The NHS five year plan 2010-2015

*NHS 2010-2015: from good to great. Preventative, people-centred, productive*

Summary

1. Introduction

1.1 A new publication, ‘*NHS 2010-2015: from good to great. Preventative, people-centred, productive*.’ sets out the NHS five year plan in the context of a new financial era and it is intended to give people working in the NHS a clear sense of direction and time to plan for the challenges ahead.

1.2 This paper summarises the main elements of the plan, highlighting specific initiatives that will potentially impact on the Trust.

2. Chapter 1: Implementing our vision: a preventative, people-centred, productive NHS

2.1 This chapter sets out the challenge ahead to accelerate quality improvement, creating services that are ‘universally great’, remaining committed to tackling inequalities and promoting equality.

2.2 It is stated that change will be on an unprecedented scale for patients and staff and hard choices about resources and priorities will have to be made, delivering £15-20 billion efficiency savings over three years from April 2011 (£10billion by 2012/13). Savings are identified in the following areas:

- Productive NHS workforce - £3.5 billion
- Reduced management cost, back office support and procurement - £1.8 billion (See the publication ‘Putting the frontline first: smarter government’)
- Care closer to home and self care for people with long term conditions - £2.7 billion
- Tighter control of the pay bill.

2.3 Reference is made to six challenges; ever higher patient expectations; an ageing society, the dawn of the information; the changing nature of disease; advances in treatments and a changing workforce. It is also stated that all savings will remain within NHS budgets and be used to respond to these challenges as well as to deliver the vision for high quality care.

2.4 There is emphasis on reform and that this can only be achieved through clinical leadership and a change in current roles for NHS staff. There is commitment to support staff to make the changes necessary to shape services around the needs of patients – more care closer to people’s homes that are better integrated around people’s needs.

2.5 The NHS Constitution helps to put the power of reform in the hands of people, rather than rely on nationally set targets (which is what has had to happen in the past) and research and innovation also have a significant part to play shaping the future of the NHS.
3. **Chapter 2 – the deal for patient and the public**

3.1 The legally binding entitlements to staff, patients and the public are now set out in the NHS Constitution. It sets out what the NHS does, what it stands for and the commitments it should live up to. New rights will be added when they become possible. There are 25 rights in the Constitution and a further 2 have been proposed:

- You have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible.
- You have the right to an NHS Health Check every five years if you are eligible for one. If you are not offered one at the provider you approach, you have the right to see an alternative provider.

3.2 There are responsibilities of patients set out in order to support NHS reform – e.g. participate in public health programmes, provide feedback.

3.3 Parents also have a vital role to be promoters of health, of healthy behaviour to be adopted by children in their early years. Changing behaviours will continue through schemes such as Change4Life, NHS Stop Smoking Service and Total Place pilots. The Total Place pilots are working to address alcohol and drug abuse through partnerships delivering more for less through collaboration, and three of the 13 pilots are in our region; South Tyneside, Sunderland and Gateshead. A new tobacco control strategy is due to be released.

3.4 There is acknowledgement that there should now be a shift from ‘diagnose and treat’ to ‘predict and prevent’ and that personalised care can only be realised by tailoring provision with services and organisations working together across traditional boundaries.

3.5 Two new publications, one due for imminent release; ‘Valuing People Now’ sets out policies and actions to improve access to healthcare and health outcomes for people with learning disabilities, and ‘New Horizons: A shared vision for mental health’ sets out plans to improve mental health services. Both of these publications will help with our own Pathways work for emergency and/or urgent care regarding the access barriers to these services that we currently face.

3.6 The introduction of NHS health checks is set to save thousands of lives by preventing stroke and heart attacks, and at least 4,000 people will not develop diabetes as a result. A significant amount of the Trust’s emergency incidents are for patients presenting with stroke or heart attack symptoms and until schemes such as the NHS health checks start to have an effect, it is unlikely that the Trust will experience decreases in these areas of activity.

3.7 More screening and earlier diagnosis of cancers is planned through increased GP access and modern laboratory medicine.

3.8 The following priority areas for achieving *High Quality Services* have been identified:

- further reductions in MRSA
- cancer care
- care for stroke patients
- care for those at risk of heart disease (95% of the population live in areas with 24x7 primary angioplasty services – we are already delivering this in the North East)
- care for pregnant women.

3.9 For the three interdependent areas of quality, as per Lord Darzi’s vision organisations will be required to:
- **Safety.** Focus on a wider set of safety challenges, safer care for patients, zero tolerance of preventable infections

- **Effective.** Reduce the number of patients who die from VTE (prevention of Venous Thromboembolism) and increase prevention of pressure ulcers.

- **Patient experience.** Expand the measurement of patient satisfaction and for those to be included in Quality Accounts from next summer. There will also be a greater proportion of provider income linked to patient experience and satisfaction – potentially up to 10% - or ~£100,000 for NEAS.

3.10 There is clear requirement to have more choice for patients and to transform the care for groups of people with the following long term conditions; diabetes, heart failure, respiratory disease (including COPD), cancer as a chronic disease and dementia. More local care is seen to be delivered by GPs and community services rather than having to be seen in an urgent or emergency setting. The three digit number service is still a commitment and this will be introduced from next year. Also in 2010 detailed plans for the National Care Service will be published, leading to better integration.

4. **Chapter 3: the deal for staff**

4.1 The focus is clinical leadership, collaborative working, reuniting doctors and nurses, managers and politicians and staff flexibility.

4.2 The concept of social partnership will be extended and the Social Partnership Forum (SFP) is acknowledged as having impressive results. An investment of £500,000 is being made to support partnership working throughout the NHS this year and next.

4.3 Change needs to be fast moving as good practice cannot be allowed to spread at its own pace. An evidence base of around 70 examples of best available evidence will be used to escalate improvements. Organisations will be supported nationally but locally led. The Trust will be able to drive this through NETS and Service Improvement.

4.4 The NHS Constitution also sets out additional pledges to staff.

4.5 There are 20 recommendations made as part of the Boorman report (an independent review of the health and well-being of the NHS workforce) and these are to be implemented in the NHS in 2010/11.

4.6 With regards to pay, future pay awards will need to strike the balance between rewarding existing staff for increased quality and productivity and the need to maintain security of employment by retraining and redeploying staff to meet additional demand. A sustained pay restraint is required. It is recommended that consultants and very senior managers receive no increase in 2010/11 and GP practice income increases are restricted and they need to make at least 1% cash releasing efficiency savings.

4.7 Work is ongoing exploring the pros and cons of offering frontline staff an employment guarantee locally or regionally in return for flexibility, mobility and sustained pay restraint. This may involve staff working in a different place or even a different organisation. The Trust will need to align training plans to support delivery of local clinical visions and new ways of working in support of retraining and redeployment of staff, utilising the new Staff Passport.

4.8 There is little proposed change to pensions, only removing barriers for third sector and private business to more easily provide NHS services.

5. **Chapter 4: how the system will support NHS staff and organisations to deliver**

5.1 The key levers include:
• Payment systems support improved quality and efficiency
  – 0% maximum uplift for next four years (hospitals)
  – Increases in payment linked to quality goals
  – Incentivising the shift of care out of hospital settings
  – Withdrawal of payments when care does not meet minimum standards
  – QOF reform 2011/12
  – Piloting of variations to the NHS dental contract from 2010.

• Helping staff through change
  – Empower and enable NHS staff to lead change
  – NHS will be given the first opportunity to improve (to be set out in more detail in Procurement Guidance due in January)
  – Commissioners will have a legal duty to secure best services.

• Strengthening regulation, dealing with failure
  – New registration process from 2010 (private ambulance are not required to register until April 2011).

• Creating leaner, stronger commissioners
  – Realisation of economies of scale
  – Commissioners expected to reach clear performance goals by April 2011
  – Freedoms and incentives to high performing commissioners
  – Poor performers to demonstrate clear and rapid improvement
  – Improve information on management costs
  – Significantly reduce management costs in PCTs and SHAs (30% over next four years)
  – Permit reconfiguration where it leads to greater coterminosity between PCTs and LAs.

• Integrating services, supporting high performing organisations
  – Reduce variation in quality among primary care providers and practice based commissioners.
  – Increase integration of services (build on learning from pilots – 3 in our region),
    may include integrating community services with existing hospital providers or
    with mental health trusts and practice-based commissioning consortia.
    Community foundation trusts may be an option if the proposals meet the
    demanding criteria that will be set. Social enterprise ‘Right to Request’ schemes
    may be another option.
  – Alignment of incentives so organisations work better together
  – Reform of provider services
  – Reduce overheads and transaction costs
  – Offer rewards and freedoms for high performers
  – High performing FTs to expand their services
− Make it easier for high performing trusts to take over poorly performing organisations.

• Streamlining the reconfiguration process
  − Further simplification
  − Better engagement.

• Driving innovation
  − £220 million Regional Innovation Fund
  − Development of NHS Evidence
  − NHS Life Sciences Innovation Delivery Board to support adoption of clinically and cost effective innovations

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