From the Office of Sir David Nicholson KCB CBE
Chief Executive of the NHS in England

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All Chief Executives of Arm's Length Bodies in England	
All Chief Executives of Local Authorities in England	Gateway ref: 14566
Chief Executives of independent sector partners	
Monitor	13 July 2010
Care Quality Commission	

Dear Colleague

***EQUITY AND EXCELLENCE: LIBERATING THE NHS* - MANAGING THE TRANSITION**

SUMMARY

I am writing to the Chief Executive community to set out how we are going to lead the implementation of *Liberating the NHS.* As we move at pace to make the Government's vision a reality, it is vital that we continue to deliver on quality, finance and performance, as well as make the required productivity savings of £15-20 billion. This first communication sets out the initial steps that I am taking at a national level to ensure we continue to deliver for today whilst designing a new system for tomorrow. It provides a framework within which Strategic Health Authorities can lead this process regionally, and sets out some initial actions that commissioners and providers need to take as part of our state of readiness for 2012.

INTRODUCTION

Liberating the NHS sets out a compelling vision for an NHS configured to deliver increasing quality of services. The ambition is high and the proposed timetable is rapid. The vision needs to be realised through a period in which the NHS needs to achieve £15-20 billion of efficiency savings to reinvest in improving quality and outcomes.

This represents a significant delivery challenge. It will not happen successfully without clarity and focus on that delivery at every point in the system. It requires a relentless focus on implementation – but that focus needs to reinforce the

objectives of the reform – of a patient-led service, local empowerment, clinical leadership and a sustained focus on improving outcomes.

I intend to build the detailed transition plan for these changes rapidly, and to build it with you. Whilst we are doing that there are actions that we need to start now. I am writing to you to set out:

1. How we should see **the vision** set out in *Liberating the NHS* accelerating the work to drive quality and productivity we have already begun;

2. The **key principles** which will govern this change process;

3. How I intend to set up the **national and regional arrangements** through which the change will be enabled;

4. The key **levers for change** through the transition period;

5. The **next steps on the White Paper** nationally;

6. How we should take forward **engagement**, nationally, regionally and locally to build understanding of and support for this change process;

7. The **actions that need to be taken now**, nationally, regionally and locally;

8. The immediate **timeline**;

9. The **behaviours** that we need to exhibit to make this a success.

1. OUR JOURNEY OF CHANGE

Liberating the NHS builds on the journey of change we have been leading. Having secured consistent standards and performance, we have sought to build a service with quality as its organising principle. We have been seeking to make that vision a reality by developing clinical leadership and engagement; improving commissioning and separating it from community provision; and freeing the provider side from centralised control through the Foundation Trust process.

I made clear last year that the challenging financial period the NHS will face over the coming years makes the need to realise this vision more, not less, urgent. Only by driving up quality and productivity together can we realise the £15-20bn savings needed by 2013/14 to reinvest in meeting increasing demand and patient expectations. That is why the Quality, Innovation, Productivity and Prevention (QIPP) challenge has been and will continue to be of central importance.

Liberating the NHS provides significant new momentum and commitment: putting clinicians at the heart of decision-making; putting GPs in charge of local commissioning decisions and creating an NHS Commissioning Board free from political micromanagement; completing the Foundation Trust process and widening choice for patients.

So those who see the White Paper as a series of technical changes misunderstand its purpose. The changes it sets out are designed to support and accelerate our aim of building a patient-led service with quality as its primary purpose. This link was clearly set out by the Secretary of State,

' I can and will create a bridge between the past and the future and help map out the journey we need to take: I will be clear what the strategy is and the shape of new priorities and systems; I will build on the good work already being done; I will devolve real freedom and responsibility to competent managers, and I will engage all NHS staff – doctors, nurses, and managers in working out how to implement a strategy with one shared vision in mind – to improve NHS care for patients and the public it serves.'

2. OUR KEY CHANGE PRINCIPLES

I have previously set out four key principles that we should use to drive change, principles that hold good for the coming period:

Subsidiarity: *Things should be done at the right level. Where necessary, the centre will play an enabling role, but wherever possible, the details of implementation will be determined locally by patients and clinicians;*

This is big change – and we need to have a clear structure to our response – but this does not mean it will have the *top down* nature of the restructurings of the past.

- *Liberating the NHS* makes clear that patients should be in the lead in the healthcare system, empowered by information and choice. Real power and authority should rest with patients and clinicians; managerial and support functions should do only what is necessary to enable the changes patients want to see.

- So the job of the centre will be to set clear criteria, hold people to account for local delivery and provide them with support – not to design or micro manage local solutions. For example, it is the job of the centre to set clear expectations of GP consortia, and to ensure they have the capability to meet those expectations - but **not** to design or enforce their size, geographical coverage or precise management arrangements.

- As the new system comes into effect this will represent a considerable reduction in national activity. Learning the lessons from past reorganisations, there is significant risk, during this transition period, of a loss of focus on quality, financial and performance discipline as organisations and individuals go through change. For this reason, I intend to *strengthen* central controls on quality, finance, operations and QIPP delivery through the next two years whilst we build the new system. We need to ensure that this does not detract from the empowerment of the devolved system, but we need to retain this focus to secure and build on the gains of recent years.

Co-production : *Implementation must be designed and decided in partnership with the NHS, Local Authorities and key stakeholders;*

Although this document sets out the main headlines of the transition programme there remains a significant amount of detailed planning to be done. This will be designed with the service and its key partners. We will work in particular with the following groups to co-produce the approach:

- Primary care commissioners;
- Clinicians from the relevant service areas;
- Leaders of organisations and representative bodies from across the NHS;
- Public, patient and staff representatives;
- Partners in local authorities, the independent and voluntary sectors;
- Key national organisations and leaders, particularly from the primary care sector. I have approached primary care leaders to begin working with them, and through them with wider colleagues, on the design and implementation of the new system. These include Dr James Kingsland and Dr Johnny Marshall from the National Association for Primary Care, Dr Michael Dixon from the NHS Alliance, and Professor Steve Field from the Royal College of GPs.

I am particularly conscious of the need to work in partnership through this change with those staff, particularly in SHAs and PCTs who will be most affected. There is significant uncertainty for these colleagues about how many jobs, of what type and in what organisations will exist in the new landscape, and what this means for them. We will work with them, and their representative organisations, both in shaping the new world but also in designing a fair and transparent process for identifying their future. Consultation with staff and their representatives will be handled locally.

Clinical Ownership and Leadership: *Our staff must continue to be active participants and leaders as we implement the White Paper and they make the necessary changes;*

This process of change has engagement at its heart. Success requires that we engage primary care clinicians in leading the commissioning process in dialogue with secondary care clinicians leading service improvement within providers.

Section 6 below describes how the clinical engagement processes we developed initially for the Next Stage Review, and took further as part of QIPP, will be developed to take forward a major programme of clinical engagement with the aims of:

- Building understanding of and support for the reform programme;

- Identifying with clinical colleagues the issues that need to be addressed nationally, regionally and locally to ensure success;

- Identifying and supporting clinical leaders at all levels of the new system;

- I have asked the NHS Medical Director Sir Bruce Keogh and the Chief Nursing Officer Dame Christine Beasley to take a lead role, working with their existing colleagues in SHAs and local health systems and prospective new leaders in primary care, in engaging clinicians across the service in this process of change.

System Alignment: *The NHS is a system, not an organisation. The wider system needs to be aligned around the same goals, enabling us to use our combined leverage for change across the system.*

Critically, we need to ensure that delivery of the White Paper's reform agenda and delivery of the essential operational and QIPP requirements are mutually reinforcing, not competing for leadership attention. I intend to achieve this by creating a single process, built on operational and QIPP processes, to deliver the whole of the coming change.

We need to get the system working in the new ways envisaged by *Liberating the NHS* as quickly as possible. Wherever we can begin through existing structures, prior to legislative or formal structural change, we should do so. In the sections that follow I set out the actions I have taken to start this nationally and regionally, and what you should be doing in your organisation.

Through this complex change process, we need absolute clarity on where quality and financial control and accountability sit at every point in the journey, and to support those who hold these accountabilities to discharge them.

3. SETTING UP NATIONAL AND REGIONAL ARRANGEMENTS

For those parts of the system for which I am directly accountable, I have begun to put in place changes to allow us to move towards the new world and manage the transition effectively.

SHAs will no longer exist from 2012/13. Instead, commissioning oversight will reside in the NHS Commissioning Board and provider issues will fall under the new system

of regulation. The final format of relevant functions will be defined in the interim and remains subject to legislation. We therefore need to take immediate steps to start to split commissioner and provider functions at national and regional level and to chart a path for the whole of the transition. In beginning to make these changes we need to ensure:

- That changes have **clear national direction** in order to ensure consistency and coherence and to reflect the end point of two new national organisations;

- That we **move with pace** in order for the system to be ready for 2012;

- That we maintain control of **finance, performance, quality and productivity** during the transition to a new system.

So in order to achieve this, I am taking the following immediate steps:

- I am today appointing a national **Managing Director of Commissioning Development**, Dame Barbara Hakin, and a national **Managing Director of Provider Development**, Ian Dalton. The Managing Director of Commissioning will oversee the separation of commissioning and engage the clinical and managerial community in the development of a commissioning led NHS. The Managing Director of Provision will oversee the separation of provision, the design of the new system of regulation, working closely with existing regulators, and the preparation of the provider side for the new system. The focus of these roles is set out in more detail below;

- We will establish an interim **bridging function** at national level. The bridge will ensure that we maintain a strong grip on quality, finance, operations and QIPP delivery. We need to learn the lessons from previous reorganisations and ensure that we do not lose vital organisational or corporate memory, including on issues of safety and quality, and to ensure that we retain aligned assumptions between commissioners and providers during the transition. The bridge will be provided by myself as NHS Chief Executive, supported by David Flory, who I am making Deputy NHS Chief Executive, and the national Director for Improvement and Efficiency, Jim Easton.

- I am asking the ten SHA Chief Executives to take the lead on and account for initial steps in the transformation process in their **regions**, working with Regional Directors of Public Health and Deputy Regional Directors for social care where necessary to ensure a co-ordinated approach.

- We will not make immediate changes to **other key functions**: workforce, clinical leadership, informatics and communications. Existing Directors General in these areas will continue to lead on their national policy frameworks. Instead, we will work with leaders in these areas as part of the next phase of the transition work

to understand how the broader changes will affect their functions. Clinical leadership will continue to have a key role in all aspects of the transition, as reflected in our overall design principles. Clinical leaders will be central to the development of effective GP consortia; to the shift to focussing on improving outcomes; and to ensuring safety and quality are maintained and improved.

We will then take the following steps by 10 September:

- We will make **changes to leadership roles at regional level** to mirror the national arrangements. These will mean appointing regional Directors of Commissioning and Directors of Provision, and establishing regional bridging functions. SHA Chief Executives will be accountable for the overall transition in their regions and for maintaining high standards of safety and quality. Together with the Department of Health leads, they will form part of an integrated national team to oversee the change process;

- Working with the Directors of Commissioning and of Provision, we will establish clear **national design principles** to inform further steps on separating commissioning from provision at national and regional level;

- We will establish a **more detailed transition path** on the commissioner and provider side to clarify what will happen when.

We will complete the commissioner / provider split at national and regional level by the end of the year. Bridging functions will remain in place at national and regional level until at least the end of 2010/11.

Primary Care Trusts will cease to exist from April 2013, in light of the successful establishment of GP consortia. PCTs will, however, play a critical role in the transition, both by ensuring that financial control and delivery are maintained, and by enabling the creation of GP consortia. This is a difficult balance and, through SHAs, I will work with PCTs to ensure capability and focus is sustained through the transition period, including ensuring the necessary powers and flexibilities exist to secure this.

4. THE KEY LEVERS OF CHANGE

The new national and regional arrangements will support a single, integrated change process which links current finance and performance, QIPP delivery and White Paper change processes. It will operate through the following arrangements:

(a) Increasing financial transparency and consistency

The 2010/11 Operating Framework, and its revision published in June this year continue to set out the key delivery expectations for organisations;

Within those requirements we will strengthen our assurance mechanisms during the interim period to keep a tight grip on finances and to standardise our mechanisms for system management. This will include specific monitoring and accounting for:

- financial support for named organisations;

- the detailed application of the 2% non-recurring funds to support delivery of change;

- the deployment of other regionally lodged funds.

The Department will establish monitoring and reporting mechanisms through the SHAs to gain assurance that local organisations are managing the transition period effectively and efficiently. This will ensure the necessary transparency, consistency and control across the service.

Regional QIPP plans will become QIPP and Reform plans. Current QIPP delivery plans will be split between commissioner and provider requirements and in due course some preventative activites will transfer to the new public health service. Revised QIPP and Reform plans will be required to set out plans for the following three key areas:

(b) Creating the new commissioning landscape

Led by the national and regional commissioning development leads, to oversee the action required to:

- enable the establishment of GP commissioning consortia with the first taking on significant levels of responsibility in 2010/11, and all GP practices working as part of effective consortia by April 2013;

- working with consortia to support the creation of commercial and NHS commissioning support capability to enable the work of consortia;

- developing changes to national payment systems to drive quality and productivity;

- ensure high quality information is available to support commissioning decisions and develop information standards for providers to ensure patients can make meaningful choices about their care;

- in doing that, to support the transition of relevant commissioning functions and skills from PCTs to the new arrangements, supporting people through the transition, ensuring continuity of capability and accountability through the period;

- identifying those functions in primary care and specialist commissioning that should be carried out by the NHS Commissioning Board and ensuring that the Board is enabled to carry them out;

- ensuring adequate systems, organisational and leadership development for all parts of the new commissioning system;

- ensuring that existing national functions to support commissioning for quality are repositioned as appropriate with the NHS Commissioning Board or other commissioner led mechanisms.

(c) Creating the new Provider Landscape

Led by the national and regional provider development leads, to oversee the action required to:

- at national level, to create the new system of economic regulation, working closely with Monitor and the Co-operation and Competition Panel and in the context of the new legislation;

- complete the Foundation Trust pipeline, including the development and implementation of high quality, safe and financially sustainable solutions for organisations where alternative governance models, merger or other solutions are required;

- complete the separation of provision from commissioning, through the Transforming Community Services process, with viable organisation models for every affected service;

- ensuring that existing provider support functions are repositioned as appropriate with provider based mechanisms.

(d) Enabling the Change

National workforce policy will continue to be led by Clare Chapman, Director General for Workforce. Sir Neil McKay, Chief Executive of NHS East of England, will lead the regional action required to:

- support people through the transition. Large numbers of people working in PCTs, Arm's Length Bodies, SHAs and the Department will be affected by this change. Numbers of managerial staff will decrease significantly. Staff may also experience change in who they work for and the nature of that work. We will put in place, in consultation with staff representatives, a framework for handling and supporting this change fairly and transparently;

- ensure continuity of the systems supporting quality, information, finance, and performance through the transition.

I will be working with Monitor and CQC to ask them to ensure their processes for financial, performance and quality regulation are consistent with these overall requirements.

5. NEXT STEPS ON THE WHITE PAPER

The publication of *Liberating the NHS* sets in train a number of national consultations on detailed elements of the proposals. I expect NHS leaders to play a full role in encouraging local discussion with clinicians and partners on these issues and responding to the consultations. We will publish documents on the following subjects in the coming weeks and months:

Commissioning for patients – seeking views on how the new system of GP consortia and the NHS Commissioning Board will work in practice;
Increasing democratic legitimacy - seeking views on strengthening local partnerships between NHS commissioners and Local Authorities;
The Arm's Length Body review - seeking views on changes to a range of our supporting organisations;
Freeing providers and economic regulation - seeking views on how best to give real freedoms to hospitals and community services and on a new system of regulation;
The NHS Outcomes Framework - seeking views on a new framework to establish improving quality and healthcare outcomes as the primary purpose of all NHS-funded care.

There will also be in the autumn publications on the future of education and training and an information strategy. The White Paper itself has now been published and draft legislation will enter Parliament in the Autumn. Subject to parliamentary approval, the Bill could receive Royal Assent by summer 2011. The White Paper, related documents and consultations, and details of how to respond to the consultations will be available in a dedicated section of the Department of Health website: www.dh.gov.uk/liberatingthenhs. I would encourage you to read them.

6. THE PROCESS OF ENGAGEMENT

I set out at the beginning of this letter my intention to build the detail of this transition process with you. To this end I have:

- asked for participation from the *Top Leaders* programme, together with leaders from primary care and social care (who are currently not well represented in that group) to work with my team to further develop the main planks of the transition;

- set up a programme of meetings during July and August in each region where I want to meet with colleagues to discuss the key implementation issues so that we can reflect local views in the transition process;

- set up a dedicated email address to collect views on the management of the transition. Please send any comments to managingtransition@dh.gsi.gov.uk

I also set out earlier that this process of change needed to have wide ranging engagement at its heart. Building on our experience of the Next Stage Review and QIPP I will:

- ask each SHA to undertake an engagement process in their region on the key issues in *Liberating the NHS*, the associated consultations and the transition. I have asked that this process concentrate on clinicians and partner organisations, including Local Authorities;

- be meeting again with national stakeholders representing patients, staff, voluntary sector and industry partners for similar discussions at a national level;

- through this letter, ask every NHS organisation to discuss these issues at Board level and throughout their organisation. I would be delighted to receive any thoughts and advice you have resulting from such engagement;

- as part of the process of supporting staff whose jobs are directly affected by these changes, ensure that every member of staff in an SHA or PCT has the opportunity for a discussion with their line manager on the changes and how they may affect them as they develop.

7. THE ACTIONS THAT NEED TO BE TAKEN NOW, NATIONALLY, REGIONALLY AND LOCALLY

Through the processes set out above, and working with many of you to co-produce the detail, we will begin to deliver the actions required. There are a range of things that you can begin work on immediately.

All NHS leaders should be:

- reinforcing arrangements for financial, operational and quality delivery this year, and preparing, as appropriate, to meet the enhanced reporting arrangements set out in section 4 above;

- shifting resources from administration to frontline care as we move from targets to outcomes;

- continuing to work on QIPP delivery in their organisation and local system, meeting the requirements of QIPP plans as set out in section 4 above;

- contributing to the consultations as part of the White Paper process;

- building relationships with the new patient and public engagement arrangements;

- urgently working with Local Authorities and other social care partners on managing the financial and service pressures facing them;

- beginning an engagement process with clinical leaders and partners building support and understanding of the change, and contributing to national, regional and local implementation thinking.

NHS Providers should be:

- finalising their plans to achieve FT or equivalent status, if they have not yet done so;

- building relationships with prospective GP commissioners;

- seeking to further strengthen clinical leadership within their organisation;

- focusing on measurable improvements in outcomes and getting ready for increasing amounts of information about those outcomes to be available;

- focusing on how to provide more integrated care and supporting the completion of Transforming Community Services.

Commissioners should be:

- supporting and enabling the new GP consortia, their leaders and members in line with the intention to create a comprehensive system of consortia;

- working flexibly with colleagues within the agreed HR framework to support people through the transition period. All staff affected by change should have an initial interview with their line manager to discuss the situation by the end of September 2010;

- working flexibly with colleagues to ensure the sustainability of key systems and processes through the transition period;

- completing the separation of commissioning from provision;

- strengthening links with Local Authorities, particularly on the integration of health and social care and health improvement;

- creating more choice for patients, in line with our ambition to significantly increase patient recall of choice and extend choice more widely across the NHS.

Strategic Health Authorities should be:

- accountable for the regional elements of the transition process, working with partners in public health and social care;

- ensuring the sustainability of local operational delivery and QIPP plans;

- redeveloping QIPP plans as QIPP and Reform plans, setting out comprehensive and detailed timelines for achieving the key aims;

- separating their functions to reflect the commissioner/provider split;

- overseeing plans for completion of the separation and liberation of the provider side, including completion of the Transforming Community Services process and driving the Foundation Trust pipeline;

- providing support to commissioners in the complex transition to GP consortia, including oversight of the development of consortia and, as part of a national process, the development of the capability assessment for prospective consortia and a market in commissioning support services;

- working flexibly with colleagues within the agreed HR framework to support people through the transition period. All staff affected by change should have an initial interview with their line manager to discuss the situation by the end of September 2010;

- working flexibly with colleagues to ensure the sustainability of key systems and processes through the transition period and that organisational memory is not lost.

The Department of Health has begun:

- leading the policy development, legislative and associated consultation processes to ensure that the transition is delivered to the intended timescale;

- reinforcing operational and QIPP delivery processes;

- working with the NHS Top Leaders programme and key partners, draw together senior leaders to work on co-production of the detail of the transition plan;

- work on the creation of the NHS Commissioning Board in shadow form;

- reshaping the National Leadership Council's work to support clinical and managerial leaders through this change;

- seeking to move relevant nationally organised functions to future arrangements with the NHS Commissioning Board or shared provider side arrangements.

8. THE IMMEDIATE TIMELINE

I have attached a timeline showing the high level transition process. It sets out the overall milestones for the next two years and more detailed actions over the next 9 months. These are the points around which we need to build the detail of the transition plan.

9. BEHAVIOURS

This letter sets out a huge agenda in terms of the tasks we need to transact. But we will only be successful if we also:

- remain true to the values of the NHS that bind the system together. The values and principles set out in the NHS Constitution and reiterated in *Liberating the NHS* should remain our touchstone through this period;

- exhibit leadership behaviours which engage positively and flexibly with the process of change, and give us the best chance of success. There are three that I want to stress:

  (i) avoiding becoming commentators. In this change we must be on the pitch not in the commentary box;

  (ii) looking out. Good leadership has always been about looking across boundaries, it has never been about standing behind walls and defending organisational self interest. This time of change could lead people to become inward looking and defensive, but it is self defeating and we must not do it;

  (iii) seeing the opportunities of this time and these changes, thinking ourselves into how we can maximise them, not just mitigating the risks.

Your leadership behaviours will absolutely set the tone for the period we are now in and directly impact upon our chances of success.

CONCLUSION

I recognise that this is a long letter. That is because it sets out, in their outline, the significant tasks ahead of us. There is a huge amount to do and I am looking forward to working with you to design and deliver it. This is only the start of the journey and I will of course continue to keep you informed and engaged as we move forward. I intend this to be the first of a series of communications over the coming months.

The scale of the changes set out in *Liberating the NHS* is unprecedented and profoundly affects all parts of the health service. Implementing these changes and delivering £15-£20bn of efficiency savings represents one of the stiffest leadership challenges we have faced. It is vitally important as we make this change that we do not lose focus on:

- the critical importance of continuing to protect and improve patient safety;
- our current strong financial performance, which we must maintain during the transition period;
- planning and implementing the quality and productivity improvements;
- ensuring our services are resilient to winter pressures and other emergency requirements.

As Chief Executives, we have a pivotal role in leading this change. Chairs and non-executives across the NHS also have a key part to play in providing direction, support, advice and challenge over the coming period. If we can work together to do these things then we can be the successful stewards of the NHS through the next stage of its development, serving the people of this country who rely upon it and cherish it.

Yours sincerely,

Sir David Nicholson KCB CBE
NHS Chief Executive