Department of Health

Shifting the Balance of Power within the NHS

Securing Delivery

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July 2001

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Foreword by Nigel Crisp

The NHS Plan is about delivering improvements for patients and the public.

All our efforts need to be focused on supporting front line staff to deliver these improvements and empowering them to make decisions locally.

This document sets out the organisational changes we are making to support this:

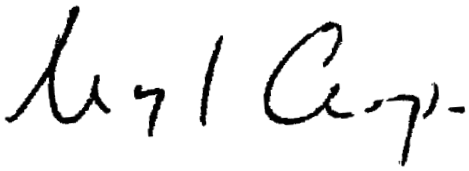
- developing Primary Care Trusts to fulfil their potential.
- creating fewer, larger and more strategic health authorities.
- re-focusing the Department of Health on doing only those things which only it can do.

It stresses our determination:

- to make these changes quickly
- to support individual members of staff through them, recognising the uncertainty and insecurity they bring for many people.
- to use the Modernisation Agency and Leadership Centre to develop new approaches and new ways of working.
- to develop a new and more patient-centred service.
- to make organisational changes designed to support a bigger and longer term change in culture and ways of working.

A complimentary document setting out guidance on the human resource issues associated with these changes will be published next week.

Comments are welcome by 7th September and should be addressed to Shifting the Balance of Power, Department of Health, Room 429 Richmond House, 79 Whitehall, London, SW1A 2NS or sent by e-mail to STBOP@doh.gsi.gov.uk



Nigel Crisp

Executive Summary

1. The NHS Plan sets out a long term programme for reform and performance improvement in the NHS. Delivering the Plan will be in part about investment and expansion of the service. But it will also be about reform. Reform to address those issues that really affect patients, reform to empower patients to have a greater say in their care and the development of their local services. Reform also to break down the demarcations between different professional groups and organisations. Reform to free frontline staff to use their skills to redesign services and improve performance.

2. Delivering this agenda requires real change in the way the NHS works. Reform in the NHS has to come from within the NHS. The balance of power must be shifted towards frontline staff who understand patients' needs and concerns. A shift in the balance towards local communities so that they reconnect with their services and have real influence over their development. Frontline staff need to be in charge of frontline services and have the power to manage to meet the local communities needs – always within the context of clear national standards and a strong accountability framework. The NHS must support frontline staff and engage local communities to deliver the necessary reform to deliver faster more responsive high quality services.

3. The changes to the way the NHS works will require cultural change supported by structural change to align responsibilities and capacity at the most local levels. This will mean change at all levels of the NHS and the Department of Health. In brief the main responsibilities within the NHS will be:

   - **PCTs** will become the lead NHS organisation in assessing need, planning and securing all health services and improving health. They will forge new partnerships with local communities and lead the NHS contribution to joint work with local government and other partners.

- **NHS Trusts** will continue to provide services, working within delivery agreements with PCTs. Trusts will be expected to devolve greater responsibility to clinical teams and to foster and encourage the growth of clinical networks across NHS organisations. High performing Trusts will earn greater freedoms and autonomy in recognition of their achievements

- About 30 **Strategic Health Authorities** will replace the existing 95 Health Authorities. They will step back from service planning and commissioning to lead the strategic development of the local health service and performance manage PCTs and NHS Trusts on the basis of local accountability agreements

- The **Department of Health** will change the way it relates to the NHS, focusing on supporting the delivery of the NHS Plan. The Department of Health Regional Offices will be abolished and four new Regional Directors of Health and Social Care will oversee the development of the NHS and provide the link between NHS organisations and the central department. Modernisation Agency, Leadership Centre and the University of NHS will support the development of frontline staff and services.

4. Resources will be devolved alongside responsibilities. Revenue allocations will be made direct to PCTs rather than to Strategic Health Authorities. PCTs and NHS Trusts will also receive direct capital allocations for the maintenance of their facilities. Strategic Health Authorities will control further capital allocations to lever strategic change and service modernisation.

5. Patients and the public will be more involved in the NHS, as the NHS moves to towards a model of increased partnership, with patients and the public having their say in how services are designed, developed and delivered. Patient Advocacy and Liaison Services and Patients Forums in every NHS Trust and PCT will provide more support to patients and provide new ways for them to influence decision making in the NHS.

6. Improvements in NHS performance are driven by the people working within the NHS. It is essential that the reorganisation needed to shift the balance of power is carried out in a way that retains the talents of those working in the NHS and matches people to the key challenges facing the NHS. The process must also be completed quickly, providing staff with as much security as possible and enabling them to concentrate on the service delivery agenda.

7. The appointment of Strategic Health Authority Chief Executives will see the introduction of NHS Franchising to promote innovation in NHS management. Open competition will provide a shortlist of managers to be invited to bid for the Strategic Health Authority franchises and produce a franchise plan setting out how they will deliver reform across the local health economy.

8. New structures alone will not deliver the necessary reform. Working practices and cultures must reform to give more power and influence to patients and frontline staff. New incentives will reward devolution to frontline teams and a major development programme will support PCTs as they gear up to take on their new roles.

9. Change is already underway and the process will be completed quickly. Formal consultation on the boundaries for Strategic Health Authorities will take place in the autumn, leading to their establishment in April 2002. The remaining structural changes will be complete by 2003.

10. It is vital that NHS organisations remain focused on the delivery of improvements to services required by the NHS Plan during this period. The organisational changes set out in this document are to support this focus on delivery.

Shifting the Balance of Power within the NHS – Securing Delivery

Introduction

1. This document summarises the work carried out so far to develop the proposals announced by Secretary of State in his speech to launch the Modernisation Agency in April to shift the balance of power in the NHS and empower NHS staff and local communities.

2. The Secretary of State's speech has heralded a major change process in the NHS. Everything possible should be done to minimise disruption if the NHS is to remain focused on its delivery of the NHS Plan. By getting clarity and moving at a quick and sustained pace the NHS can reorganise and continue to deliver. Reorganising is not an aim in itself, but simply one of the actions we have to take in order to focus on delivering the NHS Plan.

3. A National Steering Group led by Neil McKay, Chief Operating Officer, Department of Health, involving members of the Modernisation Board has taken forward the work building on the key elements of the Secretary of State's proposals to produce this document.

4. The document considers:

   - The **context** within which these reforms are being made
   - The **Roles, Responsibilities and Relationships** for NHS bodies reflecting a shift in the balance of power
   - **New ways of working** to **devolve power to frontline staff** and a new approach to **involving patients and the public** within the NHS
   - The practicalities of managing the change including **boundaries, HR and development issues.**

5. This document sets out the emerging views of how the new system will look and how it will operate. The views of the NHS and its stakeholders are vital. You are asked to share this document with as wide an audience as possible – of staff, partner organisations (especially Local Government), patients and consumer organisations.

PLEASE SEND YOUR COMMENTS BY EMAIL TO STBOP@doh.gsi.gov.uk OR TO SHIFTING THE BALANCE OF POWER, ROOM 429 RICHMOND HOUSE, 79 WHITEHALL, LONDON SW1A 2NS BY 7th SEPTEMBER 2001.

Aims and Context

6. People want the security of knowing that their health and well being is catered for. This means they want a NHS that provides fast and responsive services within a national framework that ensures national standards are consistently at a high level of quality. They want a NHS that is responsive to their needs and listens to their views – a patient centred NHS.

7. The NHS Plan sets out a long term plan for reform and performance improvement within the NHS to meet these needs. Delivering the NHS Plan will depend both on extra capacity – the 20,000 more Nurses, and 10,000 more Doctors will be recruited – and reform.

8. Over the last four years new national standards have been introduced across the NHS, tackling the lottery of care which so undermines public confidence in the NHS. National standards are in place for cancer, CHD, mental health and older people. The National Institute for Clinical Excellence gives advice about new treatments and the Commission for Health Improvement is providing external inspection and assessment for the first time. These changes represent the start of a reform process putting in place clear national standards and a strong accountability framework to ensure consistently high standards are delivered throughout the NHS.

9. The challenge now is to reform the way we deliver healthcare. Delivering the NHS Plan will involve new ways of working across the service. There needs to be a more equal relationship between the NHS and patients. Patients must be better informed and more in control of their care. New approaches to the delivery of care will be needed to speed up treatment and increase responsiveness. And new approaches to tackle the traditional demarcations between different professional groups and services will pave the way for innovative care pathways which better meet patients' needs.

10. This challenge cannot be met from Whitehall. The improvements to services can only be delivered by frontline staff working with patients and the public – reform must come from within the NHS. The reforms will be achieved through decentralisation and empowerment. The three key elements to our approach are:

- **Empowering frontline staff**. Frontline staff are best placed to understand the needs of patients, and have the skills and knowledge to develop innovative services to meet those needs. We need to devolve power in the NHS so that frontline staff have a greater say in how services are delivered and resources are allocated.

- **Empowering patients**. We need to develop a patient centred service were patients are seen as active partners in their care. Patients need to have more information about and more influence over their care. The NHS must re-engage local communities to involve patients and the public in the design, delivery and development of local services.

- **Changing the culture and structure of the NHS.** This is needed to support and empower patients, the public and frontline staff. We need to change the way we work at all levels. Structural changes to devolve power and responsibility to frontline organisations, and to PCTs led by clinicians and local people in particular. And changes to the culture and working practices within organisations to devolve decisions to frontline staff and encourage the development of clinical networks across organisations.

Roles, Responsibilities and Relationships of PCTs, NHS Trusts, Strategic Health Authorities and Regional Offices

11. The existing structures within the NHS are not conducive to devolving power to frontline staff and local communities. Too many decisions are taken too far from the frontline.

12. The new roles, responsibilities and relationships for NHS bodies must support devolution of greater power to frontline staff and local communities. This section of the document outlines how the functions of NHS bodies can be developed to do this. It will mean a bigger role for PCTs with their strong clinical leadership and close connection with their local communities. It will mean new ways of working for NHS Trusts with greater devolution of decision making to clinical teams and deeper co-operation with other parts of the NHS. It will mean new roles for more Strategic Health Authorities in performance managing the system and driving reform. The Department of Health will withdraw from some of the hands-on performance management to

oversee the development of the NHS and concentrate on supporting delivery of the NHS Plan. Further details are provided in Annex A.

Primary Care Trusts

13. PCTs are the most local NHS organisation and are led by clinicians and local people. Devolving power and responsibility to PCTs lies at the heart of our proposals. PCTs will be the cornerstone of the local NHS. Devolving power and responsibility to PCTs offers real opportunities to engage local communities in the decisions that effect their local health services. This will be one of the key changes facilitated by the new role for PCTs. PCTs will also be expected to ensure that more power is available for frontline staff.

14. PCTs will be responsible for improving health and securing the provision of services to meet the needs of their local community, building new partnerships with a range of partners including local authorities, NHS Trusts, Strategic Health Authorities, other PCTs and local communities. The functions of a PCT are briefly described below.

i. Improving the Health of the Community

15. PCTs will be responsible for assessing the health needs of their local community and preparing plans for health improvement which recognise the diversity of local needs. A strengthened public health function will be needed in PCTs to support this needs assessment and to ensure that public health surveillance and population screening are carried out across local communities. In practice some of these functions may be delivered by PCTs co-operating through public health networks to pool resources and talent.

16. PCTs will engage in improving the health of the local community through community development, health promotion and education and occupational health services. They will be the lead NHS organisation for partnership working with local authorities and other partners to improve the health of local communities and to deliver wider objectives for social and economic regeneration. PCTs will work as part of Local Strategic Partnerships to ensure co-ordination of planning and community engagement, integration of service delivery and input to the wider government agenda including Modernising Social Services, Sure Start, Community Safety, Quality Protects, Youth Offending Teams and Regeneration Initiatives.

ii Securing the Provision of Services

17. PCTs currently provide or secure the provision of a limited range of services, including primary, community care and secondary care services. In future PCTs will take responsibility for securing the provision of the full range of services for their local populations as Strategic Health Authorities step back from a hands on commissioning role.

18. PCTs will take on responsibility for all family health service practitioners. This will allow for a coherent view of the development of all NHS services in the area. PCTs will have responsibility for the management, development and integration of all primary care services (medical, dental, pharmaceutical and optical) in the light of the changes set out in the NHS Plan, "Modernising NHS Dentistry - Implementing the NHS Plan" and "Pharmacy in the Future".

19. PCTs will have a clear lead in developing local services and will be able to tailor services to local needs. If this is to be achieved successfully PCTs will need to fully engage their frontline staff and local communities and partners in their plans for improving health and health services. The opportunity for PCTs as primarily local organisations to engage and empower local communities, patients and frontline staff should bring improvements in local services.

20. As primarily local organisations PCTs will need to co-operate to secure the full range of services for their local community. Commissioning of tertiary services is likely to require PCTs within a Strategic Health Authority to actively collaborate on a health authority wide commissioning plan. Some specialist services will require even greater collaboration to allow commissioning at a higher level.

iii Integrating Health and Social Care

21. PCTs working with local authorities should maximise opportunities for patients and clients by the integration of health and social care through the use of the Health Act flexibilities and through the use of the Health and Social Care Act 2001 and the well-being power in the Local Government Act 2000.

22. Where local partners agree, Care Trusts will be important vehicles for modernising both social and health care, helping to ensure that integrated services are focused on the needs of patients and users. They will create a stable organisational framework for long-term service and organisational continuity and the kind of joined-up personal contact needed to improve services. They will enable staff to shape a new organisation around patient and user needs and provide a system that supports them in doing their jobs and rewards them for working together.

NHS Trusts

23. NHS Trusts will be responsible for providing high quality and accessible patient centred services within a framework of national standards and local agreements. They will work with PCTs, Strategic Health Authorities and other partners to meet the health care needs of communities.

24. NHS Trusts must become increasingly patient centred organisations and will be required to devolve more responsibility to clinical teams who are best able to meet patients' needs. The new structures for patient and public involvement (see sections 64 to 69) will enable Trusts to fully engage patients and involve them in decisions about the development of services.

25. Shifting the balance of power towards clinical teams will involve further development of clinical networks able to deliver and develop services across organisations and over the entire patient journey, ensuring that clinicians are in control of these services. More responsibility for delivery and development of services within NHS Trusts will also be delegated to clinicians. Modern Matrons will ensure that basic standards of care are maintained and clinicians will become involved in decisions on capital improvement programmes within PCTs and NHS Trusts.

Strategic Health Authorities

26. Strategic Health Authorities will be new organisations. They will be larger than the current HAs, covering an average population of around 1.5m, and roughly aligned with clinical networks. While the responsibility for securing local health services will be devolved to PCTs, Strategic Health Authorities will provide strategic leadership to ensure the delivery of improvements in health and health services locally by PCTs and NHS Trusts within the national framework of developing a patient-centred NHS. They will lead the development and empowerment of innovative and uniformly excellent frontline NHS organisations. The wider span of control will enable Strategic Health Authorities to consider the overall needs of the health economy across primary, community, secondary and tertiary care, and work with PCTs and NHS trusts to deliver a programme to meet these needs.

27. The key role of Strategic Health Authorities will be to ensure that all NHS organisations work together to deliver the NHS Plan for modernised patient centred services. A brief description of the functions of Strategic Health Authorities is provided below.

i. Creating a coherent strategic framework

28. Strategic Health Authorities will be charged with creating a coherent strategic framework for the development of services across the full range of local NHS organisations. They will also consider how to provide those services that need to be delivered on an authority wide basis. To command support, Strategic Health Authorities will carry out these roles in consultation with stakeholders balancing the needs and concerns of local people.

29. As part of creating a strategic framework Strategic Health Authorities will have responsibility for ensuring strong and coherent professional leadership and the involvement of all professional groups, particularly medicine and nursing.

ii. Agreeing Annual Performance Agreements and Performance Management

30. The Strategic Health Authority will take over performance management of local NHS Trusts and PCTs. Both of which will be accountable to the Strategic Health Authority. In turn Strategic Health Authorities will account to the Secretary of State for the performance of the NHS in their area. An annual delivery agreement between the Strategic Health Authority and the Department of Health will set out the progress expected against the NHS Plan. This will build on Performance Agreements with individual PCTs and NHS Trusts. Strategic Health Authorities will also be expected to manage performance across organisational boundaries and networks to secure the best possible improvements for patients. They will lead on the creation and development of public health networks to ensure sound clinical performance and patient safety arrangements.

31. Where conflicts occur between local NHS bodies or problems arise that threaten the delivery of objectives the Strategic Health Authority will intervene and broker solutions as necessary.

iii. Building Capacity and supporting performance improvement

32. Strategic Health Authorities will support performance improvement by working with local PCTs and Trusts to enhance the involvement of patients, the public and health and social care professions in developing services. They will also support the implementation of clinical governance programmes to improve the quality and consistency of care and through the development of clinical networks across organisations.

33. The Strategic Health Authority will work with the Modernisation Agency, Commission for Health Improvement, National Clinical Assessment Authority and other bodies to ensure local PCTs and NHS Trusts are equipped to meet national standards and improve performance.

34. Strategic Health Authorities will create 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.

35. Workforce Development Confederations have recently been established to give a clear leadership and direction to workforce planning and development. They will continue to have a separate identity to maintain their focus on workforce issues but they should be aligned to, or coterminous with, the new Strategic Health Authorities. Further consideration of their accountability arrangements and their relationships with the Post Graduate Deaneries will be required.

Numbers and Boundaries for Strategic Health Authorities

36. Initial discussions have taken place in each Region about the numbers and boundaries of Strategic Health Authorities to serve populations of about 1.5 million. Two principles will be followed. Firstly, that the new Strategic Health Authority boundaries should be coterminous with an aggregate of Local Authorities. Secondly, the boundaries of Strategic Health Authorities should not cut across Government Office boundaries.

37. There will be full public consultation on the boundaries for the new Strategic Health Authorities. Further guidance on the consultation process will be published shortly. Proposals for the new Strategic Health Authorities will need to establish:

- the benefits for patients to be derived from the boundary changes;
- a migration plan for the devolution to PCTs of their new responsibilities;
- ways of involving patients, the public and staff comprehensively in the delivery of a modernised NHS;
- outline costs associated with the implementation of the new system.

The Department of Health and Regional Directors of Health and Social Care

38. As responsibility is devolved to the frontline the Department of Health will need to change the way it works and its relationship with the NHS. This will mean changes for the headquarters of the Department and the Regional Offices.

39. The Department of Health is reorganising to meet the conclusions of the Departmental Review launched by the Chief Executive/Permanent Secretary. The overall aim is to create a much stronger focus on delivery, with a clear line of sight from the Headquarters to the NHS. These changes reflect a change in emphasis from the policy development associated with putting in place a strong national framework and the NHS Plan, to the practical implications of delivering the NHS Plan.

40. There will be substantial changes to the way the Department relates to the NHS and in particular its regional focus. The existing Department of Health Regional Offices will be abolished. New Regional Directors of Health and Social Care will oversee the development of local services. But the performance management function previously carried out by the Regional Offices will be devolved to Strategic Health Authorities. The Regional Directors of Health and Social Care will be national Directors of the Department of Health and will provide the link between the NHS and the Department.

41. Regional Directors of Health and Social Care will maintain key links to Strategic Health Authorities, Local Authorities and Government Offices of the Regions. They will operate on behalf of the Chief Executive of the Department of Health, using standard operational procedures, rules of engagement and management structures.

42. Their key functions will include:

- Responsibility for overseeing the development of the NHS and Social Care
- Supporting the Chief Executive, Chief Operating Officer, and Chief Inspector of Social Services in assessing performance
- 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.

43. Policy development and implementation for the NHS and Social Care has for some time now highlighted the necessity for a single care system – with the NHS and Social Care working as one. At local level closer joint working is leading to an increasingly integrated system. Regional Directors of Health and Social Care will ensure that the Department of Health adopts a similarly integrated approach and will ensure that the concept of a single system of Health and Social Care becomes a reality by:

- Overseeing the agreements on health and social care related targets included in each relevant Local Authority's Local Public Service Agreement.

- Ensuring the whole system of Health and Social Care, in planning terms, works in an integrated way.

- Ensuring the outcomes from and the arrangements for performance management of the NHS and the performance assessment of Social Services are properly integrated and joint action is taken as appropriate and fed into the wider Government agenda with the Government Offices and the Department of Health centrally.

- Ensuring that Health and Social Care joint interests are properly represented and integrated into the work of the Government offices.

- Securing the implementation of the Health Act flexibilities and supporting the development of Care Trusts.

44. To fulfil these functions Regional Directors must:

- ensure local and collective modernisation support is in place, effective and linked to the Modernisation Agency and national task forces;

- act as an integrated part of government at regional level with Government Offices.

- ensure that the appropriate pattern of NHS organisations is in place;

- must ensure strong professional leadership within medicine, nursing, and the other clinical professions in local organisations.

45. To fulfil these responsibilities Regional Directors will need a small number of staff with skills, for example, in performance assessment, financial planning and monitoring, development work, R&D and communications and briefing.

Areas covered by Regional Directors of Health and Social Care

46. There are currently eight Regional Offices for the NHS, each of which also include an Assistant Chief Inspector of Social Services and their staff. The current regional boundaries do not fully align with the boundaries of the Government Offices of the Regions.

47. Shifting the balance of power provides us with an opportunity to reorganise to meet the new role of the Regional Directors of Health and Social Care and to ensure that they are properly integrated with Government Offices of the Regions.

48. Regional Directors of Health and Social Care will not be simple replacements for Regional Offices. They will be more clearly part of the Department of Health, and will take a more strategic role as performance management is devolved to Strategic Health Authorities. To ensure Regional Directors have a wide enough view to carry out the strategic functions proposed, and to provide sufficient space for Strategic Health Authorities to develop their performance management role we propose to appoint 4 Regional Directors of Health and Social Care. They will cover the following areas, with outer boundaries coterminous with Government Offices of the Regions:

- London,
- the South (the current South East less Northamptonshire) and South West Regions,
- the Midlands (the current West Midlands, Eastern Region plus Northamptonshire, Leicestershire, Nottinghamshire, Derbyshire and Lincolnshire)
- the North (the current Northern and Yorkshire and North Western Regions plus South Yorkshire and South Humberside)

49. Shifting the Balance of Power also gives the opportunity to fulfil one of the commitments in the NHS Plan which is to create single, integrated public health groups linking with the Government Offices for the Regions. A strong regional health group will be located in each of the nine Government Offices of Regions, each with a Regional Director of Public Health accountable to the Chief Medical Officer and to a Regional Director of Health and Social Care. Further details of how Public Health functions will be carried out in the new structure can be found in annex B.

Flow of Funds

50. The flow of funds will be an important lever within the new system to shift the balance of power. It is important that the flow of funds is designed to help empower frontline staff and patients in the planning and delivery of services while at the same time ensuring that all partners collaborate to deliver modernisation and strategic change throughout local health communities.

51. The principle of devolution means that PCTs should take control of the main revenue allocation, giving them the necessary power to shape the development of local services. This will be achieved by allocating the 75% of total NHS funds direct to PCTs to secure the provision of services by 2004. Allocating resources to PCTs will enable resources to be much more closely matched to the needs of local people.

52. The principle of devolution should also apply to the allocation of capital. Currently block capital (to maintain the quality of the estate) and discretionary capital (to fund larger capital schemes) is allocated via Regional Offices.

53. In future block capital will be allocated directly to NHS Trusts and PCTs using a national formula. A national formula and direct allocation will help to deliver consistent standards across the country while giving operational managers a higher level of certainty and control over their allocation. Further work is needed to develop a national formula which can measure the need for investment in different NHS Trusts and PCTs.

54. Discretionary capital is used to fund strategic change rather than ongoing maintenance and there is therefore an inevitable prioritisation exercise involved in the allocation of discretionary capital. Strategic Health Authorities will be well placed to manage this process, large enough to sustain an effective investment programme, but close enough to local services to understand the priorities for modernisation and service change. It will be possible for brokerage to be agreed between Strategic Health Authorities as this will help ensure the best use of resources.

55. Directing the flow of funds to frontline organisations will be an early move in ensuring that frontline staff are fully involved in resource decisions and are empowered to shape service development. PCTs, NHS Trusts and Strategic Health Authorities will need to develop new ways of working that involve clinicians in all levels of decision making. This will build on the policies introduced already to require the establishment of ward budgets and involving clinicians in deciding how to use equipment budgets.

Working Differently

56. Giving front-line staff and patients the opportunity to think and work differently to solve old problems in new ways is the only way to deliver the improvements set out in the NHS Plan. The changes set out in the previous section will provide a structure that supports the devolution of power to frontline staff and patients. However a change in culture and new ways of working within organisations will be needed if we are to improve the quality of the patients' experience and of outcomes and improve health.

57. The cultural shifts needed are already taking place in many parts of the NHS. Again the change will come from within the service. PCTs and NHS Trusts, supported by Strategic Health Authorities will have to roll out and accelerate these changes to build a NHS that is centred on the needs and concerns of the patient, that encourages bottom up innovation within a national framework, and uses investment together with reform to deliver significant change and redesign. Underpinning all of these shifts must be a culture of mutual respect across all levels in the service.

58. NHS organisations with their partners are currently undertaking Local Modernisation Reviews. These are providing opportunities for considering how the NHS and its partners can work differently to deliver the NHS Plan. These local reviews will provide the basis for change, and further action at national and local level will promote the involvement and empowerment of patients and staff in all levels of NHS decision making.

Staff Involvement and Empowerment

59. A real shift in the balance of power will not occur unless staff are empowered to make the necessary change. The cultural shift needed will in many ways be more crucial to the success of the project than new management structures. Staff need to be involved in decisions which effect service delivery. Empowerment comes when staff own the policies and are able to bring about real change.

60. Staff empowerment is already bringing about modernisation in the NHS and real benefits to patients. For example clinical teams are leading the Cancer Services Collaborative which seeks to improve the patient experience by optimising the way care is delivered. The project is delivering real improvement, after 12 months a number of the teams are showing a 50% reduction in the waiting time to first treatment, and more than half the teams are already achieving their targets for booked appointments, increasing the certainty and choice for patients.

61. Empowering staff is also about ensuring that people are able to develop and fully use their skills. The development of GP specialists able to provide more complete care for patients outside hospital and in a primary care setting will form part of this process as will the extension of prescribing rights to nurses and then other professional groups. Making the maximum use of clinical skills, and enabling clinicians to drive the development of local services will form the basis of the drive to improved services for patients.

62. Other modernisation projects are adopting similar methods, and involving frontline staff in the service change necessary to improve the patient experience. If the balance of power is to shift, this culture of involving and empowering staff will have to become the norm throughout the NHS. The process of making this cultural change is already underway. The NHS Taskforce on Staff Involvement has already produced eleven recommendations for improving staff involvement in the planning and delivery of services. An Action Plan

to implement its proposals was published in April 2000. A staff involvement self assessment tool has been developed to help managers assess how they involve staff in their organisations. All NHS organisations were required to complete the assessment by April 2001 as part of the HR Performance Framework. The responses are now being collated, but earlier surveys show that most NHS organisations have mechanisms in place for involving staff.

63. This existing work needs to be continued and supported, focusing more clearly on implementation. Commitment to taking forward staff involvement will be needed at all levels. Actions to support this work at a national level will include:

- Mainstreaming Staff Involvement; working with the Leadership Centre, Modernisation Agency and the NHS Plan Taskforces to embed staff involvement in all areas of policy development

- Publication of a set of leadership competencies including an inclusive and involving style and include staff involvement in management development programmes

- Developing a Staff Involvement Toolkit, including an audit tool and practical advice on staff involvement, to be used alongside good practice materials and the products from a research and development programme

- Establishing a Joint Forum for Partnership and Involvement with membership drawn from all levels of the service, the Department and Staff side. A National Involvement Leader will be appointed to work closely with the Director of Human Resources at the Department of Health.

At a local level NHS organisations will be expected too:

- Appoint a staff involvement leader to report to a nominated non executive and executive director

- Reduce hierarchies and develop self-managed teams.

- Prepare a staff involvement plan. Staff surveys will include elements dealing with involvement.

- Build staff involvement into objectives for managers and into the performance monitoring arrangements for the NHS organisation.

Patient and Public Involvement

64. The NHS Plan sets out our ambitions to create a patient centred NHS. Our vision is to move away from an outdated system, towards a new model where the voice of the patient is heard through every level of the service, acting as a powerful lever for change and improvement. Our goal is to move away from a paternalistic model of decision making, towards a model of partnership, whereby citizens have a greater connection with their local services, and have a say in how they are designed, developed and delivered.

65. We are achieving this at a local level by establishing Patient Advocacy and Liaison Services (PALS) in every Trust to deal with patients and carers concerns on the spot, resolving issues before they escalate into problems.

66. Patient Forums will be established in every NHS Trust and PCT – with the power to visit and inspect any aspect of the care process. Made up of local patients and carers, these bodies will be a powerful focus for reform and improvement in the provision and commissioning of services in both primary and secondary care. To give patients and carers a real say in decisions about their local services each Patient Forum will appoint a non executive director to serve on the Board of the NHS Trust or PCT to which they relate.

67. More information will be made available to patients on the services offered by the Trust and patients' views of them. Patient surveys will be used to monitor patient experience and will form part of the performance management system. Every Trust will publish an annual Patient Prospectus to bring together information on its services, patient views and how the Trust is responding to patients' concerns.

68. The NHS must engage the general public as well as the patient. We are currently considering how best to develop the capacity of citizens to have their say on their health. PCT Patient Forums will play a part as they engage the public in the PCTs plans for developing local services. Local Authority Overview and Scrutiny Committees will also bring a much needed democratic oversight to the NHS.

69. We are continuing to develop proposals to ensure the best possible mechanisms are put in place to secure patient and public involvement in decisions about their local health services. We will publish further proposals next month which build on the developments outlined in this section, and on the feasibility study on a National Patient Body

carried out for the Department by the College of Health, Patients Forum, the Long Term Medical Conditions Alliance, and ACHCEW and CHCs.

Operational Freedoms and Measuring Success

70. In the same way that NHS organisations will be expected to devolve responsibilities and freedoms down to frontline staff, the Department of Health will also change the way it works to offer more operational freedom to the NHS. Devolving performance management to Strategic Health Authorities is an important step, recognising that this function should properly be within the NHS. The development of Earned Autonomy will provide more freedoms for successful frontline organisations. While more work is needed to develop incentives for clinical teams and PCTs, the significant operational freedoms will be linked to green light performance for Strategic Health Authorities and NHS Trusts, including:

- Less frequent monitoring from the Centre.
- Fewer inspections by the Commission for Health Improvement.
- The ability to develop investment programmes without the need for prior approval.
- The ability to retain more of the proceeds of local land sales for investment in local services.
- The best performers will be used as pilot sites for new initiatives such as team bonuses for staff.
- The best performers will receive extra resources for taking over and turning round persistently failing Trusts. (There are of course links between this and franchising discussed in Section 76 to 79).
- Where a successful local health service is receiving less than their fair share of cash under the resource distribution formula, they will automatically receive an accelerated uplift to help close the gap

71. Patients, the public and staff all want to see visible change and improvement in the NHS. The system for measuring, assessing and improving performance based on the Performance Assessment Framework and Traffic Lighting will be central to efforts to improve performance. Following comprehensive consultation earlier this year within the NHS and in line with the need to shift the balance of power the approach to performance management will be revised to:

- Focus on the delivery of the critical targets in the key priorities: the conditions with greatest clinical priority – cancer, CHD, services for elderly people and those with mental illness; primary care; emergency care; cutting waiting times; getting the fundamentals right

- Provide clear linkages between the priorities, targets and traffic lights

- Assessment of clinical quality and, in the longer term, the introduction of more meaningful clinical indicators but also inspection involving the Commission for Health Improvement.

- Testing staff satisfaction and patient experience on an annual basis as a central a part of performance assessment

72. These changes will focus performance management on the key priorities and take far greater account of the issues that concern staff and patient, ensuring that the system responds to their needs.

Managing the Change

Human Resources: Managing the Implications

73. Managing the human resources implications of shifting the balance of power gives the opportunity to establish a new culture of appointing, rewarding, developing and planning the succession of NHS managers. Managing the HR process will be a key priority for the Chief Executive for the NHS, with the Regional Directors overseeing implementation in their regions.

74. Changes of this magnitude will have significant implications for the staff who work in NHS organisations. It is essential that the human resources issues are dealt with as quickly and as sensitively as possible. While the principles for managing this change are included here, further detailed guidance on the HR implications of shifting the balance of power will be issued shortly.

75. The process for managing the implications for individual members of staff will be based on the following basic principles:

- The best available people should be sought for the new jobs;
- The most should be made of the existing expertise and experience in existing organisations and that everything possible is done to ensure this is not lost even where staff are displaced;
- The human and financial costs of these changes must be minimised through offering support, career counselling, training and development to individuals;
- That the processes followed for the selection of staff into the new organisations are fair and transparent, and comply with employment legislation;
- That there are full and open communications with staff and staff side organisations throughout the period of organisational change.

NHS Franchising and Senior Appointments to Strategic Health Authorities

76. NHS Franchising will be developed as a new approach to managing human resources issues in the NHS. The aim of franchising in the NHS is to identify the top NHS managers and enable them to improve performance across the NHS. This will include matching top managers to the biggest challenges, ensuring top managers support development and performance improvement in other NHS organisations and drawing together intervention teams to turn around failing NHS bodies. It is envisaged that NHS Franchising will be developed to support a range of development, support and intervention applications.

77. Establishing Strategic Health Authorities offers a major opportunity to develop the NHS franchising concept. Strategic Health Authorities will be new organisations and offer real scope for more innovative approaches to their management structures.

78. Strategic Health Authorities will have a key role to play in leading the NHS through change and in ensuring that progress continues to be made on the service delivery agenda. A NHS franchising approach for senior appointments will deliver the best people to take these key jobs, and encourage innovative approaches to the management of Strategic Health Authorities.

79. The NHS franchise process proposed for Strategic Health Authorities is as follows:

- National advertisement for potential Chief Executives with significant senior NHS experience
- Selection process to identify 35 candidate Chief Executives
- Candidate Chief Executives to prepare Franchise Plans including their proposals for the structure and competencies of their senior management team
- Candidates will be able to bid for more than one Strategic Health Authority franchise
- Appointment of successful candidates as Chief Executives followed by the appointment of their senior management teams.

- Finalised Franchise Plan agreed with Chair and Regional Director

- Franchise Plan forms the basis of performance clauses in senior managers' contracts

Further details will be included in the HR Guidance to be published shortly.

Staff below board-level

80. The national HR framework will cover staff in this category. However Strategic Health Authorities will be given as much flexibility as possible to deal with posts below board-level. This is because the new authorities will face different sets of circumstances, depending for example on how well-established their Primary Care Trusts are and the extent of current devolution.

81. In some parts of the country, many staff changes will have already been implemented ahead of creating a new Strategic Health Authority. In all cases the migration plan for the devolution of existing Health Authority functions to PCTs will need to be agreed as part of the consultation process on the new Strategic Health Authorities. In some cases on a transitional basis staff from existing Health Authorities could be transferred into the new organisation with staff transfers between the Strategic Health Authority and its local PCTs taking place over a period of time as PCTs develop. Existing Regional Directors will be tasked with ensuring that this process is concluded in line with the overall pace of change set out from section 94

Regional Office staff

82. Most Regional Office staff are employed on different terms and conditions from Health Authority staff. Nonetheless it is important in managing the implications for Regional Office staff that exactly the same principles are followed of a fair and transparent procedure, that makes the most of existing skills and experience and minimises human and financial costs to the Department of Health. As indicated above, RO staff as appropriate will be included alongside HA staff for consideration for posts in the new Strategic Health Authorities, both at Director and below Director level. The details of how this will be handled will be covered in the national HR framework document to be published shortly.

PCT Chief Executives

83. There are likely to be in the order of a further 150 or so PCTs established in two waves, all be operational from April 2002. Filling these jobs with the right people is absolutely critical. PCTs will be in the forefront of the new system. The Chief Executives must be top rate managers.

84. To help get the best people it is planned to update the competencies for PCT Chief Executives in the light of the roles, relationships and responsibilities set out in section 13 to 22. It is also intended to provide accelerated development and support for existing PCT Chief Executives.

85. To deliver the vision of management excellence described throughout this section, other work will be necessary including:

- The publication of a national HR Framework to help NHS organisations manage these HR issues.
- An examination of the pay levels, terms and conditions for senior managers including those in PCTs.
- The establishment of career management and succession planning system for NHS managers
- the establishment of a national development programme for teams through the Leadership Centre;
- proposals for PCT development (see the next section)

PCT Development

86. PCTs will take on a much enhanced role following the changes outlined in this document. This presents an enormous opportunity to do things differently and improve services for patients and the public. To make the most of this opportunity PCTs will need the capacity to take on and exploit their new responsibilities. PCTs will need an infrastructure robust enough to deliver challenging targets and manage the administrative tasks, but without losing the principle that clinicians and frontline staff are at the heart of their structures. PCTs were designed specifically to bring decision making closer to patients and to provide an opportunity for all local stakeholders to work in partnership to improve health and health services. Their success in delivering these aims will be crucial to shifting the balance of power.

87. PCTs will need additional management capacity to deliver their new agenda, without losing the clinical input and community involvement – the hallmarks of a good PCT. To meet this need management capacity will be devolved to PCTs together with the new responsibilities for health improvement, services and resources.

88. As emphasised elsewhere, PCTs must be able to work closely with one another. They must develop strong links and networks, mirroring patient pathways and clinical teams to ensure that services to patients are seamless and client groups have a clear point of contact for their views at all levels. They must work hard to ensure that the devolution of responsibility from Health Authorities to PCTs does not result in fragmentation of services and that there is consistency of service provision. They need to behave in a mature and co-operative fashion, working closely with one another and health and social care organisations to deliver effective health care across populations wider than their own individual communities.

89. This new role is a major challenge for relatively new organisations. Many PCGs and PCTs are still immature organisations, and a major programme of development work will be needed to prepare them for their new role. A National PCT Development Programme is being established in conjunction with the Modernisation Agency to meet these development needs. The aim of the programme will be to assist PCTs in delivering their three main responsibilities:

- Improving the health of the community
- Securing the provision of services

- Integrating and developing primary, community and social care

90. The Development Programme will build on the existing Regional PCT development programmes. The new Development Programmes will provide for:

    - The development of leaders who can articulate a clear and reliable vision of the PCT role, and with the sophisticated management skills to lead a new, complex organisation in a time of great change.

    - Identification of the skills and competencies of the PCT and its staff.

    - The mapping of development programmes and providing a signpost to sources of advice and guidance.

    - The provision of a modular programme that can easily be tailored to local needs while retaining a consistent message around development issues.

91. A National PCT Development Team, under the leadership of Barbara Hakin, Chief Executive of West Bradford PCT, will be established to lead the PCT Development Programme and produce the competency framework. The Team's first task will be to establish a system of PCT Chief Executive networks across the country supported by a range of workshops.

    The PCT Chief Executive networks will:

    - Create the infrastructure for commissioning and delivery of healthcare across larger populations

    - Provide a mechanism for two way communications between Ministers and frontline clinical staff via PCT Chief Executives

    - Advise on PCT policy development – ensuring reality checks are firmly established

    - Assist the National Development Team in developing a competency framework and a model to ensure that all PCTs develop the competencies

    - Share best practice

92. A series of workshops commissioned through the Modernisation Agency will support the establishment of the PCT Chief Executive networks. They will also provide a platform on which to develop the competencies framework and the development programme needed to support the implementation of Strategic Health Authorities and the effective devolution of current Health Authority responsibilities to PCTs.

Legislation

93. Full implementation of the proposals to shift the balance of power in the NHS will require primary legislation. Changes to primary legislation are required to enable resources to be allocated directly to PCTs rather than to Health Authorities as present, and to enable PCTs to engage in the management of pharmaceutical, dental and ophthalmic contractors. The NHS Reform and Decentralisation Bill announced in the Queen's speech will provide the vehicle for the necessary changes to be made. It is proposed to establish new Strategic Health Authorities under existing legislation from April 2002. The new roles and responsibilities will become fully operation subject to the passage of the NHS reform and Decentralisation Bill.

Outline Project Plan, timetable and pace of change

94. It is clear from the work done so far that to implement "Shifting the Balance of Power" requires an early view of some of the critical processes and timescales.

95. In implementing this massive change programme the following important principles need to be established:

- The necessary changes should be implemented as quickly as possible and in a way which minimises the risk of non-delivery against short term objectives.

- Consultation over **all** boundary changes for Strategic Health Authorities should be done in one go

- The open, national competition for **all** Strategic Health Authority Chief Executive posts should be managed nationally and organised in one go.

The following provides an overview of the processes and timescales:

- Discuss emerging views within NHS and local government with patients, the public and other stakeholders – comments by 7th September 2001

- Publish National HR framework. – JULY 2001

- Appoint first wave of PCT Chief Executives – AUGUST – OCTOBER 2001

- Consult on Strategic Health Authority boundaries – SEPTEMBER - NOVEMBER 2001

- Agree boundaries for new Strategic Health Authorities – DECEMBER 2001

- Appoint Chairs (designate) and Chief Executives (designate) for Strategic Health Authorities – SEPTEMBER -NOVEMBER 2001

- Appoint second wave PCT Chief Executives –NOVEMBER-JANUARY 2002

- Establish new Strategic Health Authorities and disestablish existing Health Authorities, new PCTs operational – 1st APRIL 2002.

- Establish new Offices of Regional Directors of Health and Social Care – 1st APRIL 2003.

Annex A

Roles, Responsibilities and Relationships for NHS Bodies

Primary Care Trusts

Functions

1. Primary Care Trusts will become the lead NHS organisation in assessing need, planning and securing all health services and improving health. They will actively engage local communities and lead the NHS contribution to joint work with local government and other partners. Their functions will be as follows:

i. Improving the health of the community

2. PCTs will deliver their public health role through community development, service planning, health promotion, health education, commissioning, occupational health and performance management. Key functions will include:

   - identifying the health needs of their local populations and responding to diversity;
   - developing plans for health improvement;
   - working as part of Local Strategic Partnerships to ensure co-ordination of planning and community engagement, integration of service delivery and input to the wider government agenda including Modernising Social Services, Sure Start, Community Safety, Quality Protects, Youth Offending Teams and Regeneration Initiatives;
   - leading in the development of the local health strategy to implement national priorities and to meet local health needs and to deliver this strategy by both providing and commissioning services from primary care practitioners and NHS Trusts.

3. PCTs will require a significantly strengthened local public health function to inform the above. Strategic Health Authorities will be responsible for ensuring that public health surveillance, population screening and needs assessment are carried out across local communities. In practice these functions are likely to be carried out by PCTs working in collaboration through the formation of public health networks. Other aspects of public health such as epidemiology, securing the provision of cancer registration services, and advice on communicable diseases should rest at a Government Office level rather than with Strategic Health Authorities and potentially with the public health observatories.

ii. Securing the Provision of Services

4. PCTs currently provide or secure the provision of a range of services, including primary, community care and secondary care services. In addition however many of the functions of current Health Authorities will be devolved to them. In future PCTs will assume the responsibility for securing the provision of:

- primary care, community health, mental health and acute secondary care services;
- Personal Medical Services including out of hours and walk-in centres;
- medical, dental, pharmaceutical and optical services;
- emergency ambulance and patient transport services;
- the health contribution to child protection services, working in partnership with local authorities and other agencies;
- all primary care development including supporting practices and other contractors and development of Teaching PCTs;
- managing and regulating the contracts of all family health services providers covering medical, dental, pharmaceutical and optical services;
- managing clinical performance within the PCT;
- developing a strong coherent modern nursing service bringing together both GP and PCT employed nurses and provides both clinical and public health functions;

- implementing population screening programmes (in collaboration with other PCTs);

- ensuring the involvement of patients, public, voluntary sector and local communities in plans for improving health and well being and the redesign, delivery and modernisation of services;

iii. Integrating Health and Social Care in the Local Health and Social Care Community

5. PCTs working with local authorities should maximise the potential benefit to patients and clients by the integration of health and social care through the use of the Health Act flexibilities and through the use of the Health and Social Care Act 2001 and the well-being power in the Local Government Act.

6. Where local partners agree, Care Trusts will be important vehicles for modernising both social and health care, helping to ensure that integrated services are focused on the needs of patients and users. They will create a stable organisational framework for long-term service and organisational continuity and the kind of joined-up personal contact needed to improve services. They will enable staff to shape a new organisation around patient and user needs and provide a system that supports them in doing their jobs and rewards them for working together.

Style

7. PCTs are primarily local organisations with a focus on the empowerment of clinical teams, local communities and patients maximising the potential of partnership working, ensuring that the right parties are engaged in decision-making, that decisions are made as close to the patient as possible and in an open and inclusive manner. PCTs will have robust engagement mechanisms in place to ensure that they involve local communities, as key stakeholders, in decision making and which provide forums for reporting back on progress and achievements. PCTs will be expected to work closely with other PCT and NHS Trusts locally to ensure that services are provided in support of patient need and across organisational boundaries.

Accountability

8. PCTs will be accountable to the Secretary of State through the Strategic Health Authority

NHS Trusts

Functions

9. NHS Trusts will have the following main functions:

- to deliver service agreements, making the best use of available resources;
- to work with PCTs and clinical networks in the redesign of services to ensure that they are patient centred and integrated across the continuum of primary and secondary care;
- to work with PCTs and other partners to contribute to health improvement in the local community, recognising their contribution to employment and economic development locally;
- to provide a satisfactory environment for training and development
- where appropriate provide a satisfactory environment to contribute towards both teaching and research and development.
- to meet their statutory duties of quality and partnership working;
- to meet their statutory financial duties.

Style

10. NHS Trusts will be expected to deliver these functions through the empowerment of clinical teams and patients, by working across institutional boundaries, reaching out and providing services as close to local communities as possible. Focusing on the redesign of services to make them more patient centred, they will encourage innovation and creativity and maximise the benefit of NHS resources across the whole health community.

Accountability

11. NHS Trusts will be accountable to the Secretary of State through the Strategic Health Authority.

Strategic Health Authorities

Functions

12. The key role of the Strategic Health Authority will be to ensure all organisations work together to deliver modernised patient centred services and The NHS Plan by:

    - agreeing an Annual Delivery Agreement with the Department of Health and ensuring its delivery by the local health community;

    - 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;

    - holding to account PCTs and NHS Trusts through their Performance Agreements;

    - 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;

- encouraging greater autonomy for Primary Care Trusts and NHS Trusts; 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;

13. Strategic Health Authorities will also decide, in collaboration with their constituent Trusts how functions that need to be provided across the whole health community can best be delivered.

14. Workforce Development Confederations have recently been established to give a clear leadership and direction to workforce planning and development. They will continue to have a separate identity to maintain their focus on workforce issues but they should be aligned to, or coterminous with, the new Strategic Health Authorities. Further consideration of their accountability arrangements and their relationships with the Post Graduate Deaneries will be required.

Style

15. The style of Strategic Health Authorities' will be one of facilitation and empowerment, helping NHS Trusts and PCTs to maximise their autonomy, encouraging them to empower their own clinical teams, to develop a culture of citizen involvement and ensuring that the right players are engaged and involved in decision-making so that decisions are made as close to communities and patients as possible.

16. Together Strategic Health Authorities will need to adopt and implement consistent management principles in relation to performance management and performance improvement, taking a developmental approach to performance management responsibilities.

Accountability

17. Strategic Health Authorities will be accountable to the Secretary of State

Annex B

Public Health

1. Given the high levels of premature death, chronic disease and disability in our country compared to many other European countries, and given the major health inequalities, it is essential that a highly effective, modern public health delivery system is in place.

2. The scope of a modern public health system is:

   - Health surveillance, monitoring and analysis
   - Investigation of disease outbreaks, epidemics and risks to health
   - Establishing, designing and managing health promotion and disease prevention programmes
   - Enabling and empowering communities and citizens to promote health and reduce inequalities.
   - Creating and sustaining cross-governmental and inter-sectoral partnerships to improve health and reduce inequalities
   - Ensuring compliance with regulations and laws to protect and promote health.
   - Developing and maintaining a well-educated and trained, multidisciplinary public health workforce
   - Ensuring the effective performance of NHS services to meet goals in improving health, preventing disease and reducing inequalities
   - Research, development, evaluation and innovation
   - Quality assuring the public health function

3. There appear to be a number of fixed points in designing a delivery system for improving health and inequalities:

- the full range of public health functions (set out above) must be delivered somewhere; there is no scope for abandoning any of them if the public's health is to be promoted and protected.

- As stated earlier PCTs will have major public health responsibilities and staff to address health and inequalities in the population they serve and in the delivery of preventative services.

- Goals in improving health and reducing inequalities can only be achieved by multi-sector, multi-agency working at national, regional and local level.

- There will be a strong Department of Health role within Regional Offices of Government.

- To ensure consistency of approach across the country, integration with the local NHS public health role and co-ordination of the health protection function this regional public health function will be accountable through the Department of Health.

- A modern public health function can only be delivered successfully by a workforce which is interdisciplinary in its orientation, training, remit and composition.

- The delivery of public health goals needs to be performance managed.

4. On the basis of this analysis the public health delivery system would comprise:

- A public health team in each PCT, with a board level appointment to lead the work on improving health and reducing inequalities in local neighbourhoods by integrating public health into primary care any by working in partnership with local authorities and other agencies.

- A Director of Public Health in each Strategic Health Authority with a small high level team, responsibilities including the performance management of the local public health function, the development of clinical networks, the creation and development of a public health network ensuring sound clinical performance and patient safety arrangements.

- A managed public health network within the area covered by the strategic health authority to ensure that specialist functions are available to PCTs where it is not effective or economic to provide them in each PCT. The Regional Director of Public health will approve the arrangements for each network and oversee their development.

- A strong regional public health group co-located in the nine regional offices of government led by a Regional Director of Public Health concentrating on: the development of an integrated multi-sectoral approach to tackling the wider determinants of health; informing regional work on economic regeneration, education, employment and transport, maintaining an overview to ensure that there is proper health contribution to local strategic partnerships; accountability for the protection of health (including against communicable diseases and environmental hazards) across the region; ensuring the quality of the performance management of the public health function; emergency and disaster planning and management; being the main point of contact on serious concerns about clinical standards (and associated enquiries).

- An effective health protection function to reduce risk and manage problems arising from communicable diseases and environmental hazards. The detailed national and local arrangements to support the Regional Director of Public Health's accountability for health protection are still being considered.

5. The public health function must be performance managed and developed in a consistent way in all parts of the country. The present degree of variation is not acceptable in a modernised service. The public health function within the Government office accountable to the Department of Health and its development and quality assurance will be led by the Chief Medical Officer. The Regional Director of Public Health will also be accountable to a Regional Director of Health and Social Care to ensure there is a proper input with performance assessment.

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