

NHS Future Forum

Summary report – second phase

Professor Steve Field – Chair

NHS Future Forum members



Tom Riordan



Moira Gibb



David Rogers



Terence Stephenson



Julie Moore



Niti Pall



Ash Soni



Peter Hay



Chris Long



Stephen Bubb



Duncan Selbie



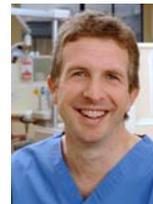
Gill Walton



Kathy McLean



Paul Farmer



Jimmy Steele



Robina Shah



Sally Brearley



Peter Nightingale



Charles Alessi



Hilary Chapman



Robert Varnam



Matthew Shaw



Anthony McKeever



Ratna Dutt



Malcolm Lowe-Lauri



Thomas Hughes-Hallett



Vicky Bailey



David Fish



Steve Field



Derek Fawcett



John Tooke



Tim Riley



Jeremy Taylor



Dermot O'Riordan



Claire Marshall



David Kerr



Victor Adebowale



Frank Atherton



Bill McCarthy



Sheila Bremner



Simon Brown



Helen Joy



Jane Cummings



David Haslam



Mike Cooke



Clare Leon-Villapalos



Paul Hodgkin



Ronny Cheung



Philippa Russell



Sol Mead



Francis Wells



Geoff Alltimes



Joanna Killian



Jason Stamp



Jonathan Fielden



Lisa Christensen



Shai Roy

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Letter to the Secretary of State for Health

Dear Secretary of State,



Over the past few months, the members of the NHS Future Forum have listened to thousands of members of the public, patients and service users, their carers, health and social care professionals and managers in a variety of settings up and down the country. Our work has taken us from Carlisle, through rural areas of Devon, Cornwall and Warwickshire, to cities including Birmingham, Leeds, Liverpool, London and Manchester.

As I have travelled the country talking to people about the NHS, I have once again been struck by how highly people value the service it provides. However, the NHS cannot stand still. It must adapt to meet the challenges ahead. I believe that the NHS must develop a more open, innovative and integrated culture – one that improves the health of the public and the quality of care by putting patient voices and patient needs at the heart of a new clinically-led system.

I have seen high quality and innovative care in our hospitals and surgeries – in many places it is amongst the best in the world. But, I have also heard stories of poor treatment and a lack of caring that should not be tolerated and looked at information sources such as the NHS Atlas of Variation, which only begins to scratch the surface in highlighting unwarranted variation in quality. As unacceptable variation becomes increasingly apparent through greater transparency, people in areas with poorer outcomes will rightly demand change. We must also learn lessons from and be prepared to act on the recommendations that will result from the Mid Staffordshire NHS Foundation Trust Public Inquiry.

In addition to the existing variation in the quality of care, there are other reasons why the NHS cannot remain exactly as it is. Medicine is changing. Every year brings clinical and technological advances, new drugs and new treatments. The world is shrinking: in an age of connectivity where people access information at the click of a button, the NHS cannot remain in the information dark ages. People are changing. Their expectations from the NHS are always increasing and they rightly expect a greater role in making decisions during their care. It is therefore critical that we hard-wire the declaration of ‘no decision about me, without me’ into every part of the system. People are living longer. We should celebrate this, but also recognise the pressure it places on the NHS and the imperative for innovation in service provision so we can always make sure we are caring for people with dignity and respect. Finally, people continue to make unhealthy choices: choosing to smoke, drink excessively, eat poorly or not take enough exercise.

We are in a strong position to respond to these drivers of change. In the first phase of our engagement, we proposed a number of substantial changes to the Health and Social Care Bill, and you accepted our recommendations. This produced a framework which allows the NHS to make improvement in quality and healthcare outcomes its primary purpose. From the conversations we have had over the past few months, I would say that people are looking forward. They are looking at the opportunities that the future of the NHS brings and considering how they can use these to address problems which have been around for years.

In our second phase of engagement, you asked us to look at four important themes:

- The public's health: how to ensure the public's health remains at the heart of the NHS
- Information: how to make information improve health, care and wellbeing
- Integration: how to ensure the Government's modernisation programme leads to better integration of services around people's needs
- Education and training: how to develop the healthcare workforce to deliver world-class healthcare

The link between these themes is clear: they are all about driving improvements in the health of the public, achieving higher quality of care for patients and providing better value for the taxpayer.

We have heard an enormous amount of support for the shift to a patient-centred approach and a great deal of frustration that this has not been achieved despite years of rhetoric. It must now become a reality for patients across England and healthcare professionals must lead the way. Success will mean that individuals' needs are truly at the heart of the NHS, offering patients more information and a greater degree of choice, control and personalised care. And this must apply to all.

Our nationwide health system must ensure that all sections of the community, particularly those who are the most vulnerable, can access mainstream services and that, where necessary, specialist interventions are made. The NHS must rise to the challenges set by the Equality Act 2010 – after all, the NHS was founded on the principle of equality. The launch of the 'Equality Delivery System: a new toolkit', will support committed leaders to ensure they are reaching all members of their community and providing fair, accessible services.

For our second phase of work, I reviewed the membership of the NHS Future Forum and strengthened the patient and carer voice. I also ensured that we had more input from local authorities, housing and social care. The level of engagement in our second phase of work has been overwhelming. In just a few months, members of the NHS Future Forum have met with over 12,000 people and attended more than 300 events. We also received more than 150 formal responses. We have spoken directly with patients, carers, local authorities, the voluntary and community sector, NHS and independent sector providers, professional bodies and academics as well as numerous managers and health and social care professionals.

In the first report of the NHS Future Forum, I described how the seven key principles of the NHS Constitution helped guide the writing of that report. During the second phase of the listening, I used the words of the NHS Constitution as a trigger for discussion. For example, when talking about information, I began with, “you have the right to make choices about your NHS care and to information to support these choices”; when talking about patient engagement in integrated services, “the NHS commits to work in partnership with you, your family, carers and representatives”.

I found sustained support for the NHS values, as set out in the NHS Constitution – respect and dignity, commitment to quality of care, compassion, improving lives, working together for patients, everyone counts. However, I was surprised that many patients and health professionals, especially in primary and community care, lacked awareness of the NHS Constitution. You accepted our previous recommendation that the NHS Commissioning Board and clinical commissioning groups should have a duty to actively promote the NHS Constitution and that Monitor, the Care Quality Commission, the NHS Commissioning Board and clinical commissioning groups should all set out how they are meeting their duty to have regard to the NHS Constitution in their annual reports. We reiterate the importance of this, so that all staff and the public understand what they can expect from the NHS.

The patients I spoke with told me that they wanted to be involved in discussions about the future of their NHS. They told me that they wanted any changes to their services to be determined locally, led by clinicians but with greater input from them.

We didn’t just hear from adults, but from children and young people too. They were open, honest and direct, coming up with many issues and suggestions that have informed our reports. At Birmingham Children’s Hospital NHS Foundation Trust, we talked to patients, carers, staff and members of the CLIC Sargent charity. Here, we found a hospital working in partnership with a charity, local schools and colleagues in primary and social care. We saw the key role that the charity played in commissioning services and in providing care. The hospital’s integrated and holistic approach puts children and their families at the centre of the system – the young people had important roles as expert patients while others were contributing to the design of services and running of the Trust through their roles as governors. The young people were challenging and inspiring – they said they wanted better access to information about their illnesses, they voiced concerns about the transition from children’s to adult services and argued that doctors should gain a better understanding of people with learning disabilities and mental illness in their training.

We heard from many clinicians involved in establishing clinical commissioning groups across England who were enthusiastic about leading changes locally and saw opportunities to develop more patient-centred and integrated systems. We also heard concerns about how clinically-led commissioning might place their responsibility to the individual patient at odds with their responsibility to their wider population of patients. This potential conflict has always existed and as the financial situation becomes more difficult, it is vital that the NHS stays values-based in addressing it.

The NHS's Role in the Public's Health

In our first report we stated that the NHS needed to move from focussing on treating people when they are acutely ill to focussing on prevention and supporting self-care. Vicky Bailey and Ash Soni's report on the NHS's role in the public's health describes the rise in preventable illness and the persistence of health inequalities as amongst the greatest challenges that the health system faces.

We have seen excellent examples of NHS and partner organisations working innovatively to improve their local communities' health and reduce health inequalities. The report focuses on three key themes. Firstly, we must support the NHS to use every contact with patients and the public to help them maintain and improve their physical and mental health and wellbeing, including those already living with a condition. Each day, GPs and practice nurses see over 800,000 people and dentists see over 250,000 NHS patients. There are 31,000 NHS sight tests, while approximately 1.6 million people visit a pharmacy. Secondly, we must help the NHS workforce to improve their own health and act as role models for their patients and communities. And finally, we must embed the prevention of poor health and promotion of healthy living into the NHS's day-to-day business.

Information

We heard very clearly that people want more control over their health, through better information, better communication and a louder voice. We heard a strong consensus that "it's the patient's data", not "the system's data". We heard of huge frustration with the obstacles to capturing and sharing information that get in the way of delivering high quality, integrated care. There was a consensus that current information governance procedure does not get the best balance between protecting patient confidentiality and sharing information to ensure high quality care. There was a plea for the NHS to embrace and use patient-generated comment.

Jeremy Taylor and David Haslam open their report by highlighting the importance of information. Their conclusions are threefold. Firstly, the health and social care system must use and communicate information much more effectively – we should regard poor information as poor quality care. Secondly, the barriers to making the 'information revolution' a reality are more cultural than technological. Here the NHS must recognise that: information is an integral part of the therapeutic process; communication matters; records belong to the patient; responsibly sharing data is vital for patient safety and continuity of care; consent matters; professionals must know how well they are doing and how they can improve; and openness and transparency are vital. Finally, all of this is possible and is being done somewhere but adoption remains patchy.

We have seen excellent examples of leadership and innovation in the use of information in many parts of England that are making a difference to people's lives. In Stoke-on-Trent we spoke to patients, carers, managers and clinicians about how technology, including remote monitoring, was improving the quality of life for their patients with long-term conditions and also helping to bring health and social care

professionals together in a more integrated system. We heard from patients how it helps them manage their conditions better by automatically monitoring various metrics and giving them instant feedback and advice. The clinicians told us that it has improved the quality of care and reduced admissions to their local hospital. These and many other case studies exemplify the local drive, leadership and focus on the patient that will be needed to turn the ‘information revolution’ into practical improvements to care.

Integration

As a GP in an inner-city practice, I know that the NHS is struggling to meet the demands of increasing numbers of patients who have complex and long-term physical, psychological and social problems.

While many people told us of excellent care, we heard alarming stories, particularly from the most vulnerable, of poor access, falling through gaps between services and being unable to understand how to navigate their way through the convoluted ‘system’. We heard from people who had experienced delays and come to harm. The universal feedback was that the current system is fragmented and all patients, regardless of their circumstances, want a more joined-up and integrated health and social care service, planned around their needs.

In our report to you at the end of the first phase of the Future Forum listening exercise, we highlighted the importance of integration in improving care for patients. During this second phase, we collaborated with the King’s Fund, the Nuffield Trust and the Health Service Management Centre in Birmingham. We considered several successful integrated health and social care systems that have emerged across the world but we also looked at integrated care systems in England including those in North West London, Torbay and Lincolnshire.

We come back to our conclusion that centrally dictating a model for integration will not work. Many areas we visited and people we spoke to have shown, in line with the academic evidence, that local commissioners and communities can indeed provide innovative services that are more integrated around the needs of patients – but it is never easy. In their report, Geoff Alltimes and Robert Varnam conclude that there is no “silver bullet” that will solve integration. They recommend a number of important changes to the system that, if accepted, will transform it into one that makes it easier for local leaders to work together to improve care for their communities, rather than one that they must battle against.

Education and Training

Julie Moore continued to lead the Forum’s work on education and training in its second phase of engagement. We met with nurses, allied health professionals, clinical scientists, managers and doctors, including those in training. We also spoke with academics, education specialists and service providers across the country. We heard very clearly that education and training underpins the NHS and is essential for delivering high quality patient care and outcomes. We believe that education and

training should be based around patient needs and curricula should reflect the principles that guide the NHS and the values enshrined in the NHS Constitution.

We want to see increased consistency and quality in education and training, a payment system which reflects good and excellent practice and a live conversation about the importance of education and training to all aspects of healthcare. We also want to see a more nimble approach to workforce planning, education and training and a system that is able to respond more quickly to the challenges of changing patterns of care.

The overarching thread that brought our four themes together is improving the quality of care that patients receive, helping them to achieve better outcomes. Realising this aim will require change. It will not always be easy – we will need to make difficult decisions and challenge existing ways of doing things. We will need to change the culture of the NHS and ensure that this change is reflected in the way we recruit and train those who work in the NHS.

This is fundamentally what leadership is about. The improvements in care which we have described in our reports can only be delivered if strong local leaders at all levels, whether from a clinical or managerial background, articulate a clear vision, embrace innovation, promote collaboration and champion change. The system must support them to do this by aligning levers and incentives and facilitating the sharing of best practice. And, as the reforms begin to bed down, we will all have the opportunity to learn the lessons of implementation and evaluate the individual and combined impact of the reforms. This will allow us to adapt solutions in the interests of driving even better outcomes for patients.

It has been a tremendous privilege to lead the NHS Future Forum. I would like to thank the thousands of individuals who have engaged with us. I would particularly like to thank the workstream leads Vicky, Ash, Jeremy, David, Geoff, Robert and Julie and the other 49 members of the Forum itself, who, in addition to their busy roles, found the time to listen and reflect.

Through the work of the NHS Future Forum, I believe you have found a powerful new way of engaging people in the development and implementation of policy. We have not been a group of experts and frontline staff who just sat in a room and agreed a position. Instead, we have tried to leave our prejudices to one side, go out and listen, reflect and then synthesise the views we heard and report back. We hope that this is a model which will be used again in the future.

A handwritten signature in black ink that reads "Yours, Steve Field". The signature is written in a cursive style with a horizontal line underneath the name.

Professor Steve Field CBE FRCGP FFPH FRCP

Summary and key recommendations

Integration

We heard from many places that although the case is clear for more integrated care, there are many barriers and disincentives to integration that make it difficult for local areas to come together to re-design care that everyone knows is better. Some of these barriers were to do with a lack of shared leadership, culture and vision at local level between health and local authorities, or within health itself. Others were to do with the centre being seen to have too much control - issuing guidance, rules and restrictions that made it difficult to produce more locally appropriate solutions. More were cited around financial incentives, which were misaligned and often made it impossible to integrate care. But, we also heard great stories from communities on the ground who have managed, despite the system's barriers, to create solutions that work for people and for the public purse. And we didn't hear from anyone who didn't want to at least try – and for them, we want to make it easier to do. Below are our key recommendations to make integration happen.

- **Integrate around the patient, not the system.** Integration is not about structures, organisations or pathways; it is about better outcomes for patients. The entire health and social care system should embrace a definition of integration that truly puts people at the centre. The NHS Commissioning Board should therefore focus its commissioning guidance on supporting clinical commissioning groups to commission for people not specific diseases.
- **Make it easier for patients and carers to coordinate and navigate.** NHS commissioners should ensure that every patient with long-term or complex needs has easy access to a named person or team who act as the coordinating point for all of their care, taking into account their personal preferences.
- **Information is a key enabler of integration.** Every individual should own their own patient record and be able to share it as they wish. All care records should be electronic and accessible at the point of care throughout the whole care journey, regardless of sector or provider.
- **You can only improve what you measure.** The Department of Health should urgently support the development of a new generation of patient reported experience measures that evaluate patients' experiences across whole journeys of care, and within and between services. The aim should be to start reporting against these measures from April 2013. These should be incorporated into the national and local outcomes frameworks for the NHS,

social care and public health as soon as possible and should form part of the Mandate set for the NHS Commissioning Board. The Department of Health should seek to achieve greater alignment and coherence between the national outcomes frameworks for the NHS, public health and adult social care.

- **Health and wellbeing boards must become the crucible of health and social care integration.** All local commissioners must fully and properly explore the potential benefits of joint commissioning and pooled budgets in health and social care for key populations requiring integrated approaches; such as frail older people, people with mental health problems, children with complex needs and the socially excluded including the homeless. Emerging health and wellbeing boards should consider the allocation of £1bn of NHS funds already earmarked by the Government towards delivering social care services in partnership with health as one of the first major decisions they make. PCT clusters and local authorities must facilitate this.
- **Providers need to be able to work with each other to improve care.** The NHS Commissioning Board should develop and test innovative approaches to incentivise care outside hospital settings. The NHS Commissioning Board should work with local commissioners to introduce measures of service interoperability in contracts, to drive integration. These could include measures of the efficiency and reliability of admission and discharge processes, patient understanding of their care plan, and patient experience measures.
- **Clarify the rules on choice, competition and integration.** Monitor and the NHS Commissioning Board should urgently support commissioners and providers to understand how competition, choice and integration can work together to improve services for patients and communities – in particular they should explain how this fits with the principles and rules for cooperation and competition and UK and European competition law. Guidance should be jointly published as soon as possible in 2012.
- **Freedom and flexibility to “get on and do”.** Monitor and the NHS Commissioning Board need to jointly signal as soon as possible (2012/13) their methodology for establishing and policing prices (tariff, currencies) within and for markets in order to provide stability and predictability for commissioners and providers. This should include a proportionate, transparent and consistent approach to local price variations and adjustments where this is needed to enable more integrated care, and a clear and simple account of the rules. Clinical commissioning groups should be allowed the freedom and flexibility to develop innovative local integrated solutions, including variations to tariffs and contracts, while these new funding models are developed. The NHS Commissioning Board should, as far as possible, build on the principle of certainty around under- and over-spends (including multi-year settlements) in order to allow clinical commissioning groups the ability to plan across multiple years to design, commission and

invest in longer-term, sustainable solutions with their local partners, for example local authorities who already receive multi-year settlements from central government.

- **Allow the funding to follow the patient.** The NHS Commissioning Board and Monitor should develop new funding models which support and incentivise integration, and share with commissioners examples of how others have used such models. This should accelerate progress already made on the Year of Care funding model (based on need and not on single conditions).
- **National level support for local leadership is essential.** National level leadership and collaboration are essential to supporting local efforts to design and deliver integrated services for patients. There should be a national level forum to support this and oversee an enabling programme of work beginning in 2012. This could be provided by the National Quality Board with extended membership to include the Local Government Association and local representation from clinical commissioning groups and local authorities.
- **Sharing best practice and breaking down barriers.** The NHS Commissioning Board working with local government through the Local Government Association (LGA), should make available a responsive facility providing advice and support to local commissioners on practical implementation issues of integration. This support could include practical support (model tariffs, contracts and tools), best practice and peer-support, and training for leading change jointly for clinical commissioning groups and local government.

Read the full Integration report at www.dh.gov.uk/nhsfutureforum

Information

People see massive untapped potential for information to underpin and drive great care. By engaging through our listening exercise, they have painted a picture of:

- Informed and involved citizens, responsive healthcare professionals, and a system that enables both groups;
- Information integrated around the needs of people, rather than (as often at present) around organisations;
- Excellent communication as well as excellent information;
- Moving from a focus on collecting data (often too much data) to a focus on using data to generate intelligence to inform action;
- Every encounter between the citizen and care systems being appropriate, because the information is right for the citizen and because it is an opportunity for the system to learn from the person. Citizens should be equal partners in their care rather than passive consumers.

The NHS Future Forum's recommendations focus on six key areas:

Information for patients and service users

1. Information is an integral part of the service to patients and service users and the Government's information strategy must clearly set out the responsibilities of commissioners and providers in affirming this principle.
2. Service providers must ensure that information integrates around the needs of the individual, and commissioners must ensure that they do so. The NHS Commissioning Board must lead by example in its direct commissioning of primary care and other services. It should also ensure that the levers and enablers it uses for improving quality align with this requirement.

Patient ownership of data

3. In the Chancellor's 2011 Autumn Statement, the Government announced new measures as part of its Growth Review¹, which set a deadline for patient access to their online GP held records by the end of this Parliament. We support this commitment as a first step, but the information strategy must now make clear how this will be achieved, recognising that there is both a financial and time burden to GP practices and by providing meaningful help and support to them.
4. The Royal College of General Practitioners, in partnership with the British Medical Association, NHS Commissioning Board and relevant patient organisations, should be invited by the Department of Health to develop a plan that delivers the roll-out of access to patient records by 2015.

¹ http://www.hm-treasury.gov.uk/as2011_index.htm

5. Switching on patient access alone is not enough, and potentially detrimental if appropriate support structures are not in place for patients so that they understand and know how to use the information. The planned roll-out of patient access to electronic records by the Government must acknowledge this and ensure that a support structure is in place, including a proper consent process.

Data sharing is vital for safety, quality and integrated care

6. The NHS must move to using its IT systems to share data about individual patients and service users electronically – and develop a consent model that facilitates this – in the interests of high quality care. How this is achieved should be for individual providers to decide, but with common goals and standards. The key requirement is interoperability – IT systems talking to each other – not a “national programme for IT”. The information strategy must set clearly set out what is expected of providers of NHS services, and a challenging deadline for when this must be achieved.
7. There should be a clear contractual requirement that all organisations delivering care in the NHS or in adult and child social care have systems that allow full electronic data sharing against set standards. There can be no opt-out, regardless of whether the provider is in the NHS, private or voluntary and community sector. Commissioners must strive to ensure that this does not unfairly exclude smaller organisations which would otherwise be accepted as “any qualified providers”.
8. The information strategy should set out how the Government will ensure the establishment of technical interoperability standards and of common standards for the structure and content of health records.
9. There must be a clear presumption in favour of hospital discharge summaries being made available to the GP and patient (or their nominated carer) at the point of discharge, and of GP referral letters being made available at the point of referral.
10. The universal adoption of the NHS number at the point of data capture and across health and social care must be turned from a long-held – and generally ignored – aspiration into a reality by 2013.

Information governance

11. The Government should commission a review of the current information governance rules and of their application, to report during 2012. The aim of the review should be to ensure that there is an appropriate balance between the protection of patient information and the use and sharing of information to improve patient care.

Using data to drive quality

12. Using data to drive quality is a fundamental governance responsibility for health and social care organisations. The NHS Commissioning Board must be charged with ensuring that commissioners and providers uphold this principle.
13. The kind of cultural change we want to see needs to be 'championed' at every level. A clinician who is responsible for organising information in support of better patient care should be identified in every organisation.

Transparency

14. The Government should set a clear deadline within the current Parliament by which all information about clinical outcomes is put in the public domain.
15. The Government should set out a clear plan for the progressive development of quality and outcome measures to underpin the new outcomes frameworks and support frontline clinicians in measuring for quality improvement.
16. The information strategy should emphasise the growing importance of patient-generated comments via all forms of social media, and the need for the NHS and social care to learn how to use these to improve services. It should set out a clear way forward.

Read the full Information report at www.dh.gov.uk/nhsfutureforum

The NHS's role in the public's health

We have heard that people expect the NHS to do more than treat them when they are ill; it must also help them to stay well. Everyone has a responsibility for their own health, but the NHS is also responsible for helping people to improve their health and wellbeing. The NHS's role in preventing poor health and promoting healthy living is essential to reduce health inequalities and sustain the NHS for future generations.

Millions of people come into contact with the NHS every day, and we believe that every contact must count as an opportunity to maintain and, where possible, improve their mental and physical health and wellbeing. Our recommendations reflect some of the changes needed at all levels to reach an NHS where every contact counts. A summary of key recommendations is below, and the full set of recommendations is set out in the full report.

Healthcare professionals making every contact count

1. Every healthcare professional should “make every contact count”: use every contact with an individual to maintain or improve their mental and physical health and wellbeing where possible, whatever their specialty or the purpose of the contact. To emphasise the importance of this responsibility, the Secretary of State should seek to include it in the NHS Constitution.
2. Health Education England, Public Health England and the NHS Commissioning Board should build a coalition with professional bodies to agree a programme of action for making every contact count. Key features should include:
 - a. Professional bodies promoting this broader role to their members and the public, and issuing guidance about the responsibilities it entails;
 - b. Managers identifying where healthcare professionals' skills and knowledge for making every contact count need development and working with public health and education and training partners to support this;
 - c. The NHS Leadership Academy demonstrating to leaders that supporting staff to make every contact count is a key part of their role.

Improving the health and wellbeing of the NHS workforce

3. In partnership with their staff, NHS organisations and their delivery partners should design and implement a strategy for improving staff mental and physical health and wellbeing. They should report annually on their progress against this strategy and hold their chief executive, or other senior responsible officer or partner, to account against it. Key features of this strategy should include:

- a. Implementing the recommendations of the Boorman review of NHS health and wellbeing and using NICE public health guidance and the Public Health Responsibility Deal pledges to guide how they support their staff;
- b. Developing managers and leaders to support staff mental and physical health and wellbeing, and holding managers and leaders to account for doing so in their performance appraisals.

Refocusing the NHS towards prevention and promotion

3. All providers of NHS-funded care should build the prevention of poor health and promotion of healthy living into their day-to-day business, and be recognised for achieving excellence.
4. NHS commissioners should ensure that providers of NHS-funded care redesign their business in this way, using contracts and incentives to encourage providers to improve health and wellbeing and reduce health inequalities, and working with public health commissioners and providers to design interventions into NHS care pathways that achieve these outcomes. To support clinical commissioning groups to do this:
 - a. The NHS Commissioning Board, with support from Public Health England and the Department of Health, should provide them with guidance;
 - b. The NHS Commissioning Board, Public Health England and the Local Government Association should jointly publish arrangements showing how, from April 2013, the Board will access national and local public health advice; emerging clinical commissioning groups and local authorities should put in place transparent arrangements showing how, from April 2013, clinical commissioning groups will access local public health advice.
 - c. The national and local outcomes and priorities for NHS commissioners should encourage them to work in partnership with the public health system to improve health and wellbeing and reduce health inequalities, underpinned by NICE quality standards or other accredited evidence. In particular, the outcomes frameworks should be aligned, with further shared outcomes across the NHS and public health system.

Building partnerships outside the NHS

5. NHS commissioners and providers of NHS-funded care should use partnerships with other local services to improve the health and wellbeing of communities that the NHS locally finds difficult to reach, providing training where appropriate.

Sharing learning and best practice

6. Healthcare professionals, NHS commissioners and providers of NHS-funded care should share learning about improving the public's health and wellbeing and reducing health inequalities, and seek to learn from others. Public Health England should ensure that evidence and best practice are spread across the NHS, and we recommend that a top priority should be evidence about improving the health and wellbeing of children and young people.

Read the full NHS's Role in the Public's Health report at www.dh.gov.uk/nhsfutureforum

Education and Training

People have welcomed the second opportunity to contribute to the development of the NHS's education and training system. This summary sets out the main themes of the report and provides an overview of the recommendations we have made for a range of organisations.

Respondents have acknowledged that there have been some positive developments since our first report, including the moves to establish Health Education England (HEE) and the plans to further develop the role of the Centre for Workforce Intelligence (CfWI), though this is taking longer than expected. People were curious about how HEE would operate and the relationships it will develop, firstly with the NHS Commissioning Board, to ensure production of the appropriate health care workforce to meet planned health care provision; secondly with the CfWI, as accurate workforce data is essential to its planning; and thirdly with Public Health England to develop the public health workforce.

There has been great interest in the plans for local education and training boards (LETBs), in particular in their relationship to HEE and how to make the views of all stakeholder groups, irrespective of size or influence, integral to decision-making. Of the possible operational models, we have heard most support for direct accountability to HEE, a view we support. There was also recognition that the key to success will be through strong partnerships between service delivery and academia with LETBs focusing on delivery rather than just representing views.

The interest in local structures was matched by recognition that greater local responsibility is an opportunity to strengthen these partnerships between education, service and academia to deliver new practices and innovation. There was agreement that developing LETBs should align with the recent conclusions of the NHS Chief Executive's Review of Innovation. Therefore we recommend that:

1. The Department of Health (DH) and HEE should assure themselves, through the authorisation criteria, that LETBs have robust and transparent governance in place to deliver strong partnerships across healthcare providers, academia, education and professions with the appropriate skills to serve the functions of the LETB.
2. LETBs must be able to demonstrate to HEE that they have the governance and partnership arrangements in place to deliver recommendation 1, including how the work and functions of the deaneries will be transitioned, working with the royal colleges and General Medical Council.
3. DH and HEE should ensure that the development of LETBs allows flexibility to evolve as the wider system matures, so that local organisations are able to take opportunities to work in new ways across service, education, research and innovation; for example in building closer ties with Academic Health Science Networks as they develop.

Issues of quality and consistency of care have been at the heart of our engagement in this phase. The key role that patients and the public can play in education and training was highlighted along with the recognition that they need to be supported to do so.

There is support for the need to widen participation in healthcare careers by selecting for the required academic ability and also for values and beliefs and the wish to work in healthcare.

We found agreement for the principle that not all institutions should train and that those that do should be recognised at an organisational and personal level. This should include all organisations providing healthcare, including the NHS, independent and voluntary and community sectors. Quality assurance was also raised as an issue. To support these changes we recommend that:

4. HEE should provide guidance for those who have a role in scrutinising local providers on how to challenge providers on the quality of their education and training provision.
5. Education and training organisations, including higher education institutions, NHS foundation trusts and GP practices, should be able to demonstrate that patients and the public have been engaged in their training programmes, for example in their annual report.
6. The NHS Commissioning Board should set out how it will work with the medical royal colleges and other professional bodies to promote an understanding and awareness of the central role of education and training in the delivery of high quality services for patients.
7. LETBs should only commission from institutions that select students and trainees in partnership with employers, ensuring wider participation through the use of processes such as value based recruitment based on the NHS Constitution.
8. DH, and in the future HEE, should develop a system which rewards high quality education and training at all levels and for all professions. This should include development of a quality premium for teaching which would be paid to organisations that demonstrate quality outcomes in learning.
9. DH, and in the future HEE, should ensure that LETBs can demonstrate their ongoing support for high standards of education and training and will properly address substandard clinical education.
10. LETBs must be able to provide assurance that they have sought proper evaluation of the local education and training provision, including:
 - ensuring the ongoing, necessary specialty based expertise has been obtained and considered
 - demonstrating that local providers have clear quality control mechanisms in place and offer value for money, and
 - putting systems in place to address any conflicts of interest that might arise.

11. Clinical commissioning groups (CCGs) must demonstrate a commitment to commissioning from service providers who are able to show evidence that high quality education and training is at the heart of their service.
12. The NHS Commissioning Board must assure itself that CCGs are delivering on Recommendation 11.
13. The Care Quality Commission (CQC) should agree a memorandum of understanding with professional regulators to set out the steps to take where CQC finds, or is alerted to, issues affecting quality of care which they believe are indicative of problems with the education and training of staff. This should include how they will inform LETBs and HEE.

The critical role of ongoing development of staff was once again of particular importance and we were told of significant local variation in practice. With regard to continuing professional development, while there is good practice in places, this is not universal. Ongoing development needs to be recognised by staff and employers alike as necessary for the individual, and also critical for improving care. Equally, the value of interprofessional working needs to be more widely appreciated. Our recommendations are that:

14. The DH, and in the future HEE, should set out how it will embed training for team working, leadership development and the principles and values of the NHS Constitution at every level of the training and educational process.
15. The DH, and in the future HEE, should work with regulators to develop guidance to support programmes of appraisal and continuing development for healthcare workers. This should include a systematic approach to appraisal and personal development plans with an expectation that a minimum percentage of staff have plans.
16. LETBs should agree and allocate a minimum percentage of funding for continuing professional development. Employers will need to demonstrate how that money has been spent. This would need to be supported by local challenge mechanisms and publication of the information in their annual report.
17. LETBs should take account of the available evidence and tools to build a greater appreciation of interprofessional training approaches and take advantage of shared learning opportunities including common modules.

There was strong agreement that medical education and training has become too rigid and inflexible. Many felt that there needed to be consideration given to developing alternative career pathways as well as a refocusing on developing generalists, in all care environments. Many respondents pointed out that much of what is needed was covered in the Tooke Report in 2007, including the case for extending GP training. One other theme was national consistency, with polarised views on the value of a national exam for medicine. This needs further consideration. Recommendations are:

18. The DH, and in the future HEE, should set out how it will review the principles and aims of the Tooke Report, considering which aspects and outcomes remain relevant for implementation in the new system; in particular the extension of GP training, the development of a more flexible career pathway and the means to foster generalism in medicine both in the community and the hospital.
19. The General Medical Council should lead discussions on the desirability of implementing a national exam in medicine that would support alignment of registration and qualification.

Quality and consistency were also major themes for nursing and midwifery, and particularly for support workers. There was support for a more rigorous selection process for nursing school places and a strong belief that employers need to take responsibility for the quality of those trained in their locality. Many respondents raised concerns regarding the lack of structure in nurse and midwife post-qualification careers, particularly in developing their leadership skills.

The recent announcements on developing codes of practice for support workers are welcome, but concerns remain about how robust a voluntary system will be. This is also the case for the new and developing professions in healthcare more generally, and in particular we have heard significant concerns about the lack of regulation for non-medical public health practitioners.

20. The Nursing and Midwifery Council should work with the Royal College of Nursing, Royal College of Midwives, HEE, higher education institutions and providers to develop properly structured processes to support individual nurse and midwife development in post-qualification career pathways, ensuring support for clinical, managerial and specialist development. Other professional groups should consider developing post-qualification career pathways where they do not exist.
21. LETBs should lead work with local partners, including professional representatives, to develop the quality of nurse and midwife training locally. This should be replicated for all clinical training programmes.
22. CCGs must work with LETBs to develop their community services to deliver the movement of care to the community including increasing the provision of community placements for trainee nurses, midwives, allied health professionals and other appropriate professionals.
23. The DH should ensure that all public health specialists are regulated.

Respondents told us that they believe that the current funding system has largely been effective in delivering the required levels of education and training, but care needs to be taken that this is not reduced during the transition to HEE. There was universal support for a transparent approach to funding flows with widespread agreement of the idea that funding should follow the trainees and that only high quality education and training should be commissioned. Our recommendations are:

24. The DH should establish a transparent approach to funding flows for education and training monies, with a clear implementation plan for HEE, once established. In doing this, as part of the Multi-Professional Education and Training (MPET) review; the DH should:

- consider how to take forward the principle of having a fair tariff for trainees, money following the trainee and how to take account of outcomes not just volumes; and
- provide clarity for the future direction on fair funding to all training providers; it should also
- include clarification of the funding for professional development (CPD) and expectations on employers to resource professional development.

25. Establish transparent systems with robust accountability to make sure that organisations in receipt of education and training money are held to account for using it for the education and training of the NHS workforce.

26. LETBs must ensure there is transparent and unambiguous accountability to HEE for all MPET funding it receives for education and training.

Finally, though the majority of discussions and responses have focused on how to improve quality in the current system, there has been recognition that we need to develop a much more flexible and responsive approach to planning for the future. We need a system that is able to respond to the changes in patterns of care and engages commissioners, employers and professionals in anticipating what will be needed in the future. To ensure this happens we recommend that:

27. HEE and LETBs should work with the range of stakeholders, including the CfWI, to set out the strategic direction for the development of the workforce to more effectively meet the changing needs of patients and communities.

Read the full Education and Training report at www.dh.gov.uk/nhsfutureforum

The NHS Future Forum members

- **Lord Victor Adebowale**, Chief Executive, Turning Point
- **Dr Charles Alessi**, Senior GP Partner, The Churchill Practice
- **Geoff Alltimes**, Former Chief Executive, London Borough of Hammersmith and Fulham
- **Dr Frank Atherton**, President, Association of Directors of Public Health, and Director of Public Health, North Lancashire Cluster
- **Vicky Bailey**, Chief Operating Officer, Principia Rushcliffe Clinical Commissioning Group
- **Sally Brearley**, Patient Representative and lay member, National Quality Board
- **Sheila Bremner**, Chief Executive, North Essex Cluster PCTs
- **Dr Simon Brown**, Huntingdon GP Consortia Pathfinder Lead
- **Sir Stephen Bubb**, Chief Executive, Association of Chief Executive Voluntary Organisations
- **Professor Hilary Chapman**, Chief Nurse, Chief Operating Officer, Sheffield Teaching Hospitals NHS Foundation Trust
- **Dr Ronny Cheung**, Specialist Registrar in Paediatrics, Guy's and St Thomas' NHS Foundation Trust
- **Lisa Christensen**, Director of Children's Services, Norfolk County Council
- **Professor Mike Cooke**, Chief Executive, Nottinghamshire Health Care NHS Trust
- **Jane Cummings**, Chief Nurse NHS North of England
- **Ratna Dutt**, Chief Executive, Race Equality Foundation
- **Paul Farmer**, Chief Executive, Mind
- **Mr Derek Fawcett**, Urological Surgeon, Royal Berkshire NHS Foundation Trust
- **Dr Jonathan Fielden**, Chief Medical Officer, Royal Berkshire NHS Foundation Trust
- **Professor David Fish**, Managing Director, UCL Partners
- **Moira Gibb**, Chief Executive, London Borough of Camden, and Chair of Social Work Task force
- **Professor David Haslam**, National Clinical Adviser, Care Quality Commission, and expert member, National Quality Board
- **Peter Hay**, President, Association of Directors of Adult Social Services (ADASS)
- **Dr Paul Hodgkin**, Founder and Chief Executive, Patient Opinion
- **Thomas Hughes-Hallett**, Chief Executive, Marie Curie
- **Helen Joy**, Chief Executive, Brunelcare
- **Professor David Kerr**, Professor of Cancer Medicine, Oxford University
- **Joanna Killian**, Chief Executive, Essex County Council
- **Clare Leon-Villalpos**, Intensive Care Nurse, Imperial College Healthcare NHS Trust
- **Chris Long**, Chief Executive, Humber Cluster
- **Malcolm Lowe-Lauri**, Chief Executive, University Hospitals of Leicester NHS Trust
- **Claire Marshall**, Head of Professions, Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- **Bill McCarthy**, Managing Director, NHS Commissioning Board Authority
- **Anthony McKeever**, Managing Partner, The Clinical Commissioning Collaborative
- **Dr Kathy McLean**, Clinical Transitions Director, NHS Medical Directorate
- **Sol Mead**, Patient Representative, Chair, Academy of Medical Royal Colleges Patient Liaison Group
- **Julie Moore**, Chief Executive, University Hospitals Birmingham NHS Foundation Trust
- **Dr Peter Nightingale**, President, Royal College of Anaesthetists
- **Mr Dermot O'Riordan**, Medical Director & Consultant Surgeon, West Suffolk NHS Foundation Trust
- **Dr Niti Pall**, Chair and Clinical Lead, West Midlands Third Wave clinical commissioning pathfinder
- **Dr Tim Riley**, Chief Executive, Wellstate Group Ltd
- **Tom Riordan**, Chief Executive, Leeds City Council
- **Cllr. David Rogers**, Chair, Local Government Association Community Wellbeing Board
- **Dr Shaibal Roy**, National Institute for Health Research, CLAHRC for North West London
- **Dame Philippa Russell**, Chair, Standing Commission on Carers
- **Duncan Selbie**, Chief Executive, Brighton and Sussex University Hospitals NHS Trust
- **Dr Robina Shah**, Chair, Stockport NHS Foundation Trust
- **Mr Matthew Shaw**, Orthopaedic Surgeon, Royal National Orthopaedic Hospital NHS Trust, and Co-founder, Remedy UK
- **Ash Soni**, Community pharmacist, and Clinical Network Lead, NHS Lambeth
- **Jason Stamp**, Strategic patient and public involvement and Chair, Hull LINK
- **Professor Jimmy Steele**, Head of School and Professor of Oral Health Services Research, Newcastle University
- **Professor Terence Stephenson**, President, Royal College of Paediatrics and Child Health
- **Jeremy Taylor**, Chief Executive, National Voices
- **Professor Sir John Tooke**, Vice-Provost, University College London
- **Dr Robert Varnam**, GP, Manchester
- **Gill Walton**, Director of Midwifery, Portsmouth Hospitals NHS Trust
- **Mr Francis Wells**, Consultant Cardiothoracic Surgeon, Papworth Hospital NHS Foundation Trust

