



*Shifting the Balance of Power:
The Next Steps*

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Shifting the Balance of Power: The Next Steps sets out the way forward on implementing the policy of shifting the balance of power in the NHS. It builds on comments and advice received during the discussion period in the autumn on *Shifting the Balance of Power: Securing Delivery*

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1: Overview from the Chief Executive

1.1 Introduction

- 1.1.1 Shifting the Balance of Power is about putting patients and staff absolutely at the heart of the NHS. It does so by giving greater authority and decision making power to patients and frontline staff and underpinning this with changes in organisational roles and relationships.
- 1.1.2 This paper sets out the framework and principles for these changes but – in line with its own philosophy – it leaves the practical arrangements, the how, when and where of working arrangements and service delivery, to be decided locally.
- 1.1.3 Shifting the Balance of Power is radical in concept. But it also needs to be radical in reality. Behaviour needs to change as well as organisation. And the new structures themselves need to be very different from the old with greater focus on team working and on enabling and supporting people and less on hierarchy and control.
- 1.1.4 Changing long established behaviours and ways of working on this scale requires support and development programmes for individuals and organisations at every level. These need to be planned and sustained over time.
- 1.1.5 These changes also need to be implemented in a way which reinforces – and is reinforced by – all the other changes involved in implementing the NHS Plan. These many changes – whether involving giving patients greater choice and more information, introducing national standards, improving patient safety or creating new partnerships – need to be introduced in a consistent fashion. Shifting the Balance of Power provides the organisational underpinning to allow this to happen.

1.2 Why Change is Necessary

- 1.2.1 The NHS Plan sets out an ambitious vision for a service designed around the patient – a service of high quality and national standards which is fast, convenient and uses modern methods to provide care where and when it is needed. Such a service will not only be designed around patients but also be responsive to them, offer them choices and involve them in decision making and planning.
- 1.2.2 Shifting the Balance of Power recognises that we need to reform the way the NHS works in order to achieve the vision. Central policy can create the framework for reform but we need reform locally to create the environment in every PCT and Trust where patients truly experience a changed health service. This reform will create new working partnerships between patients and frontline staff who have the skills and knowledge to design, develop and deliver services geared to the needs and concerns of local communities. And it will also ensure they have the authority to do so.
- 1.2.3 This reform will also make sure that the public can be more involved in shaping the services they use, given more information about decisions affecting their care and have more influence on how that care is delivered.

- 1.2.4 PCTs will have a leading role in this change. They have a unique perspective across community, hospital and primary care and across both the NHS and local authorities. They also have a very clear relationship both with frontline staff and with patients. These features will allow them to become the cornerstone of the modernised NHS. As such they will take over many of the current functions of health authorities. The smaller number of health authorities will in turn take on an increasingly strategic role including the performance management of both PCTs and NHS Trusts.
- 1.2.5 Structural change in itself does not necessarily make people work differently – how successful the NHS is in changing its culture and truly shifting the balance will depend on the determination, behaviour, attitudes and actions of healthcare staff at every level.
- 1.2.6 Achieving our vision for the NHS will involve all these elements of cultural and organisational change with the key elements being:
- empowering front line staff to use their skills and knowledge to develop innovative services with more say in how services are delivered and resources are allocated;
 - empowering patients to become informed and active partners in their care involving them in the design, delivery and development of local services;
 - changing the NHS culture and structure by devolving power and decision-making to frontline staff and PCTs led by clinicians and local people, and by building clinical networks across organisations.

1.3 Changing the Culture

1.3.1 Culture will need to change in very many ways with new ways of working and behaving:

	From	To
A shift in organisation and ways of working	<ul style="list-style-type: none"> • Hierarchical & nationalised • Detailed guidance with many milestones and targets • Focus on institutions 	<ul style="list-style-type: none"> • Devolved local networks • Clear long term outcomes with latitude about method • Working through networks
A shift in the scale and quality of staff, patient and community involvement	<ul style="list-style-type: none"> • Small pockets of excellence • Many enthusiasts but not fully embedded • Supported by time limited 'soft' funding • Many Boards still viewing this as peripheral to core business 	<ul style="list-style-type: none"> • Mainstream way of achieving change • Professional and systematic everywhere • Properly resourced through recurring funds • Central to Boards' way of working
A shift in management focus	<ul style="list-style-type: none"> • All management effort driven by delivery of centrally imposed key targets as ends in themselves • Meetings, plans and strategy dominating management time • Risk avoidance because of fear of penalties 	<ul style="list-style-type: none"> • Delivery of targets achieved as the by-product of wider and sustained improvements in service quality • Walking the job with a strong focus on clinical quality • Incentives as a key part of improvement • Penalties seen by all as fair

1.4 Changes in Roles and Relationships

1.4.1 The main organisational changes which will underpin these changes in culture are:

- giving PCTs new powers and control over resources to shape and commission services across the whole spectrum of hospital, community and primary services and from the whole range of possible providers in the public, private or voluntary sectors;
- leaving NHS Trusts with their current responsibilities whilst holding them to account through Strategic Health Authorities and requiring them to develop further patient and staff involvement in their own organisations and engage in creating networks for care with their partners externally;
- replacing health authorities by fewer and smaller Strategic Health Authorities with the responsibility for developing strategy and performance managing PCTs, NHS Trusts and Workforce Development Confederations so as to secure delivery and consistency of approach. They will in effect manage the NHS on behalf of the Department;
- reducing the Department's direct role in management, abolishing its eight regional offices and creating 4 Directors of Health and Social Care to support and develop the NHS, provide local contact and performance manage the Strategic Health Authorities. This will leave the Department better able to do those things which only it can do: in ensuring the development of national standards, securing resources and setting direction.

1.4.2 These organisational changes have also provided the opportunity to review the way significant functions are delivered across the NHS with new more appropriate arrangements being introduced for, amongst others, public health, clinical leadership, information management and technology and communications.

1.4.3 It has also set the scene for the strengthening of relationships both with local authorities and across government through:

- the potential to provide strong links at PCT and Care Trust level, particularly where there is co-terminosity;
- the drive to develop networks of care, wherever appropriate, which are designed around care pathways which may involve both health and social care;
- the emphasis on tackling the determinants of health both within the PCT role and through the placing of Regional Directors of Public Health alongside Government Offices for the Regions.

1.5 Making it Happen

1.5.1 There is already a very strong foundation for making the changes necessary in ways of working. There is good co-operation and partnership in many areas and for many services. There are developing networks both in specialist services and in more local ones. The Local Modernisation Reviews carried out last year have led to a strengthened sense of local partnership with teams, individuals and organisations identifying shared issues and solutions.

1.5.2 We need to go further by building on these foundations to develop greater capacity and improved skills. This will involve:

- the work of the Modernisation Agency not only in re-designing services but in supporting organisations to change;

- taking the opportunities presented by the new structures for patient and public involvement. Making sure that the Patients' Forums, the Patient Advice and Liaison Service and the Commission for Patient and Public Involvement in Health can really contribute to a change in culture and change ways of involving patients and the public;
- building clinical networks, learning the lessons from the early forerunners such as cancer;
- strengthening greater staff involvement. This will be supported by the appointment of a national leader through the National Joint Forum for Partnership and Involvement and greater devolution of budgetary and decision making within organisations;
- new performance rating systems which focus on patient satisfaction and staff as well as service outcomes and which provide better, and better validated, information for public and staff alike.

1.5.3 The Department of Health has an important role in supporting these changes and developing the new organisations and ways of working. It too will change to adopt a less hands-on approach with clear priorities, fewer targets and less guidance and instruction from the centre. We have already started to change by, for example, publishing a very different – shorter and more precise – planning framework for 2002/03 (see <http://www.doh.gov.uk/planning2002-2003/index.htm>), and involving NHS and local authority people more in policy development and implementation. We will continue this approach, shifting the balance of power and creating more space for local initiative and decision making.

1.6 Managing the Transition

1.6.1 Following discussions with the NHS, and on the advice of very many people, we are making the organisational changes as quickly as possible. Most of them will be in place by April with others following, subject to legislation in October.

1.6.2 Regional offices, health authorities, community trusts and PCTs all have project arrangements and, where necessary, transitional management and business continuity plans in place. These all fit within the national project management arrangements and make use of the national human resources framework for handling staff moves which was published in July.

1.6.3 Many of the transitional arrangements will need to continue beyond April whilst staff are recruited into new jobs and the new organisations take shape and develop to their potential. We will continue to manage this development over at least the next two years by:

- instituting specific development programmes for PCTs and StHAs as part of the wider set of development programmes being run through the Modernisation Agency and Leadership Centre;
- instituting a transition fund of £100m in each of the next two financial years to help manage the change, pay for “double running” where necessary and support the guarantee of continuing employment for staff as well as other transitional costs;
- continuing to lead this development through a national project linked in to regional and local project plans.

1.7 Delivery

- 1.7.1 These are very major changes. However good our project management arrangements, successful implementation of Shifting the Balance of Power will depend on the decisions, behaviour and actions of very many people throughout the whole NHS.
- 1.7.2 We also need to maintain and improve delivery services for patients whilst we make these changes. In the longer term they will help us deliver what patients and the public need and deserve from their service. In the short term I recognise the huge effort that is going into managing these changes and simultaneously maintaining delivery. On a personal level I am continually impressed by the tremendous efforts and leadership shown by individuals at all levels in the NHS in making this happen. It is an enormous achievement. Thank you.

Nigel Crisp
7 January 2002

2: Roles and Responsibilities

2.1 Primary Care Trusts

- 2.1.1 The strengthening and development of Primary Care Trusts (PCTs) is central to Shifting the Balance of Power.
- 2.1.2 Primary Care staff are uniquely placed to have an overview of services in the community and in hospitals, of public health and health services and of local authorities and the NHS. PCTs give them the opportunity to take the lead in developing and redesigning systems in primary and secondary care as well as tackling public health issues locally. In addition, subject to legislation, they will have 75% of the total NHS budget allocated to them for decision making by 2004.
- 2.1.3 The main roles of PCTs will continue as now to be:
- improving the health of the community;
 - securing the provision of high quality services;
 - integrating health and social care locally.
- 2.1.4 These roles will be enhanced when, subject to legislation, PCTs become responsible from around October 2002, for the delivery of the vast majority of current Health Authority functions.
- 2.1.5 These changes provide the opportunity for PCTs to develop as new types of organisations which not only take on these formal responsibilities but manage them in very different ways from health authorities.
- 2.1.6 To succeed they will need to involve patients and the public as well as their own practices and partners. They will need to develop capacity to manage the co-ordination of all the agencies who deliver local health care, taking the responsibility for creating strong local partnerships, addressing the broader determinants of health and truly representing the populations which they serve. In doing so they will also need to work collaboratively with other PCTs, StHAs and NHS Trusts as well as local authorities.
- 2.1.7 This will take time, support and development as described below.

Improving the Health of the Community

- 2.1.8 The PCTs' role in improving the health of the community will involve:
- taking the lead with the public and their partners on public health issues;
 - developing Health Improvement and Modernisation Programmes based on health needs and integrating service planning and health promotion;
 - engaging fully in Local Strategic Partnerships and other community based health and care initiatives.

2.1.9 In order to do this they will need to take the leading role locally in the new public health approach described in 3.2 and appendix C and be staffed accordingly.

Securing the Provision of Services

2.1.10 PCTs will be responsible for planning and securing the provision of the totality of care and services that their population needs, either by direct management or through agreement with other organisations. In order to meet its objectives, the PCT will have to develop a planning system which focuses on patient need in its broadest sense, quality of outcomes, activity and finance. This will need to be underpinned by strong clinical governance arrangements to assure the quality of services, to identify opportunities for quality improvement and to ensure patient safety.

2.1.11 Their role in securing the provision of services will embrace:

- commissioning all acute and specialised services for their populations, working singly or in partnership with others as described in 3.4.
- responsibility for securing the provision of Personal Medical and Dental Services (PMS and PDS). When the PCT is the actual provider of such services, formal responsibility for them must remain with the Strategic Health Authority.
- responsibility for securing all mental health services, Walk-in Centres, local NHS Direct services, emergency ambulance and patient transport services and the implementation of population screening programmes.
- responsibility, subject to legislation, transferred from existing Health Authorities for all Family Health Services (FHS). This will include the administration, management, development and integration of all FHS: medical, dental, pharmaceutical and optical. In practice, this will mean maintaining lists of practitioners, admissions to the list, dealing with applications for the siting of new pharmacies and managing the national complaints policy amongst others.

2.1.12 From April 2002 until the legislation takes effect, the new Health Authorities will continue to have legal responsibility for the FHS function as well as for PMS and PDS. However, the new Health Authorities will work closely with PCTs to ensure the smooth transfer of legal responsibility as soon as the legislation allows. It is anticipated that Health Authorities will discuss with PCTs the arrangements which are likely to be put in place after the passage of legislation. Arrangements from April 2002 should take account of the desired end point while acknowledging that the legal responsibility rests with the Health Authority.

Integrating Health and Social Care Locally

2.1.13 PCTs offer the opportunity, probably for the first time, for family health services and community health care to be integrated within one organisational structure. This will allow them to bring service planning and delivery together for all non-acute hospital services. This in turn should encourage a more coherent direction to securing secondary acute services.

2.1.14 Ensuring that local NHS organisations work together and with social care and local authorities more generally is fundamental in the new ways of working and the success of PCTs. PCTs have a responsibility to ensure social care needs are met and should make full use of the Health Act flexibilities where appropriate. Where it is felt that closer integration is needed or would be beneficial then there may be a role for a Care Trust. Care Trusts can provide opportunities for integrating commissioning and provision, according to local needs. By joining together teams and resources, they can provide a highly responsive service.

2.1.15 Integration – and working across PCTs and local authority boundaries – may be further enhanced by the use of the arrangements within the Health and Social Care Act 2001 and the ‘well being power’ in the Local Government Act, which allows Local Authorities to contribute towards activity outside their geographical boundaries.

PCTs Working Together

2.1.16 In all their roles, there is a need for PCTs to have robust arrangements in place for working together. Such arrangements will support a range of activities where it is not anticipated that PCTs will be totally self sufficient eg commissioning, public health, partnership working with local government, implementation of National Service Frameworks (NSFs), clinical networks etc. The form of co-operative arrangements will be determined locally by PCTs.

Support and Development

2.1.17 PCTs are new and developing organisations with ambitious goals and huge potential. In order to support them a National Development Programme has been established to support PCTs and Care Trusts. Its work programme will focus on four main strands:

- ensuring that development programmes for individuals and teams is available through the Leadership Centre, the NHS Appointments Commission and the Modernisation Agency;
- supporting the development of PCTs working together through network events provided locally and nationally;
- securing tailored support to individual PCTs through the Leadership Centre and Modernisation Agency;
- establishing links and communications nationally and regionally with other PCTs, other parts of the NHS and the Department.

2.1.18 Further information on the work of the PCT Development Programme can be found at <http://www.doh.gov.uk/pricare/pctdp.htm>.

2.2 Strategic Health Authorities

2.2.1 All NHS organisations locally – PCTs and NHS Trusts – will become part of a single structure and be held to account through the StHA. This will not only support the creation of shared strategies but also facilitate working together and whole systems approaches.

2.2.2 With performance management delegated mainly to StHAs they will in effect be responsible for managing NHS locally on behalf of the Department.

2.2.3 The three key functions of a Strategic Health Authority are:

- creating a coherent strategic framework;
- agreeing annual performance agreements and performance management;
- building capacity and supporting performance improvement.

2.2.4 StHAs will determine their own structures and working arrangements.

However, there are a number of clear principles about the style of StHA working. They should be:

- focused on **delivery** – agreeing and reviewing local delivery plans, securing improvement for both the short and longer term; where necessary intervening to secure improved performance. Consistent performance management principles will apply across all StHAs.
- committed to **service quality and patient safety** – creating the environment where they are at the centre of decision making.
- **empowering** – seeking to devolve power to the frontline and to patients and the public and supporting them in tackling the improvement of the NHS. StHAs should focus on their core roles and not seek to retain those functions which could be operated on a collaborative basis across PCTs and NHS Trusts.
- **facilitative** – sitting at the centre of a range of networks that represent a health and social care system, not as the peak of a hierarchy, and brokering solutions across those networks that address the needs of patients from all parts of society.
- **developmental** – ensuring that the capacity, skills and infrastructure are in place to support local clinical teams in the redesign of services; working with the Modernisation Agency and coming together where required to provide shared infrastructure between StHAs; supporting whole systems development across PCTs, NHS Trusts, public health and clinical networks, and partnership arrangements.
- **involving** – building patients, the public and staff into all the work of the StHA and the wider health community; working closely with other local and national agencies.
- **leading** – ensuring that leadership for the professions and of professional issues is provided for the local health community; ensuring that leadership on key areas of policy (such as public health, workforce and clinical priority areas) is in place, commands support and reflects the diversity of modern society.

Organisation and Operation

2.2.5 Chief Executives will be appointed to StHAs on the basis of Franchise Plans which set out the delivery plans for the local health community and describe the organisation and ways of working which will be developed.

2.2.6 Alternative models for running StHAs will emerge from the franchising process, ranging from the radical to those that draw more on currently established models. However, they will share some common characteristics in terms of team based approaches and focus on performance and development. Specific activity will include:

- developing a strategic framework for the delivery of services across all local organisations. PCTs' Health Improvement and Modernisation Programmes (HIMPs) will inform this process as will PCTs' and Trusts' local delivery plans. This framework together with its underpinning plans and agreements will also enable StHAs to support local authorities' Overview and Scrutiny Committees to carry out their new role in the NHS.
- supporting patient and public involvement through working with patients forums, the Commission for Patient and Public Involvement in Health and otherwise.
- intervening and brokering solutions between PCTs where conflicts or problems arise between local NHS bodies to reach the best outcome for all stakeholders; for example: in developing public health networks, HIMP activity, engagement with non NHS partners such as local authorities and the Prison Service, and any challenges arising relating to cross boundary working.

- playing an important role in fostering partnerships with universities and further education institutions.
- performance managing PCTs, NHS Trusts and Workforce Development Confederations.
- ensuring the delivery of safe, quality services through effective clinical governance arrangements in PCTs and in NHS Trusts.

2.2.7 StHAs will be new organisations and work very differently from their predecessors. As with PCTs they will be supported by a development programme to work both with individuals and with the organisation as a whole.

2.3 NHS Trusts

2.3.1 Although the statutory functions of NHS Trusts will not change following Shifting the Balance of Power, they will be deeply affected by these changes and need to be fully involved in their implementation.

2.3.2 In the future, NHS Trusts will be performance managed by the new Strategic Health Authorities. They will need to work ever more closely in partnership with PCTs and other local partners to:

- redesign local services around the needs and convenience of patients; develop strategies to reduce health inequalities and improve the health of the whole population;
- deliver safe, high quality services and have effective clinical governance arrangements to fulfil their statutory duty of quality;
- deliver national priorities;
- address local priorities as identified through local surveys of patient experience and the Local Modernisation Reviews.

2.3.3 Internally they will need to review their systems and approaches to provide greater devolution to clinical teams and front line staff and increase the involvement of patients and the public. This will involve:

- delegating budgetary responsibility and decision making to frontline clinical teams;
- engaging frontline staff in service modernisation and improvement;
- involving patients and communities in programmes to improve health and healthcare services;
- delegating responsibilities for ward staffing budgets to ward sisters and charge nurses.

2.3.4 There will also be an increased emphasis on delivery of services through clinical networks which span institutional boundaries. NHS Trusts will therefore need to promote the development of such networks with PCTs, other NHS Trusts and with partners in Social Care, and, as appropriate, voluntary and private sector partners.

2.4 The Department of Health

2.4.1 As responsibility is devolved to the frontline, the Department of Health needs to change the way it works and its relationship with the NHS. It needs to step back from operational issues and do only those things that only it can do.

- 2.4.2 The role of the Department in the new arrangements can be described broadly as follows:
- **securing management and accountability of the overall system:** the Department is responsible for the overall health and social care system, setting direction and securing resources, relationships with other Government Departments, helping the services integrate and modernise and ensuring delivery;
 - **developing policy and project managing major changes** such as the National Service Frameworks;
 - allowing the space for local initiative and responsibility but within **a regulatory and inspection framework**, the latter increasingly happening at arms length;
 - **intervention** where necessary.
- 2.4.3 As with the other parts of the system the Department will develop a more participative and enabling style which supports front line staff and organisations to deliver.
- 2.4.4 Within the Department, 4 Directors of Health and Social Care (DsHSC) will between them have the main responsibility for working directly with the NHS and performance managing StHAs. This role will involve:
- the oversight and development of health and social care – ensuring that local health and social care communities are developed in an integrated way to deliver modernised services. This will involve close working in particular with the Modernisation Agency;
 - supporting the Chief Executive, Chief Operating Officer and Chief Inspector of Social Services in assessing performance of the whole system;
 - public health: the DsHSC will have a Regional Director of Public Health (RDsPH) and public health team co-located with each Government Office. The RDsPH will be jointly accountable to the DHSC and to the Chief Medical Officer;
 - managing as part of a national programme, the appointment, development and succession planning of senior management staff;
 - supporting Ministers through casework, Ministerial visits and local intelligence;
 - troubleshooting.
- 2.4.5 In the first instance DsHSC will play a major role in developing the new organisations and ways of working and will maintain close involvement, whenever necessary, with StHAs and their performance management of NHS organisations. Over time however, as StHAs develop, the role of DsHSC in the regions will diminish and they will begin to take a national role whilst retaining regional responsibility.

2.5 Staffing and Organisational Costs

- 2.5.1 Shifting the Balance of Power will mean reducing the whole staffing and management costs of the intermediate tier – Health Authorities and Regional Offices – and devolving maximum resource to frontline organisations and in particular to Primary Care Trusts. Savings from the abolition of Regional Offices and the number of current Health Authorities will pass to PCTs as well as providing £100m to go towards child care costs.

- 2.5.2 In the short term the £100m will be used in the next two financial years to provide a transition fund. This fund will be used to fund development costs for new organisations, double running costs, transition costs and the costs of maintaining staff in guaranteed employment. From 2004/05 this £100m will be used for improving childcare facilities.
- 2.5.3 The bulk of the resources recovered from Health Authorities and Regional Offices will flow to PCTs. When these are freed up, this should provide PCTs with around £14 per head of population for the overhead costs of running their organisations. In addition, PCTs will have access to the transition fund to help meet the costs of transition and guaranteed employment. PCTs assuming responsibilities for managing community services should also secure the appropriate transfer of management resource from Community Trusts.
- 2.5.4 Taken together those resources should enable PCTs to operate effectively. However, the actual costs of management necessary for PCTs will be kept under review in the next few months as they begin to take on their new roles and limits may be adjusted as necessary.
- 2.5.5 Strategic Health Authorities will have a cap on their staffing numbers of 75 staff and £4m of running costs. In practice, however, we would expect their costs to be lower than this. Strategic Health Authorities will receive a direct allocation for running their organisation. The level of allocation will be agreed as part of the franchising process, within the limits outlined above. During the franchising process we would expect Chief Executives to be able to demonstrate how they will deliver the objectives of the StHA whilst at the same time maximising resources going to front-line organisations. The direct allocation of running costs will effectively be the Strategic Health Authorities' management costs envelope.
- 2.5.6 Staff numbers in the four offices of the Directors of Health and Social Care will be capped at around 40, plus staff in R&D undertaking a national function. In addition, there will be a team of 15–20 public health staff in each of the 9 Government Offices together with some outposted staff.

3: Specific Functions

3.1 Introduction

3.1.1 The previous chapter set out the roles and functions of the new organisations. To provide a more complete picture, this chapter explains how some of the major functions and processes will be undertaken.

3.2 Public Health

3.2.1 *Shifting the Balance of Power* has provided the opportunity to review the way public health services are delivered and operate across the whole NHS.

3.2.2 As with other functions and services, *Shifting the Balance of Power* has led to the creation of:

- a renewed and powerful role at the most local level;
- the development of improved team working and networking across organisations;
- strengthened partnerships locally and across government.

3.2.3 The arrangements for public health are described in more detail in Appendix C. The broad scope and composition of this public health delivery system will be:

- a strong public health team in every PCT, engaged with local communities, local authorities and non-Governmental agencies and focussed on improving health, preventing serious illness and reducing health inequalities in the populations they serve. Every PCT will have a Director of Public Health; the post will be open to both medical and non-medical public health specialists.
- a public health network of skills, knowledge and experience in every area designed according to local needs and circumstances; this will enable the provision of public health expertise which cannot be provided in every PCT but can be made available through the network.
- a senior public health doctor/medical director in every StHA as a member of its top team, in a performance management role in relation to clinical governance in local NHS providers and clinical networks and public health.
- a Regional Director of Public Health and support team in each of the regional offices of Government to provide the Department of Health's public health function. These senior officers and their teams will have a wide-ranging role. They will manage and co-ordinate the health protection and emergency planning functions in their regions; they will design, develop and maintain public health networks; they will tackle the root causes of ill health and inequalities through the health component of cross-Government policies in the regions (e.g. transport, environment and urban regeneration), deal with major health service incidents and provide overall medical leadership.

3.3 Securing Clinical and Professional Leadership

- 3.3.1 Shifting the Balance of Power also provides the opportunity to create new arrangements for securing and supporting clinical and non clinical leaders throughout the professions and introducing new and more participative ways of working.
- 3.3.2 If we are to devolve power closer to patients we need leaders who can facilitate, motivate, and engage clinical staff and who can create an environment in which practitioners have the freedom to improve services for their patients and communities. These leaders also need to be able to involve users and front line staff in decision making and work across professional and organisational boundaries.
- 3.3.3 The particular arrangements for this need to be determined locally with PCTs, NHS Trusts and StHAs all considering how they can secure good leadership of all the professions including the Allied Health Professions.

Nursing, Midwifery and Health Visiting

- 3.3.4 However for the largest group of staff – nursing, midwifery and health visiting – there is a national requirement to have nurses involved in the top team. The specific arrangements are described in Appendix D, and outlined below:
- every PCT will have a senior, experienced lead nurse to provide clinical and professional leadership for front line nurses and to input to the corporate functions of the PCT;
 - there will be a senior nurse on the top team of StHAs to input into performance management and strategic planning, develop networks with front line staff, provide a link to the Chief Nursing Officer (CNO) and discharge the StHA responsibility for the statutory supervision of midwives;
 - the Directors of Health and Social Care will have a nurse adviser in their core team to support them in their key functions: in particular, the development of health and social care, assessing performance, trouble shooting and supporting Ministers. The nurse adviser will provide a vital link between the Department of Health and the NHS for the CNO, developing/leadership professional and clinical strategic networks of nurses and midwives and creating nursing capacity in the StHAs.

3.4 Commissioning of Services

PCTs' Commissioning Responsibilities

- 3.4.1 The arrangements for commissioning services reflect the need to:
- plan services at the most local level, near the patient;
 - co-operate and co-ordinate across boundaries, involving all relevant parties;
 - commission specialist services for the appropriate size of population often covering several PCTs.
- 3.4.2 PCTs are responsible for identifying the health needs of all parts of the community they serve and for securing services for them. They may do this by directly providing the service or by commissioning it from health or social care bodies or the voluntary or private sectors. This may involve developing or

changing services to improve quality, access, responsiveness and outcomes. Real improvements will only happen where all the interested groups work together on a shared agenda and collaborate to tackle common problems. This will often mean pooling resources to ensure that change happens.

3.4.3 In discharging this responsibility PCTs will need to work with public and patients' groups, other PCTs, NHS Trusts and local authorities to provide patient focussed and "joined up" plans and services. This will mean:

- involving local people in the process of shaping local services. Partnership working and community development will be essential, notably by engaging the expertise of Patients' Forums and Local Networks of the Commission for Patient and Public Involvement in Health. Through these partnerships PCTs will develop innovative and effective ways to involve people and give them confidence that local services have their interests at heart.
- collaborating with neighbouring PCTs to commission services and work as part of consortia. The shape of these consortia will differ between services. For one service, the consortium might work within the boundaries of the local StHA; others may be larger, smaller, or indeed cut across StHA boundaries – on occasion the location of the unit providing services may suggest the "ideal" shape of the consortium. However the consortium is set up, the decisions made by that consortium will be binding on all members. Every PCT will need to maintain a close interest in the work being done to invest in services or support new developments – and in any proposals to move services from one provider to another.
- through joint arrangements with local authorities, building on the many examples already operating. The exact arrangements will depend on the services involved, geography and existing partnerships.
- building good relationships and a good understanding of the services and potential of local NHS Trusts and other providers in order to help influence and develop services as well as commission effectively.

The Role of the StHA

3.4.4 The StHA's role is to ensure that each PCT has appropriate arrangements in place both for commissioning by itself and with others through consortia. It will also be represented on commissioning consortia for specialist services and provide support and experience as well as ensuring consistency across PCTs.

3.4.5 Where necessary the StHA will resolve disputes between PCTs or between a PCT and a provider within its own boundaries. The Director of Health and Social Care will facilitate agreements, and if necessary, determine disputes that cross StHA boundaries.

3.4.6 The range of services commissioned through consortia will vary from place to place. However the three significant areas described below will require consistency and may need special treatment.

Securing Specialised Services

3.4.7 Those specialised services which are defined by the National Specialised Services Definitions Set are currently commissioned by Regional Specialised Commissioning Groups. In the future they will need to be collaboratively commissioned by all the PCTs covering the planning population.

3.4.8 Securing specialised services is particularly complex because of the inter-dependence between caring for patients and the arrangements needed for research, education and training of small numbers of very

skilled staff. Changes in best practice occur rapidly in these services, driven often by new technologies. Providers and PCTs will need therefore to establish mechanisms to work together to test whether developments actually bring clinical benefits and whether or not they are cost-effective.

- 3.4.9 There is a particularly important issue in the short term of ensuring that enough people with the right skills continue in their current roles to provide stability. In the year ahead (2002–03) Regional Specialised Commissioning Groups (RSCGs) will therefore continue to exist with the responsibility of ensuring that a planned transition to successor arrangements takes place. They will have a specific role in developing PCT capacity to commission specialised services.
- 3.4.10 Consortia arrangements created under the auspices of current RSCGs should be continued with PCTs honouring existing financial commitments. Where experienced staff, who are currently responsible for commissioning specialised services, transfer to a PCT then individual consortia could be led by that PCT in the first instance. The membership of RSCGs need to be altered to include at least one PCT representative per StHA. The existing programme of reviews under RSCG auspices should also be continued.

Emergency Ambulance Services

- 3.4.11 PCT commissioning of ambulance services has raised some concerns particularly where services are provided across boundaries. The same principles of consortia commissioning need to apply here with StHAs ensuring commissioning is co-ordinated, timely and well led.

Population Screening Programmes

- 3.4.12 Population screening programmes raise other issues of co-ordination and infrastructure. PCTs will be responsible for securing the provision of screening programmes for their population by working collaboratively. Together and with the StHA they need to make sure effective arrangements are in place to ensure coverage and maintenance of population registers, to bring together the range of clinicians, managers and public health professionals contributing to screening programme delivery and to shape the commissioning and development of screening programmes.

3.5 Working Across the Health Community

- 3.5.1 There are a number of semi-formal arrangements that have developed to carry forward activity involving a number of organisations across a health community, including commissioners, service providers, and wider partners in local government and the community. Examples include National Service Framework local implementation teams and cancer networks.
- 3.5.2 Many of these have developed around current Health Authority and Regional Office boundaries, and questions were raised during the discussion period about their future. It will be the responsibility of PCTs working with their partners to determine the form of future arrangements. However it is important that momentum is maintained during the coming transitional period; where local health communities have previously agreed on specific arrangements, they will need to ensure that this work (and the resources needed to support it) continues, until suitable alternative arrangements are in place.
- 3.5.3 Nationally the most advanced networks are for cancer. The arrangements for maintaining them through these changes are described below.

Cancer Networks

- 3.5.4 Cancer networks have evolved since the Calman-Hine report of 1995 to help organisations improve work on cancer across institutional boundaries. They are based around flows of patients to tertiary centres so they do not map exactly with Health Authorities. By early 2001, the 34 established cancer networks covered the whole of England, each serving a population between half a million and three million. Managed cancer networks can develop:
- integrated care;
 - improved clinical outcomes;
 - cost-effective services;
 - improved patient experience;
 - equity of service provision.
- 3.5.5 During summer 2001, all cancer networks have been taking stock of action on cancer in their areas and developing strategic service delivery plans to deliver the Cancer Plan. The issue of how networks will fit with the new NHS structures has been discussed with a range of players from Regional Offices, Health Authorities, the Modernisation Agency, cancer networks, PCTs, Trusts, the independent sector and patient representatives.
- 3.5.6 In order to deliver improvements in the prevention, screening and treatment of cancer, PCTs and Trusts will continue to need to co-operate and cancer networks provide an established route for this across the care pathway. Local discussions will be needed on how exactly the new organisations want to participate in the network: national discussions have resulted in the following principles for the involvement of networks in delivering the Cancer Plan:
- Trusts (PCT and acute) are, and should remain, accountable for delivery of the cancer targets and Cancer Plan.
 - they will need to continue to work together in cancer networks to ensure implementation of the totality of the Cancer Plan, across the care pathway and institutional boundaries. They need to involve commissioners, providers (including hospices and other services in the independent sector) and users.
 - cancer network populations should be defined around patient flows so they may not be coterminous with Strategic Health Authorities.
 - PCTs should use cancer network Service Delivery Plans to commission cancer services collaboratively across the network with agreed levels of new investment.
 - all investment in cancer services should be in line with agreed priorities identified in these Service Delivery Plans.
 - Chief Executives of Trusts (acute and PCTs) should be members of the cancer network Board, nominate the network Chair, and agree the work that the network, including its lead manager, lead clinician and lead nurse, will undertake on their behalf. It may be helpful to develop a formal agreement as to the authority vested in the network on behalf of its members.
 - arrangements may look different in 2-3 years time. Exact arrangements and relationships are likely to evolve as the new NHS organisations develop.

3.5.7 Strategic Health Authorities are responsible for ensuring that these networks are in place and operate effectively. They will need to engage at senior level with the cancer network Board. They will need to support the development of cancer networks and, in exceptional cases when network members cannot agree, facilitate agreement. They will also need to ensure that the network plans for cancer fit in with the wider agenda and agree the networks' Service Delivery Plans.

Health Action Zones

3.5.8 Within their own areas the 26 Health Action Zones (HAZs) in England have the potential to play a strong role in supporting implementation of the *Shifting the Balance of Power* agenda based on their own achievements, knowledge, learning and skills. They have demonstrated particular success in:

- joined up working and partnership in complex environments;
- engaging patients and local communities;
- new ways of working to improve the health of communities and address inequalities;
- involving and empowering staff;
- supporting and developing clinical teams and networks; and
- encouraging and supporting cultural change within the NHS.

3.5.9 From April 2002, Health Action Zones will align themselves to the new structures in local health systems depending on their size and relationship with partners, either:

- with a single PCT;
- with a group of PCTs working collaboratively;
- with a local authority; or
- as part of one or more Local Strategic Partnerships (LSPs) – as set out in the NHS Plan.

3.5.10 In the last two examples, the PCT in receipt of HAZ funding will be able to delegate functions and resources through existing Health Act flexibilities.

3.5.11 Strategic Health Authorities will performance manage HAZs. Local Authorities, through their new scrutiny function, will also have a part to play in overseeing performance. Regional Public Health groups, with their regional Government Office partners, will have a key role in facilitation and mediation as well as accreditation where the HAZ operates as part of the LSP.

3.6 Workforce

3.6.1 All NHS organisations need to develop proper workforce plans and contribute to the workforce plans which support Health Improvement and Modernisation Programmes (HIMPs) and help ensure equal opportunities in all NHS employment. It will also be important to ensure appropriate relationships between NHS organisations and universities, including medical schools, if the partnership between teaching, research and service is to be given full meaning in practice. The current 24 Workforce Development Confederations (WDCs) have a key role to play in driving forward work to increase staff numbers, change the way in which staff from all parts of society are trained and educated, and develop new ways of working. The long term development of the NHS University will play an important role in these issues.

- 3.6.2 *Shifting the Balance of Power – Securing Delivery* said that WDCs would continue to have a separate identity to maintain their focus on workforce issues but should be aligned to, or coterminous with, the new Strategic Health Authorities. *Securing Delivery* also said that further consideration of their accountability arrangements and their relationships with the Post-graduate Deaneries would be required. Since then, the Department of Health has been discussing with Workforce Development Confederations and other stakeholders how best to handle workforce issues under the new arrangements and how to ensure proper accountability for the work of WDCs.
- 3.6.3 A WDC is more than just the staff employed in the organisation. It is a member organisation bringing together all local NHS organisations with non-NHS employers and other key stakeholders including universities. WDCs provide a local focus for the development of the whole healthcare workforce and need to be outwardly accountable to those local organisations for the way in which they work. However, they have a key role to play within the NHS and will be responsible for the effective use of significant NHS funding.
- 3.6.4 As such it is important that they are properly accountable within the NHS. To achieve this, Confederations will in future be hosted by Strategic Health Authorities which will hold the contracts of the Chief Executive and staff. Confederation CEOs will be accountable to StHAs for performance including delivery against the NHS Plan and other targets. DsHSC will have an overall performance assessment role for workforce as for other issues.
- 3.6.5 Final decisions on the configuration of Confederations are being made: they will either be aligned to new Health Authority boundaries or be coterminous with two Authorities where this is appropriate.
- 3.6.6 WDCs will be responsible for the Multi Professional Education and Training Budget (MPET) which will be allocated from the Department of Health to StHAs, who will act as the paymasters for WDCs. This resource will only be available for use by WDCs to support education and training. WDCs will be accountable to the Department of Health, through StHAs, for the use of these resources. The Department will work with WDCs to develop a performance management system for education and training.
- 3.6.7 Postgraduate Deaneries will remain as separate bodies, responsible for managing the delivery of high-quality post-graduate medical and dental education and training. Funding for this work will form part of the integrated MPET funds which will flow to Confederations. While deaneries will continue to work in partnership with a range of organisations, including NHS Trusts and universities, their main route of management and organisational accountability will be to Confederations. There will be service level agreements between Confederations and deaneries to manage postgraduate education on their behalf and Confederations will performance manage deaneries' delivery.
- 3.6.8 WDCs will also take on a number of workforce functions currently discharged by Regional Offices. These will include:
- providing leadership on professional workforce issues;
 - linking with higher education;
 - managing activity on recruitment and retention;
 - taking forward work on “Improving Working Lives”.
- 3.6.9 These new arrangements will give WDCs a wide-ranging role in developing workforce policy and in advising on the workforce implications of policy initiatives.

3.7 Local Representative Committees

- 3.7.1 Local Representative Committees (LRCs) provide the means for representation of their members and can provide some continuity through this period of change.
- 3.7.2 At present LRCs are required to be coterminous with Health Authorities. In the future in England they will relate most naturally with PCTs rather than StHAs. But LRCs need flexibility in order to represent their members and therefore it is proposed that in future each profession will organise its own affairs in the way it sees fit: profession by profession and area by area. It will be possible for Medical, Dental, Pharmaceutical and Optical Committees to be of different sizes to cover different PCT areas if that is what best suits the needs of the individual professional group.
- 3.7.3 From 1 April 2002, the existing legislation means that all LRCs will be required formally to reconfigure themselves so as to be coterminous with the new Health Authorities. Informally however, during this transitional period LRCs may continue on their current arrangements. Subject to Parliament, this formal requirement will cease when the LRC provisions in the National Health Service Reform and Health Care Professions Bill are enacted and LRCs will be expected during this transitional period to decide their future configuration.

3.8 Managing and Assessing Performance

- 3.8.1 The Department will set out annually its priorities and planning framework within which the NHS will need to operate. This will be reflected in the longer term plans for PCTs (HIMPS) and the StHA franchise plans, and will lead to annual performance agreements between:
- StHAs and the Department;
 - PCTs, NHS Trusts, Workforce Development Confederations and StHAs.
- 3.8.2 The respective roles in managing performance are that:
- the Department of Health will assess the performance of the NHS as a whole and hold Strategic Health Authorities (StHAs) to account on behalf of Secretary of State. This will be done via the Directors of Health and Social Care within a transparent and simple framework applied consistently across the country.
 - StHAs will have responsibility for performance managing PCTs, NHS Trusts and the Workforce Development Confederations.
- 3.8.3 Increasingly performance assessment will rely on external and publicly available information and assessment provided, for example, through the performance rating (star) system or CHI inspections.
- 3.8.4 In future it will be StHAs which will take on the main performance management function. They will negotiate Trust and PCT annual performance agreements; monitor in-year performance; address under performance; oversee the development of recovery plans and monitor their implementation, providing support to the local NHS to assist under performing organisations; and, assess the adequacy of local operational plans.
- 3.8.5 The focus of the DsHSC performance management function will be taking a national overview of performance, negotiating performance agreements with StHAs, holding StHAs to account for performance, and supporting the development of individuals, organisations and the whole system to help them deliver improvements for patients.

3.8.6 The way performance management is undertaken will also need to change to reflect the following principles:

- organisations will be assessed on the basis of performance against a small group of priorities and progress towards the longer term vision of the NHS.
- performance management of StHAs, PCTs and NHS Trusts will adopt the principles of earned autonomy to allow high performing organisations the greatest level of operational freedom. Such organisations will be subject to lighter touch financial, operational and monitoring requirements.
- performance management will give more attention to health outcomes and patient impact. In particular PCTs will be performance managed on the outcomes of the care that they provide (including preventive health improvement work and the commissioning of acute services). Process indicators that currently stand as proxies for outcomes will increasingly be phased out, giving PCTs much more operational freedom in the way their services are configured and run.
- the new performance management system will place maximum responsibility on organisations to manage their own performance. They should report on information which they need for themselves.

3.9 Finance

3.9.1 Shifting the Balance of Power has implications for financial management. The main ones are summarised below. Further detail may be found at <http://www.doh.gov.uk/finman.htm>.

Revenue Allocations

3.9.2 The Department of Health has made allocations for 2002-2003 to the present 95 Health Authorities. In April 2002 these allocations will be aggregated for the new Health Authorities. The new HAs will allocate to their PCTs all of their allocation except:

- resources needed for functions which remain with the HA pending legislation; and
- resources needed for the running costs of the Health Authority.

3.9.3 In October 2002 the Department of Health will allocate to PCTs revenue resources for functions transferring to PCTs from HAs.

Capital Allocations

3.9.4 Regional Offices will distribute capital resources for 2002-2003 to NHS Trusts and PCTs using current methods; by September 2002 capital planning totals will be disaggregated to Strategic Health Authorities. For 2003-2004 the Department of Health will:

- allocate operational (“block”) capital directly to NHS Trusts and PCTs using a national formula;
- distribute planning totals for strategic (“discretionary”) capital between Strategic Health Authorities, which will distribute their strategic capital planning total between NHS Trusts and PCTs.

3.9.5 Transitional arrangements will protect existing capital commitments.

Accounts Preparation

- 3.9.6 The new Health Authorities will be responsible for completing the 2001–2002 accounts of the 95 former HAs. The Accountable Officer appointed for the new HA will sign these off. There will be a single set of 2002–2003 accounts for the new HAs including their role as Strategic HAs. These accounts will be completed by the Strategic Health Authorities.

Financial Management

- 3.9.7 The Department of Health will manage the financial performance of the NHS as a whole and performance manage Strategic Health Authorities. The key roles of Strategic Health Authorities, through their Directors of Finance, will be to produce a balanced financial plan for the whole of their health economy and performance manage the individual NHS bodies within their boundaries. PCTs and NHS Trusts must comply with their statutory and other financial duties and co-operate with the Strategic Health Authority in producing a balanced financial plan. StHAs and the PCTs and NHS Trusts will need to co-operate with the Department to secure an appropriate end of year spending outcome for the NHS.
- 3.9.8 There will be no central contingency fund or special assistance fund. Financial problems will need to be handled through self-help (which includes help for NHS Trusts by their main commissioner) supplemented by mutual help and assistance organised by Strategic Health Authorities. These mutual aid arrangements will need to cover any support already agreed for individual organisations and on which their financial planning depends. Both the mutual aid arrangements and the end of year control arrangements will require NHS Trusts and PCTs to temper their individual financial aims and objectives in the interest of the wider health economy to which they belong and of the NHS as a whole.

Organisation of Internal Audit

- 3.9.9 The prime objective here is to ensure that adequate internal audit is not put at risk as a result of these structural changes. There is no intention to impose organisational uniformity, for example to align agencies or consortia with StHA boundaries. However, smaller consortia and agencies are strongly encouraged to merge to ensure they can provide the full range of skills required of them. In house arrangements are only appropriate for very large NHS Trusts where sufficient resources are available. Where internal audit agencies and consortia are in difficulty with their hosting arrangements, their NHS Trust members and clients are encouraged to take on the hosting role.

Trust Funds Held by Health Authorities

- 3.9.10 Where funds exceed £350,000 they should be transferred to a PCT. Where funds fall below this threshold they should be transferred to the most appropriate local NHS body. PCT members should then be appointed to the charity sub-committee of that body.

3.10 Information

- 3.10.1 Developing information management and technology requires local action and investment within a national strategy. Shifting the Balance of Power brings with it a new emphasis on information management – linking together the NHS – and new organisational roles.

- 3.10.2 A national strategy, locally implemented, involves a clear understanding of what needs to be done centrally (national infrastructure), uniformly (standards), and locally (front line implementation). The aim will be to provide maximum local choice consistent with a nationally integrated service. The implications for the different organisations are set out below:

Department of Health

- 3.10.3 The DH provides the leadership, setting national IM&T policy in collaboration with the other policy initiatives around key drivers such as the NHS Plan. National policy is set out in 'Information for Health' which was updated by 'Building the Information Core' in January 2001, both of which are viewable at <http://www.doh.gov.uk/ipu/develop/index.htm>. It sets targets for the various constituencies throughout the NHS that move the whole NHS forward in a co-ordinated way. It commissions those services, which are best undertaken centrally by the NHSIA (e.g. NHS wide clearing service). It secures and allocates funding to enable progress on targets and national IM&T infrastructure. The key elements are local, robust, costed implementation plans and effective control by StHAs. IM&T will be a component of the performance management agreements with individual StHAs. As the process matures an approach based on earned autonomy can be used.

Strategic Health Authorities

- 3.10.4 Strategic leadership for all IM&T issues rests with the StHA. This includes both organisations within its patch and the need to collaborate with other organisations where care networks span boundaries. The principal tasks will be to:
- agree and review each costed implementation plan from local health communities;
 - allocate earmarked funds against approved delivery plans;
 - approve IM&T business cases;
 - monitor progress using nationally consistent performance management criteria;
 - broker IM&T solutions across care networks;
 - interpret national policy within a local context;
 - provide local leadership for Health Informatics;
 - ensure continuity of data flows and data quality across local organisations and to the centre;
 - provide the centre with detailed feedback on risks to national targets and potential remedial action;
 - contribute to the processes for national infrastructure management;
 - inform the development of national strategy by feeding back front-line priorities and issues;

NHS Trusts

- 3.10.5 NHS Trusts will:
- collaborate with their local PCTs in the formulation of integrated and costed local implementation plans;
 - implement their local plans to achieve the specific targets set;

- take an active role in the co-ordination of data flows across their local community and the care networks to which they contribute;
- ensure appropriate training and cultural change initiatives are in place to support clinicians' use of the implemented IM&T.

Primary Care Trusts

3.10.6 Primary Care Trusts will need to consider their information needs and plan to support these either individually or in collaboration. In addition they will need to play an intelligent customer role with the NHS Trusts providing services to their patients. They will be responsible for funding IM&T developments of care networks and will need to ensure they contribute their fair share.

3.10.7 PCTs will:

- collaborate with their local NHS Trusts and Social Services in the formulation of integrated and costed local implementation plans;
- ensure that IM&T for the care networks providing their services are fully integrated and supported around the needs of their patients;
- resource collaborative implementations as part of the wider commissioning of services.

Maintaining Expertise

3.10.8 Expertise will be available to support the new NHS organisations to:

- ensure local communities re-configure their plans around the new model;
- assist PCTs to develop their role with NHS Trusts and care networks within the IM&T context;
- provide brokerage services between local organisations whilst StHAs get up to speed;
- identify as early as possible risk areas and pressure points and agree resolution with the centre;
- put in place firm local arrangements based on national criteria to handle earmarked funds, pending establishment of full working arrangements of StHAs.

3.11 Research and Development

Research Policy and Management

- 3.11.1 *Shifting the Balance of Power* has also provided the opportunity to realign research and development support and activity with the NHS.
- 3.11.2 The Director of Research, Analysis and Information at the Department of Health has overall responsibility for R&D in the Department and in the NHS. He will be supported in the future by Directors of R&D based in the four Directorates of Health and Social Care (each with a small team), and by senior staff in the central Department. The four Directors of R&D will champion R&D, ensure implementation of agreed policies, review R&D activity in their respective regions, promote productive relationships with higher education and bring local intelligence to the Department's R&D Board, which will be concerned with R&D policy and resource allocation. In addition (and again alongside senior central staff) these Directors will each have national roles leading on, for example, NHS cancer R&D, mental health R&D, primary care R&D or R&D capacity building.
- 3.11.3 There will also be an R&D presence in the Regional Government office locations where there is not an R&D Director. This will consist of an experienced R&D Manager plus administrative support. They are likely to link closely with the Regional Directors of Public Health in these locations.

Support Funding

- 3.11.4 The great majority of NHS R&D funding goes directly from the Department to NHS Trusts to support programmes of R&D that are carried out in collaboration with universities and which receive support from research councils, charities or other non-commercial funders. In the future there will be a greater emphasis on allocating to Trusts the responsibility for responding (along with their academic partners) to NHS priorities and needs for research. There will be a more prominent role for R&D directors and managers in Trusts. The Forum of these directors and managers (which is already established) will be the focus for mutual support to promote high standards of delivery throughout research in health and social care.

Commissioned Research

- 3.11.5 The Department of Health will commission research on priorities that cannot be delivered in other ways. This commissioning will be done nationally, largely through contracted out arrangements. Regional Office programmes cannot continue but the national programmes will be sensitive to local needs. There will be renewed emphasis on working in partnership with other funders of R&D in health and social care.

Research Governance

- 3.11.6 In line with the NHS Plan, there will be a strong emphasis on governance throughout NHS R&D, as well as on accountability for the quality and relevance of the research activity. The Department of Health has set and will maintain the Research Governance Framework. Strategic Health Authorities will be responsible for performance management of the implementation of the Research Governance Framework. A network of PCTs will be identified that can be the host to shared research governance and management capacity, strengthening governance across primary, community and social care. Details are available at <http://www.doh.gov.uk/research>.

3.12 Communications

- 3.12.1 A fundamental part of Shifting the Balance of Power is the need to improve communications systems across the NHS and social care. The variability of the current arrangements in organisations is no longer acceptable as we move to an NHS that is more patient and staff-focused.
- 3.12.2 There is now an expectation that staff, patients and the public must have a significant voice in how NHS care is delivered. To be able to make decisions they must be well-informed. Communications services across the NHS will have a prime role in ensuring that information is both clear and accessible.
- 3.12.3 A project looking at the communications needs of the NHS and social services has been started and is due to report in early January. This will identify the needs, functions and accountability of communications in the different NHS organisations. It will also look at how social care can be better involved and supported – particularly important as Care Trusts begin to come on stream.
- 3.12.4 However, it is already clear that a lot of the spotlight will fall on Primary Care Trusts as these will be the lead organisations in assessing need, planning, securing and providing services. With the resources which will be available to them, it is likely they will need to work together to provide proper communications systems.
- 3.12.5 Strategic Health Authorities will also need to have communications and empowerment systems. As these new Health Authorities will have a performance management role, it would not be appropriate for them to provide communications services to Trusts and PCTs. However, StHAs will be expected to provide support and development to their local NHS organisations much as the current Regional Offices do now.
- 3.12.6 The need for robust communications, to handle serious untoward incidents, patients surveys and health information, as well as satisfying the media which is increasingly interested in health issues, will lead to a greater demand across the NHS for communications professionals. A structure that continues to develop a steady stream of skilled practitioners will be required to support and retain these people. Work is underway to determine how this will best be delivered.

4: Timetable for the Way Forward

- 4.1 *Securing Delivery* marked a key stage in the Government's programme for reform in the NHS, setting out plans for achieving change by decentralisation and empowerment.
- 4.2 Since *Securing Delivery*, we have published an HR Framework which set out the arrangements for handling staff moves between organisations (see <http://www.doh.gov.uk/shiftingthebalance/hrguidance/index.htm>), which was followed by HR Question and Answer material in October. We have also undertaken a series of parallel consultation exercises between September and November on the formation of 28 proposed new Health Authorities in April 2002 (which will then, subject to legislation, become Strategic Health Authorities in October 2002). <http://www.doh.gov.uk/shiftingthebalance/haconsultation/index.htm>
- 4.3 The timescales for future developments are:
- January – March 2002:**
- Strategic Health Authority Chief Executives developing staffing structures and franchise plans;
 - appointments to StHAs and PCTs;
 - PCT and StHA development programme underway;
 - final details of new arrangements and guidance available on: governance arrangements, the transition fund, management costs.
- April 2002:**
- existing Health Authorities disestablished;
 - new Health Authorities established;
 - franchise plans to be approved and new Health Authority CE appointments made by the new Board;
 - new PCTs will become operational;
 - new and existing PCTs will begin to take on their new/extended role (some functions eg family health services will only be formally transferred following enactment of the necessary legislation);
 - Directors of Health and Social Care will start operating.
- October 2002: (subject to legislation)**
- new Health Authorities to become Strategic Health Authorities;
 - PCTs formally take on all new functions.
- March 2003:**
- final date for the abolition of NHS Regional Offices.
- 4.4 This document has provided clarification on a number of areas where questions have been raised about future direction. It is important to recognise, however, that we have not embarked on a purely structural change which will be completed in a relatively short time-scale, but on a major programme of development which, as Chapter 1 indicates, will take a longer time to yield genuine and sustained change at the frontline.

Appendix A

Summary of Main Reactions to *Shifting the Balance of Power – Securing Delivery*

1. This document sets out the framework for implementing *Shifting the Balance of Power*. It builds on the discussion period on *Shifting the Balance of Power – Securing Delivery* in the autumn, the main results of which are set out in this appendix.
2. Over 400 responses were received in response to *Securing Delivery*. These responses were considered and thoughtful and have provided us with a clear picture of the reactions both to the principles of devolution and aspects of its implementation.
3. Responses were received from:
 - existing Primary Care Trusts who gave us an invaluable insight as to how the changes will affect both them and the many more PCTs that will be created;
 - existing Health Authorities and NHS Trusts;
 - Local Representative Committees, Voluntary Organisations, Community Health Councils, Local Authorities, Universities, Royal Colleges, major national representative bodies and numerous individuals.
4. Overall the general thrust of the policy has been extremely well received. The vast majority of the respondents have supported the aim of empowering frontline organisations, patients and staff. The necessary structural changes needed to achieve this aim – that is the strengthening of PCTs, changes in size, number and function of Health Authorities, and changes within the Department of Health – have also been well supported. Out of over 400 responses there have been no serious reservations about the direction of travel.
5. The concerns and questions which have been raised, relate mainly to the detailed implementation of the proposals rather than the policy direction. The main concerns expressed were about:
 - the pace of change and concerns at the speed we are moving (set against this however, there is support from some NHS organisations for moving quickly);
 - the capacity of PCTs to take on their new role fully from April 2002; scepticism as to whether or not they will have the adequate capability/capacity and resources to be robust organisations at the “cornerstone” of the NHS;
 - the disruption the changes may cause, and the ability of Health Authorities and subsequently Strategic Health Authorities to hold the programme together while they are re-organising and PCTs are developing.

6. There are also a number of specific areas where respondents have either expressed concern or identified the need for clarification, particularly where areas were not covered in *Securing Delivery*. The main points raised included the following:
- whether or not the principle of devolution will actually be demonstrated in practice; if indeed frontline staff and patients *will* be empowered significantly;
 - concern that the time and efforts required to successfully implement the structural changes will remove focus away from delivery of the NHS Plan;
 - the need to invest in PCT management and the feasibility and desirability of removing £100 million from the costs of management;
 - the need for clarity between some of the proposed roles of the Strategic Health Authorities and those proposed for the Directors of Health and Social Care;
 - how certain functions (for example the commissioning of services) or organisations (for example, Local Representative Committees) will fit into the new structure;
 - the need for clarity regarding the proposed governance arrangements for Primary Care Trusts and Strategic Health Authorities: various bodies wanted to ensure that they are appropriately represented; (Further guidance will follow on governance arrangements.)
 - a lack in understanding of plans for franchising within the NHS;
 - the need for clear clinical leadership;
 - the organisation of the public health function;
 - aspects of the proposals for public and patient representation;
 - the potential contribution of bodies such as local authorities.

Appendix B

Franchising Specification

Introduction

1. This specification sets out the areas which will need to be covered in the franchise plans developed by Chief Executives of HAs/StHAs. These arrangements will apply to the new HAs which will be created in April and will, subject to legislation, become StHAs later in the year. For simplicity the term Strategic Health Authority is used throughout.

Purpose of Franchising

2. Strategic Health Authorities will have a pivotal role in the new NHS, directly accountable to the Department of Health and responsible for the performance management of NHS Trusts, Primary Care Trusts and Workforce Development Confederations. In this context, we can think of the Strategic Health Authority being given the Franchise to manage the local NHS on behalf of the Secretary of State. Franchising will enable us to make best use of the skills in the NHS. It will mean that the CE and his/her top team will be committed to, and performance managed, against a shared plan.

The Franchise Plan

3. The key functions of StHAs are set out at Annex A. The Franchise Plan will need to specify how the CE proposes to deliver these functions, and will include three main elements:
 - a) the delivery plan for the StHA;
 - b) the style and process of working;
 - c) the proposed structure.
4. Each of the three elements is addressed in turn:
 - a) **The delivery plan for the StHA**

The Franchise Plan will need to set out what the CE envisages achieving over the 3 year franchise period, with firm plans for Year 1 and indicative plans for the following 2 years, consistent with NHS Plan requirements. The Plan should show how the Chief Executive will deliver the NHS Plan and achieve genuine improvements in the quality of health care, responsiveness to needs of patients and local communities and the health status of the population served. The Plan will demonstrate how through working with other organisations/stakeholders, the reduction of health inequalities and improved outcomes to patients will be achieved. Particular attention should be given to the areas set out in the 'Priorities and Planning Framework 2002/2003' (see <http://www.doh.gov.uk/planning2002-2003/index.htm>).

In particular, the Franchise Plan will set out:

- how national and local priorities will be met, identifying methodologies and milestones;
- a capacity plan setting out bed and placement capacity in health, social care and the private sector;
- a workforce plan setting out growth targets, recruitment and retention strategies, education, training and leadership;
- mechanisms for support for organisational development, information and capital planning;
- a financial programme encompassing NHS investment, joint investment with local authorities, local authority mainstream funding monies from area based initiatives;
- an information and IT plan setting out arrangements covering the delivery and performance of information systems;
- risk assessment and risk management plans.

The Plan will need to be soundly based reflecting the plans and targets of local PCTs, NHS Trusts and WDCs. It should also be informed by an assessment of the particular local issues affecting the StHA concerned eg workforce issues, no star Trusts, major capital changes anticipated, presence of specific services (eg high security hospitals). It should also reflect action taken to ensure performance improvement in areas highlighted as requiring local action through the performance ratings of host organisations.

b) Style and process of working

The Franchise Plan needs to describe the intended style of management and the relationships to be developed with key stakeholders locally. The management philosophy needs to be described including such areas as:

- deployment of staff/use of secondments;
- training and development;
- capacity/capability building in StHA and health system locally.

The StHA will be the leader of the NHS locally. The Plan will need to demonstrate how in the context of greater autonomy for PCTs and NHS Trusts, the following will be taken forward:

- local community involvement and involvement of key local partner agencies;
- staff involvement: for example methods and approaches to engage and empower nurses and midwives;
- patient and public involvement;
- ensuring strong, clear clinical and professional leadership and the involvement of all professional groups;
- equality and diversity in service delivery and employment;
- development.

The approach of the Strategic Health Authority to the modernisation agenda should also be described. This should set out how the Strategic Health Authority will develop capacity within each local health community in the areas of service redesign, clinical governance, leadership development, and patient and community engagement. In so doing, it should demonstrate how this work will enable both the delivery of national programmes (eg NSFs) and also local priorities as identified through the Local Modernisation Reviews.

The particular challenges of managing the local health system over the transition period and enabling PCTs to take on their new role fully should also be addressed.

c) The structure

The CE needs to set out the structure proposed for the Health Authority in order to deliver the functions set out in Annex A.

The following constraints will apply:

- a maximum headcount of 75;
- a maximum budget of £4 million to cover both staff and non staff costs, but with the expectation that the actual costs will be significantly lower.

An organogram or similar is required showing:

- Board level posts;
- other senior posts and their key responsibilities;
- the structure as a whole.

The Plan should identify:

the number, qualities, experience and aptitudes of the senior staff they wish to appoint. Plans will need to demonstrate how they can deliver director level leadership in the following fields:

- strategic clinical and professional leadership. In nursing, for example, how will a clearly identified senior nurse presence within the top team be secured, how will nursing input into the core functions be achieved and how will the StHA link to CNO as professional head of nursing;
- public health. Each StHA should have a public health doctor/medical director at top team level;
- performance management and delivery;
- finance. Each StHA should have a Director of Finance;
- commissioning;
- information management and IT;
- integration with other organisations;
- modernisation;
- strategic and local planning, with full involvement of catchment populations;
- national programmes such as NSFs and specialised services.

There is no requirement for staff to be employed exclusively by the StHA.

Managing Two Organisations

7. Where a candidate CE is submitting franchise bids to run two StHAs, they need to make clear in both bids how they will effectively manage their contribution to both organisations and any special arrangements they will need to put in place.

Duration of Plans

8. Franchise Plans should be drawn up to cover 3 years, with firm plans for the first and indicative plans for the following 2 years. There will be a rolling process of renewing Franchise Plans at the end of each year.

Approval of Plans

9. CEs will, at the beginning of March, discuss their developing plans with the DsHSC and their teams prior to submitting them to the Board in April. Following approval by the Board they will be submitted to the DHSC to form the basis of the performance agreement, both of the individual CE and Directors and of the organisation as a whole.

Annex A

Strategic Health Authority Functions

The main functions of the Strategic Health Authority are:

- creating a coherent Strategic Framework in consultation with stakeholders
- agreeing annual performance agreements and performance management
- building capacity and supporting performance improvement.

This will be undertaken within the context of encouraging greater autonomy for PCTs and NHS Trusts: the key role will be to ensure all organisations work together to deliver modernised patient centred services. Key elements of this role include:

- agreeing an Annual Delivery Agreement with the Department of Health and ensuring its delivery by the local health community;
- holding to account PCTs and NHS Trusts and WDCs through their Performance Agreements;
- creating a coherent Strategic Framework always in consultation with stakeholders which balances the needs and wishes of the population, commands the support of patients, local communities, PCTs, NHS Trusts and local authorities and ensures the reduction in health inequalities and the requirements of The NHS Plan;
- securing performance improvement where necessary by:
 - managing the performance of programmes and networks which span organisational boundaries;
 - supporting PCTs and NHS Trusts to improve the consistency and quality of healthcare through their Clinical Governance Programmes;
 - supporting PCTs and NHS Trusts to involve patients, the public, local communities, voluntary sector, health and social care professionals in developing and implementing plans to achieve more integrated patient centred services;
 - supporting PCTs and NHS Trusts to maximise their contribution to achieving the wider Government agenda to improve health and well being through Local Strategic Partnerships;
 - supporting the development of clinical networks and organisations that are fit for purpose;
- ensuring appropriate arrangements exist for securing the provision of national and regional specialist services;

- brokering strategic solutions as necessary to resolve conflicts and ensure delivery of objectives across the local health community;
- creating capacity through the preparation and delivery of cohesive strategies for capital investment, information management and the development of the workforce including managerial and clinical leadership;
- ensuring appropriate consultation on major service reconfiguration proposals that span organisations; and supporting local authorities with their responsibilities in this area;
- ensuring that effective arrangements exist with the Modernisation Agency, Commission for Health Improvement, National Clinical Assessment Authority and other statutory bodies which will enable Primary Care Trusts and NHS Trusts to meet national standards and improve performance;
- ensuring the provision of arrangements to ensure the proper leadership and involvement of professional groups.

Appendix C

Public Health

The Public Health Role in Primary Care Trusts

1. Every PCT will have a Director of Public Health on its board. This post will be a high level appointment and it is essential that the new posts are taken up by public health professionals of the highest calibre. Regional Directors of Public Health will have a key role in the selection process for these posts to provide the necessary quality assurance.
2. For the first time the director posts will be open to all suitably trained public health specialists (both medical and non-medical). National work, led by the Department of Health, is being undertaken to develop and strengthen the public health workforce and ensure that high quality training programmes are designed to deliver the next generation of public health professionals.
3. The new role for public health in primary care has enormous potential. The new Directors of Public Health and their teams will be the engines of public health delivery up and down the country. The focus of their activity will be on local neighbourhoods and communities, leading and driving programmes to improve health and reduce inequalities. They will also play a powerful role in forging partnerships with, and influencing, all local agencies to ensure the widest possible participation in the health and health care agenda. Partnership arrangements will vary but may involve joint appointments of the DPH to a PCT and local authority where this is deemed to be sensible.
4. It will also be the job of the public health teams in Primary Care Trusts to ensure that maximum improvement to health is brought about by prevention and other interventions – for example making sure that everyone with hypertension is being effectively treated, using smoking cessation services to achieve the best possible long-term ‘quit’ rates, ensuring that the primary care element of the targets of National Service Frameworks (e.g. for coronary heart disease) are met, making the most of opportunities provided by Sure Start and other cross-cutting social and health programmes.
5. The Director of Public Health will not be a remote strategic figure. She or he will be well known, respected and credible with local people – particularly those in the most deprived communities, local authorities, general practitioners and other local clinicians. They will be accessible to local media, explaining and educating on health and inequalities issues. The Director of Public Health will have a team whose composition is a matter for local determination. However, they will also seek to ensure that the public health role of the primary care workforce (e.g. health visitors, school nurses, health promotion and other community workers) is fully realised by encouraging practitioners to lead specific programmes.

Health Protection and Infectious Diseases

6. There is no doubt we possess a world-class system for public health surveillance, and outstanding public health specialists. The strand of the public health function that addresses the prevention and control of infectious diseases is a vital one. Even before the events of 11th September 2001 in the United States, we recognised its importance, for example, in combating new and emerging infections, in tackling the

resurgence of diseases like tuberculosis and in trying to turn the tide on health care associated infection and anti-microbial resistance. Since September 11th we have once again seen the strength of this element of our public health function in the excellent emergency planning work undertaken to prepare against the possible threat from bio-terrorism.

7. We recognise the professional excellence of the Public Health Laboratory Service and particularly its communicable disease surveillance centre. We value the expertise of consultants in communicable disease control and their teams working in local public health departments. We increasingly see demonstrations of the importance of Regional Directors of Public Health with their overarching responsibility and co-ordinating role in relation to health protection in the regions.
8. We need to build on these major strengths and ensure better co-ordination of the health protection function so that there is a clear line of sight from national to regional to local level. This recognises that protecting the population against infectious diseases, has common features with action necessary to protect the public against chemical or radiation hazards: surveillance, outbreak investigation, instigating control measures, utilising diagnostic and treatment services.
9. This desire to achieve a better co-ordinated and integrated service is at the heart of the proposals being prepared by Sir Liam Donaldson, the Chief Medical Officer. The details of how this will be implemented will be set out as part of the proposals in the forthcoming infectious diseases strategy.

Public Health Networks

10. This local public health action needs to be underpinned by a range of specialist expertise which cannot be provided in every Primary Care Trust.
11. This need will be fulfilled by public health networks. The purpose of the networks will be to pool expertise and skills in specialist areas of public health which can then be available to all Primary Care Trusts, to share good practice, manage public health knowledge and very importantly, act as a source of learning and professional development.
12. Public health networks will not be an additional tier of NHS management. They will not be a vehicle for performance management of the public health function. They will not adhere to rigid professional boundaries.
13. Public health networks will be flexible and responsive and will change and evolve over time. For example, a network will be able to respond to cities for public health advice and action programmes. New NHS structures will not be able to match every local authority boundary but a flexible responsive network would, for example, be able to support 'healthy cities' initiatives, so vital in many parts of the country.
14. This country has a long and highly respected tradition in academic epidemiology and public health. It has been vital in contributing to the knowledge base for disease prevention. Its high quality is internationally recognised. Academic departments of public health in universities (with and without medical schools) have also played a vital part in education and training, not just of public health staff but a wide range of other health professionals. It is essential that these academic strengths are preserved and maintained in the changes. It is important that the existing public health research and development funding by Health Authorities continues to be spent on public health R&D. We are considering the most appropriate management arrangements to ensure this.

15. Public health networks will also include non-Governmental organisations which have a key role to play in improving health and reducing inequalities and also dental public health.
16. Public health networks will be designed 'bottom up'. The precise composition and way of organising the network is a matter for local decision-making and the Regional Director of Public Health will be responsible for ensuring that they are properly established and function effectively over time.

Regional Directors of Public Health and their Teams

17. From April 2002, the Regional Directors of Public Health and their teams will be located as the Department of Health's presence in each of the regional offices of Government.
18. The Regional Director of Public Health's responsibilities will necessarily be major and wide-ranging in relation to:

a. Protecting the Public Health

Regional Directors of Public Health will be accountable for ensuring that there are appropriate high quality health protection arrangements (covering infectious diseases and other risks to health) in place in all locations in their region. They will also be accountable for managing and co-ordinating the health aspects of the Government's response to emergencies and disasters.

b. Tackling the Wider Determinants of Poor Health and Inequalities

For the first time, the Department of Health's Regional Directors of Public Health and their teams will be uniquely positioned to work with other Government Departments in the regions to build a strong health component into regional programmes in areas such as transport, environment and urban regeneration. Tackling the fundamental root causes of poor health and inequalities is vital to underpin effective local public health action. Their wider public health role will allow Regional Directors of Public Health to inform the accreditation of local strategic partnerships.

c. Serious Failures in Standards of Care

The Regional Director of Public Health (together with the senior lead nurse) will be responsible for securing and providing professional advice to the Director of Health and Social Care generally, and particularly in this area. Much of the work with regard to clinical governance and serious incidents will be managed through Strategic Health Authorities. It is vital that capacity to deal with such incidents is built up during the transitional period. The Regional Director of Public Health will be responsible for building the capacity and also be the point of contact for any clinical governance issues that are likely to give rise to grave public concern. She/he will be an important source of advice on how these should be handled, and in particular on whether or not a CHI investigation is required.

d. Leadership and Development

Regional Directors of Public Health will have an important role in developing and mentoring the public health function in their regions. A key feature of this will be through their involvement and oversight of the design and running of public health networks. In relation to the NHS, they will continue to play a strong medical leadership role.

Regional Directors of Public Health will be managerially accountable for their public health and health protection functions to the Chief Medical Officer as well as to the relevant Director of Health and Social Care. They will also need to work closely with the regional offices of Government Directors on jointly agreed work programmes and will be expected to contribute fully to the corporate business of the Regional Offices of Government.

e. Public Health Observatories

Information is a vital resource to inform policy-making, performance management and local action. Public health observatories play an important role in developing and analysing data and making public health information readily available to a wide audience. They will continue this role and seek to enhance links with intelligence systems across all Government Departments and with other organisations. Their extended role will include closer links with cancer registries, establishing HES safe havens, widening access to drug misuse databases and a role in analysis of, and dissemination of, infectious disease surveillance data. At a local level public health staff will need analytical support and this should be provided as part of the public health network and linked to the observatories.

Public Health in Strategic Health Authorities

19. Strategic Health Authorities will have a distinctive performance management role in relation to the constituent NHS organisations within their boundaries, taking over many of the functions of the existing NHS Regional Offices.
20. Good outcomes of health care contribute to the health of the population. Successful implementation of clinical governance in NHS Trusts and Primary Care Trusts therefore has an important part to play in achieving public health goals as does the functioning of cancer and other clinical networks. A successful Strategic Health Authority will lead and performance-manage to ensure that each of the organisations for which it is responsible has vibrant clinical governance arrangements and powerful, effective clinical networks.
21. Whilst not duplicating the work of Directors of Public Health in Primary Care Trusts or that of the Regional Directors of Public Health, Strategic Health Authorities will also have responsibility for the performance management of public health action within Primary Care Trusts and in hospital Trusts. This is not about managing people but about Primary Care Trust performance across Public Health.
22. This means that each Strategic Health Authority will need a medical director/public health doctor with the appropriate strategic management skills to undertake this function as a member of its top team.

Appendix D

Nursing

Clinical and Professional Leadership in Nursing, Midwifery and Health Visiting

1. Nurses and midwives are the largest staff group in the NHS delivering 80% of care, 24 hours a day, 365 days a year. Their commitment and active engagement is essential for delivering the NHS Plan and improving health and health care. A visible, senior lead nurse with credibility, strategic experience and the skills required of a modern leader will be provided at every level of the NHS to ensure that the contribution of front line nurses and midwives is optimised and high quality services are delivered.
2. Shifting the Balance of Power will bring about new forms of nursing leadership and a change in the culture of management and leadership – from the DH to the front line. New forms of nurse leadership will include:
 - a style that is demonstrably facilitative and values the contribution of all;
 - a style of working that facilitates the sharing and development of good practice;
 - devolving power whilst at the same time ensuring service quality through clinical governance and learning from service evaluations such as CHI;
 - a structured approach to engaging front line staff across the NHS, such as the Standing Conference for nurses, midwives and health visitors in London;
 - a multi-disciplinary approach to clinical leadership reflecting new ways of working within health and social care.
3. In many parts of the country lead nurses and midwives are breaking the mould of traditional hierarchical nurse management by devolving power, facilitating shared governance, setting up new structures and networks and developing leadership within the front line. The National Nurse Leadership Centre is supporting this work. Shifting the Balance of Power will strengthen these new forms of leadership by integrating new approaches within the core structures of the NHS.

PCTs

4. Every PCT will have a senior, experienced lead nurse to provide clinical and professional leadership for front line nurses and to input to the corporate functions of the PCT. This role will become even more important as PCT responsibilities increase and they are required to engage and empower frontline nurses, midwives and health visitors. Clinical leadership is not only the responsibility of the lead nurse; nurses on the Professional Executive Committee will also have a key role in clinical leadership and empowering frontline staff. The National PCT Development Programme and the Leadership Centre of the Modernisation Agency are strengthening the leadership skills of these nurses through a range of local and national programmes.

StHAs

5. Strategic Health Authorities will have a senior lead nurse on the top team with the competencies and experience to function at this level. Their role will be to ensure that clinical governance, performance improvement and strategic decision making are clinically informed and deliverable in practice. They will develop networks with front line staff across the NHS, provide a link to the Chief Nursing Officer and discharge the StHA responsibility for the statutory supervision of midwives. In their franchise plans Chief Executives will have to demonstrate how they will secure senior nursing and midwifery leadership within the StHA.

Directors of Health and Social Care

6. In order to develop strong networks with frontline staff and optimise the nursing contribution to health and social care, DsHSC will have a senior nurse as part of their top team with high levels of credibility and skills who inspires confidence within and outside the NHS. This person is likely also to have another core team role and will report directly to the DHSC and the Chief Nursing Officer. They will also provide nursing and midwifery advice to the RDPHs.

Summary

7. Shifting the balance of power to the frontline aims to improve services by giving those who deliver health care a greater say in how the service is run and delivered. Nurses and midwives are the largest staff group in the NHS, close to patients and their carers and crucial to delivery of The NHS Plan. Three vital elements will be put in place to optimise their contribution:
 - local nursing, midwifery and health visiting networks that empower front line staff and develop practice;
 - senior nurse leaders in key strategic positions in PCTs, Trusts, StHAs and DsHSC; and
 - an effective network of senior strategic lead nurses to enable CNO to advance the corporate agenda and discharge her head of profession function.
8. These new leaders will develop and nurture new and innovative ways of engaging and sustaining the contribution of the largest part of the NHS workforce whilst playing a lead role in ensuring clinical governance.

Appendix E

Quality and Safety

Maintaining and Developing the NHS Quality Framework

1. Over the last four years, the Government, the NHS and the health professions working in partnership have developed a co-operative framework for the quality of care in the NHS. The details are set out in a document signed by the Secretary of State for Health and the medical professional leaders called “A Commitment to Quality, a Quest for Excellence” in July 2001 (www.doh.gov.uk/cmo/quality.htm).
2. This NHS quality framework is attracting a great deal of interest internationally and aspects of it are being developed in collaboration with the United States of America. This was recognised by the agreement signed by Alan Milburn and the U.S Secretary for Health, Tommy Thompson, in Washington DC in October 2001.
3. At a time of changing roles and responsibilities within the NHS, it is essential that the impetus is not lost in the development and implementation of the quality programme.
4. Other documents describe roles and responsibilities in detail but in this Appendix the key points that need to be taken account of are summarised:

a. Duty of Quality

Every local NHS organisation has a statutory duty to assure, monitor and improve the quality of its services. This has been implemented through the clinical governance programme. Primary Care Trusts are required to have robust clinical governance arrangements in place as well as to ensure that in commissioning services from NHS and other providers that quality and safety are core elements of their commissioning decisions.

The principles of clinical governance are set out in “A First Class Service: Quality in the new NHS”. Support in developing clinical governance is provided by the National Clinical Governance Support Team (CGST) which has already run programmes for more than 200 organisations. Details of the CGST and its work can be found at www.doh.gov.uk/clinicalgovernance.

b. Poor Practitioner Performance

It is essential in protecting patients that instances of poor practitioner performance are recognised much earlier than they have been in the past and effective solutions found. It is anticipated that many more doctors who are performing poorly (whether in general practice or in hospital medicine) will in future be helped by retraining or other means to restore an acceptable standard of practice.

The principles in protecting patients against poorly performing doctors are set out in “Supporting Doctors, Protecting Patients”. This document is viewable at <http://www.doh.gov.uk/cmoconsult.htm>.

A key role will be played by the National Clinical Assessment Authority (NCAA) whose Medical Director should be contacted by Chief Executives or Medical Directors of PCTs or NHS Trusts where there are concerns.

Details of the NCAA's role can be found at www.ncaa.nhs.uk.

c. Commission for Health Improvement

The Commission for Health Improvement's role is to undertake a rolling programme of clinical governance reviews for NHS organisations and investigate serious service failure. CHI will also review progress with the standards set in National Service Frameworks, in the NHS Cancer Plan and in NICE guidance.

The NHS Reform and Health Care Professions Bill set out proposals to strengthen the role of CHI and increase its independence. CHI will be given a new function of carrying out inspections of quality against clear published criteria – CHI will continue to publish its reports. They will be able to recommend to the Secretary of State when special measures are warranted to address significant failings in NHS services.

Whilst PCTs, NHS Trusts and StHAs may call in the Commission for Health Improvement (CHI) directly, where there are serious concerns about the performance of service, standards of care or the safety of a service, contact should be made with the Regional Director of Public Health who will be based in one of the Regional Offices of Government (and will be part of the Department of Health's senior management team). The Regional Director of Public Health will discuss the matter with relevant senior officials in the Department of Health. Decisions will then be taken on what further investigation or action is appropriate.

d. Patient Safety

A programme to establish a system to report, record and learn from adverse events and near misses was proposed in "An Organisation with a Memory" (www.doh.gov.uk/orgmemreport), endorsed in the NHS Plan and developed further in "Building a Safer NHS for Patients" (www.doh.gov.uk/buildsafenhhs).

The new system is currently being piloted in 26 NHS sites under the supervision of the National Patient Safety Agency (NPSA). From early 2002 the reporting system will be rolled out to all NHS Trusts and Primary Care Trusts and will be overseen and managed by the NPSA.

Details of the NPSA's role are set out at www.npsa.org.uk

e. Appraisal for Doctors

It is the Government's plan to introduce appraisal for all NHS doctors over the next year. Appraisal for consultants was introduced in April 2001 and the scheme is to be rolled out for non-consultant career grades, junior doctors, locums and GPs. The scheme is designed to dovetail with the GMC's plans for revalidation planned to be launched next year. Annual appraisal will be based on the GMC's headings of "Good Medical Practice" and will consider for example how well doctors have kept up to date, the quality of their practice and individual development needs. This establishes important links between the duty of quality, clinical governance and appraisal.

Further details can be found at www.doh.gov.uk/nhsexec/consultantappraisal

f. Patient Experience

These reforms will and must be driven by giving patients a greater voice in the running of the NHS. Patients will become active partners in their care, receiving more information so they can make more informed choices, both about the health services they receive and about their own treatment. Communities will also be involved in the strategic planning and decision making to ensure the NHS is responsive both clinically and to patient experience overall.

Good patient experience demands more than providing good and safe clinical care and improving public involvement. It requires an environment that is clean, warm and welcoming – where the buildings and people inspire confidence and pride – a system which treats patients as individuals.

A listening exercise was carried out in 2001 to develop further our proposals for involving patients and the public in healthcare (see <http://www.doh.gov.uk/involvingpatients>) The proposals, subject to the approval of Parliament, will lead to the replacement of Community Health Councils with Patients' Forums in every NHS Trust and Primary Care Trust and the creation of a Commission for Patient and Public Involvement in Health. Local authorities are also being given powers to scrutinise the development of health services in their area.

From April 2002 a Patient Advice and Liaison Service will be established in every NHS Trust and PCT to provide information and on the spot help for patients, carers and their families. In addition to PALS, Independent Complaints Advocacy Services will provide an independent source of information and support for people making complaints.

The NHS complaints procedure will be replaced with a more responsive and independent mechanism for dealing with complaints and the system for clinical negligence is currently being reformed to resolve disputes more quickly and more satisfactorily.

Patient experience will be central to any assessment of performance. All NHS organisations will undertake a new patient survey programme and will publish the survey results and action taken to address any shortfalls identified by patients in a new patient prospectus.

In planning and overseeing NHS services, NHS Trusts, PCTs and StHAs will need to ensure full and active patient and public involvement. The new proposals described above will provide the principal vehicle for achieving this. The degree to which NHS Trusts, PCTs and StHAs can engage and work constructively with them will be key to successfully addressing the patient experience in the long term.