost doubled in size with more doctors, more nurses, and better facilities than ever before. The quality of care delivered has improved with new treatments and innovations in clinical practice. Patients have seen the difference with waiting times down, access to care up, and high levels of satisfaction with the care received². In the few months since my Interim Report³, patients have seen further improvements. The number of hospital-acquired infections is falling following new guidance and new resources for infection control. Investments are being made in primary care with new GP-led health centres. Waiting times continue to fall. And since 1st April this year NHS patients have been able to choose any hospital in England for their treatment – for the first time ever. These changes have been delivered by NHS staff and, in this anniversary year, their successes should be recognised and celebrated.

Nevertheless, world-class quality of care is a moving target. This is a reflection of constant innovation in healthcare as a whole – whether it is new treatments, better clinical practice, modernised facilities or care delivered closer to people’s own homes. This means more lives saved. It means better experiences for patients. It means more convenience. It means fulfilled staff, able to give the quality of care to patients that they aspire to – and taking professional pride in doing so. Too often in its 60 year history, the NHS has been too slow in making the improvements that are of benefit to all and at times too ready to pursue change without absolute clarity about its benefits. We will change that. Where I have seen change that is clinically-driven and evidence-based, I’ve found patients, the public and staff excited and energised by the prospect of a better future. NHS staff are rightly tired of upheaval, especially when change is imposed from above, which is why we are absolutely convinced that change must be locally-led, responding to the needs of local communities.

² Healthcare Commission survey, June 2006, found 92% of patients rated the care they received as good, very good or excellent.

³ Darzi A. Our NHS, our future: NHS Next Stage Review—Interim Report. Oct 4, 2007. http://www.ournhs.nhs.uk/fromtypepad/283411_OurNHS_v3acc.pdf



Clinically driven

When it comes to change, improving outcomes, safety and quality, patients and the public understandably want clinicians to be in the lead. So the purpose of change should be to meet the current understanding of best clinical practice, working with commissioners to ensure that patients get the best possible care. We now know, for example, that for patients suffering a stroke, the right diagnostic scan within 2 hours and, where appropriate clot-busting drugs substantially improve outcomes. It means lives are saved and quality of life is improved. Patients, the public and staff understand the value of specialist stroke centres. The case study in Box A is just one example of the difference that an evidence-based approach can make.



A local approach

In my interim report I made the case that our aim should be to create an NHS that delivers world-class quality of care to patients. By definition, world-class quality of care is tailored to personal needs and local circumstances. It cannot be imposed from the top but must be led by local clinicians, care professionals in Local Authorities and the third sector responding to local needs. An essential principle of the NHS is that it is based on need – we recognise that different places have different and changing needs, and that local clinicians are best placed to understand and respond. A grand plan or national blueprint cannot possibly achieve the world-class quality of care that patients want and NHS staff and partners aspire to deliver.

Involving patients, the public and partners

Health and healthcare are fundamental to what we can achieve in life. The NHS touches everyone, our families and our friends, from the beginning of our lives to the end.

BOX A: South Devon Healthcare: Development of an evidence-based care pathway for stroke patients

Following publication of the National Service Framework for Older People⁴ and the National Stroke Strategy⁵, the NHS in South Devon has significantly changed service delivery, responding to the needs of people who have had a stroke, and their families.

They have changed services to ensure admission for all stroke patients and timely transfer from hospital to rehabilitation and, by improving links with social care, back to home.

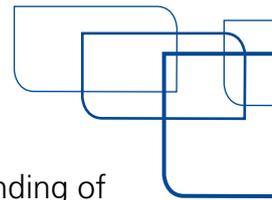
Following consultation with patients and the public, it was decided to appoint a consultant therapist to develop community services and lead a newly established stroke rehabilitation unit based in a community hospital.

Staff with specialist skills in community stroke care received additional training to enable faster discharge of patients and better longer-term rehabilitation. A rapid referral process for transient ischaemic attack (often called a mini-stroke) assessment (TIA) and a thrombolysis service was also implemented.

The service continues to develop and now provides a secondary prevention guide, information booklet and patient held record to ensure that people with complex needs have the information they require. A peer support role has also been introduced whereby volunteers who have had a stroke provide support to current in-patients.

⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003066

⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062



Our NHS is the most cherished of British institutions – the patients who use it, the public that funds it and the staff that work in it care deeply about its present and its future. Public concerns about change in the NHS are a reflection of public affection for the NHS.

Local health services matter to local people – curing them when they are sick and caring for them where no treatment can be found.



We all make a contribution to the funding of the NHS through paying taxes. And it should not be forgotten that during the course of their lives, NHS staff are NHS patients too. This is why it is right that patients, the public and partners have the opportunity to be involved in the process.

Patients, the public and NHS staff are not opposed to change in principle. They simply want to make sure that it strengthens their local services and that it is being done for the right reasons. Furthermore, since we believe that the NHS should respond to local needs, patient and public involvement is essential to getting proposals right. Proposals for change are stronger when they are created and shaped by a coalition of patients, the public and staff. Throughout much of the NHS, this is the approach that is taken – and it is successful. In the East of England, for example, a broad-based coalition for change was built around the fact that more patients would survive when suffering a heart attack.

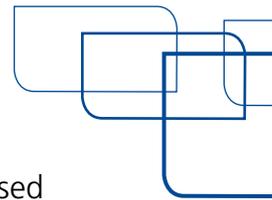
BOX B: Heart Attack in East of England

In order to reduce the time between a reported heart attack to the administration of thrombolysis treatment, the East of England Ambulance Service has trained paramedics to deliver treatment at the location of the incident. Electrocardiogram (ECG) readings are taken on site which are then transmitted for consultation to specialists at Ambulance Service headquarters. This has reduced the time required to administer the treatment and increased survival rates.

A consultation with all relevant stakeholders was conducted prior to instituting the programme. This included the PCT, cardiologists, public interest groups, and the local cardiac network.

Prior to this, the patient had to be taken to hospital before thrombolysis treatment could be administered. As a copy of the ECG is also transmitted ahead of the patient the A&E clinical team are able to be placed on standby in advance of the patient's arrival, saving crucial time.

Training has also been provided to ambulance technicians so that if a paramedic is not among the crew the symptoms can be quickly recognised and a paramedic contacted to co-ordinate the fastest way to administer the treatment.



Seeing the difference

People are reassured that the NHS is there for them when they need it. Understandably, in times of change, they want to see the difference first before out-dated or ineffective services cease to operate. They want to be able to see the benefits in practice, not just understand what they are in theory. Patients, the public and staff want to be sure that good outcomes are secured by making sure that there is as little disruption as possible. This means that new services need to be up and running before old services are ended.

Our support for a locally-led, clinically-driven approach is not simply warm words. It is the reason why I took the decision to make the NHS Next Stage Review a locally-led process. Since last October, local clinicians and other staff working in health and social care organisations have come together in 74⁶ Clinical Working Groups to determine the future of services across eight pathways of care – from maternity and newborn to end-of-life care. Their membership has included some 2,000 frontline clinicians and other staff working in health and social care organisations. I am very grateful to them

for their hard work. They have discussed their work with thousands of patients, carers, members of the public and other staff who work in NHS and other local organisations. Overall the depth and breadth of engagement has been extraordinary – in a Review that will touch the lives of millions, I am delighted that 60,000 people have shared their views and experiences.

Over the next month each NHS region will set out its strategic vision for the next decade, based on the work of these clinical groups and their engagement with their local communities. These visions are founded on consideration of the best available clinical evidence. It is precisely because this process has been locally led by clinicians using the best available evidence that patients and the public can have confidence that they will lead to real improvements for everyone. In implementing the vision in each region, the NHS will continue to change according to these principles – change led locally by clinicians and their fellow care professionals, based on the best available evidence, responding to local needs and local priorities. This document – together with the detailed best practice guidance⁷

⁶ Eight in each of the nine NHS regions outside London and two in London

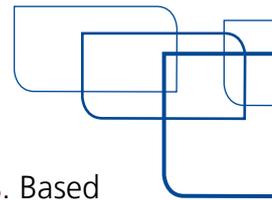
⁷ www.dh.gov.uk/changingforthebetter

for NHS organisations published alongside it – confirms the process that all major NHS change will follow.

Our pledges to you

We understand patient and public concerns about change in the NHS. They want to know that change is taking place to make improvements for them, not simply to deliver efficiency savings. They want to know that there is a strong clinical case and that decision makers have considered the best available evidence. They want us to show them the improvements before the outdated services are stopped. They want to be informed and they want to be involved. That is why today we are making five pledges on change in the NHS, which PCTs will have a duty to have regard to:

1. **Change will always be to the benefit of patients.** This means that they will improve the quality of care that patients receive – whether in terms of clinical outcomes, experience, or safety.
2. **Change will be clinically driven.** We will ensure that change is to the benefit of patients by making sure that it is always led by clinicians and based on the best available clinical evidence.
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5. **You will see the difference first.** Existing services will not be withdrawn until new and better services are available to patients so they can see the difference.



Making change happen takes courage and it takes leadership. Living up to these pledges will ensure that the NHS makes the right changes and will be able to count on the support and understanding of patients, the public and staff. In a national service, it is right and proper that we set national standards for change that can command their confidence.

Securing this approach locally

The detailed re-configuration guidance for the NHS that we are publishing today will revise the way in which changes are taken forward locally to make these pledges a reality. It reinforces the 8 key steps to deciding on substantive service changes:

1. **Driven by clinical need.** Your local NHS will carry out a planning and needs assessment led by local clinicians. This will look at current services and how they fit with the latest developments in clinical practice and current and future needs of patients.
2. **Early involvement in proposals.** Based on the understanding of clinical needs, your local NHS will develop proposals for improving services, in conjunction with Local Authorities, the local third sector, local stakeholders and the public – ensuring that local people have the chance to have their say early on in the process, and that all proposals respond to their needs.
3. **A high clinical bar for change.** All proposals will be subject to independent clinical and management assessment. We will make this possible through the Office of Government Commerce's Gateway Review process. This is a process of peer review that identifies risks and issues at an early stage. This process will be supported by the National Clinical Advisory Team, whose membership will be drawn from members of the Clinical Working Groups. This means there will be a high clinical bar for change everywhere in the NHS, so that change is always to the benefit of patients.

4. **Listening to you.** There will be a formal period for everyone affected by a substantial change to have their say. Public consultation on the proposals for change will take place normally for a minimum of 12 weeks, although it may be possible to reach local agreement about a different timescale where appropriate. This will mean patients, the public and staff will be involved in the process.
5. **Responding to you.** The local NHS will analyse what you have said, helping to inform, shape and strengthen local proposals for change.
6. **Local decision.** A decision on whether to go ahead with the proposed changes will be taken locally, based on the clinical and management case put forward, the benefits for patients and consultation responses. When the other steps are taken, we are confident that the local decisions will be the right ones for local people.
7. **Making sure it's right.** The Local Authority, through its Overview and Scrutiny Committee, may review and scrutinise the proposal. We believe that local issues need local solutions, so we are exploring options for the introduction of local mediation where multiple Overview and Scrutiny Committees in a Joint Overview and Scrutiny Committee cannot agree.
8. **Appeal.** The Overview and Scrutiny Committees will reserve the right to refer the decision to the Secretary of State for Health if they believe that the proposal is not in the interests of local health services. The Secretary of State may then ask for expert advice from the Independent Reconfiguration Panel, whose advice will be made public.



I am determined that we will live up to the pledges made here today. But determination from Whitehall can never be enough. To ensure that future service changes meet the expectations of patients, their carers and the public, we will make sure that there is strong clinical oversight at the heart of the local system. So we will ask each region of the NHS to develop plans to harness the energy and enthusiasm of the Clinical Working Groups to be the guardians of the pledges made in this document and oversee the implementation of each strategic vision. Their local judgement will make sure that the right local solutions are found. In this endeavour they can be confident of our full support.

Where next

Over the month ahead, each region of the NHS will publish its strategic vision for the future of services. These reflect the ambitions and aspirations of some 2,000 frontline staff. They have stepped up to the challenge and displayed precisely the leadership that will secure the NHS in years to come. The publication of these local visions for NHS services marks the end of the beginning. Following local engagement and

consultation, your local NHS will implement these visions over the decade ahead. It is now up to local clinicians and other health and social care staff to champion their proposals to make sure they become a reality for patients. In that mission, they have my absolute confidence and support.

That's why the final report of the NHS Next Stage Review will be all about *enabling* these local visions to become reality. It will not be a grand plan or a national blueprint. We are continuing to listen and learn from NHS staff, their partners and from our stakeholders across the spectrum of health and social care. I was delighted to receive policy ideas from over 200 separate organisations, and to have engaged with over 300 national stakeholders. Our national working groups for quality, innovation, primary and community care, workforce, leadership, information, and an NHS constitution, involve clinicians, managers and stakeholders alike, and each is chaired by a fellow minister.

My final report will respond to the challenges of implementing the changes that regional visions have identified and enable nationally what the NHS aspires to locally. That is the only way that real change in our health service and in our health can happen.



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