Strengthening Local Services: The Future of the Acute Hospital

The Report of the National Leadership Network Local Hospitals Project

21st March 2006

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Sir Ian Carruthers
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Dear Sir Ian,

Early in 2005, the National Leadership Network (NLN) established a Project Board to consider the future of the local NHS acute hospital. The *Local Hospitals* Project Board Terms of Reference are provided at Appendix 1, and membership of the Project Board is detailed on page 7. This report presents the findings and proposals of the *Local Hospitals* Project. A reference version of our report, complete with more detailed examples, analysis and technical appendices, is available at http://www.nationalleadershipnetwork.org and at http://www.nhsconfed.org/acutefuturereference.

Much work has already gone on in this area across the NHS and we have tried to draw out examples of best practice throughout the report. Building on the earlier work of *Keeping the NHS Local*, we have focused on the local hospital base to the NHS and not on the particular challenges faced by specialist/tertiary centres. Throughout the course of this project, we have encountered numerous temptations to broaden our scope to incorporate issues not in our original terms of reference. We have resisted these temptations as far as possible; however, we have highlighted several areas beyond our core remit which we feel will need to be considered as part of the Department's ongoing policy work as set out in Annex C of *Health Reform in England*.

Above all, though, we want this report to highlight the significant discontinuity which exists between how the NHS has viewed the operation and role of the acute hospital in the past, and how we will need to see it in the future. The publication of the White Paper *Our health, our care, our say: a new direction for community services*, with its clear aim of shifting important areas of service provision closer to patients and local communities, underscores the need for this step change. Any sustainable future for local acute services will be about commissioned networks of hospitals working in tandem with community-based services providing high quality, local care as part of a whole system – and not about individual hospitals struggling to survive in isolation. It will need to deliver high levels of cooperation and service integration in a way which promotes competition and choice rather than local monopoly.

It is our clear view that the most productive and innovative approaches to defining hospital services must be shaped by local circumstance: we have drafted this report with the aim of local NHS commissioners and providers finding it a useful tool for assessing the sustainability of local services and for considering different solutions for the future. There is no "one size fits all" solution.

We have undertaken an extensive programme of engagement with the local NHS, meeting with Chief Executives and senior managers from acute trusts, PCTs and SHAs across England, and engaging with clinical leaders both locally and nationally. We believe that this engagement process has significantly strengthened our work and the robustness of our recommendations.

We commend this report to the National Leadership Network and the Department of Health on behalf of its Local Hospitals Project Board. We hope that the principles set out in this report can be supported by the NLN and the Department, and that the report promotes a mature and constructive debate about this vitally important area. We hope the Department finds it a useful contribution on which to build in its programme of policy development and forthcoming publications on commissioning, supply side reform, and system management and regulation.

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Mike Deegan
Chair, Project Board

Martin Hensher
Project Director

Membership of the *Local Hospitals* Project Board

Chair:	
Mr. Mike Deegan	Chief Executive, Central Manchester & Manchester Children's University Hospitals NHS Trust
Project Director:	
Mr. Martin Hensher	Policy Manager, The NHS Confederation
Prof. Sir George Alberti	National Director for Emergency Access, Department of Health
Mr. Charles Auld	Chairman, Summit Healthcare (Dudley) Ltd.
Dr. Peter Barrett	Chair, Independent Reconfiguration Panel
Mr. Peter Bradley	Chief Executive, London Ambulance Service / Department of Health National Ambulance Adviser
Mr. Mark Britnell	Chief Executive, University of Birmingham NHS Foundation Trust
Mr. Matthew Coats	Head of Secondary Care, Department of Health (member until February 2006)
Dr. David Colin-Thomé	National Clinical Director for Primary Care, Department of Health
Mr. Steve Collins	Directorate of Policy & Strategy, Department of Health
Dr. Maggie Cork	Chief Executive, Leicestershire Partnership NHS Trust (member until July 2005)
Prof. Sir Alan Craft	Chairman, Academy of Medical Royal Colleges
Prof. Alan Crockard	National Director, Modernising Medical Careers
Mr. David Dalton	Chief Executive, Salford Royal Hospitals NHS Trust
Mr. Nigel Edwards	Policy Director, NHS Confederation
Ms. Mary Edwards	Chief Executive, North Hampshire Hospitals NHS Trust
Prof. Chris Ham	Health Services Management Centre, University of Birmingham
Mr. Julian Hartley	Chief Executive, Tameside & Glossop PCT
Ms. Candace Imison	Strategy Adviser, Department of Health
Ms. Eve Knight	British Cardiac Patients Association (member until August 2005)
Dr. Helen Law	Consultant in Emergency Medicine, Harrogate & District NHS Foundation Trust
Ms. Sue Page	Chief Executive, Northumbria Health Care NHS Trust (member until September 2005)
Mr. Dermot O' Riordan	Chair, Royal College of Surgeons Reconfiguration Working Party
Mr. Tony Shaw	Chief Executive, Independent Reconfiguration Panel
Prof. Jenny Simpson	Chief Executive, British Association of Medical Managers
Mr. Matthew Swindells	*Formerly* Chief Executive, Royal Surrey County Hospital NHS Trust *now* Policy Advisor to Secretary of State for Health (member until May 2005)
Ms. Julie Taylor	Director of System Reform, Department of Health (member until October 2005)
Prof. Hilary Thomas	Medical Director, Royal Surrey County Hospital NHS Trust

Supported by:

Ms. Carolyn Jones	Policy Officer, The NHS Confederation
Ms. Rachel Robertson	System Reform Team, Department of Health
Ms. Penny Usher	System Reform Team, Department of Health

Executive Summary

The Changing Environment

NHS acute hospitals face a challenging and fast-changing environment. The introduction of PbR, Practice Based Commissioning, choice and contestability – and the continuing need to improve the integration of services – will create important pressures for change in service delivery. Changing staffing patterns, driven by pressures such as the European Working Time Directive 2009, more rigorous approaches to patient safety, and changes in the training of junior doctors, will require new models of care and service organisation if services are to remain safe and sustainable. The White Paper *Our health, our care, our say: a new direction for community services* sets clear goals for the transfer of significant activities and services from acute to community settings. Meanwhile, the rapid growth in funding experienced in recent years may soon return to historic levels. Major threats to health such as rising rates of obesity and alcohol consumption may lead to significantly increased burdens on health services, while technological advances continue to improve health outcomes and spur on public expectations.

It is essential that acute trusts, Foundation Trusts and commissioners all acknowledge these multiple pressures for change, and that they consider the extent to which their own local services will need to change *before* such pressures become irresistible. **The *Local Hospitals* Project aims to set out a sustainable future vision for the general acute hospital; to provide the local NHS – and commissioners in particular - with a framework for developing innovative solutions to service design and configuration; and to propose practical mechanisms by which to implement radically different organisational models of care, aligning both the benefits of competition and of service integration**.

The Future Vision

The future local NHS hospital will be an essential vehicle by which truly local access to most acute care services is maintained. The local hospital will serve as one key component of local urgent care networks - closely integrated with primary care, out-of-hours care, ambulance services, hospital, social care and mental health services. Critically, trauma and emergency surgery (alongside a range of other services, for example, specialist surgery, paediatrics, obstetrics/gynaecology) will be managed across well-defined and accountable networks. Ambulance services will play an expanding role in providing immediate care and in making key decisions on appropriate routing of patients requiring further treatment. Where Accident & Emergency Departments are provided, they will always need to be supported by a minimum set of acute care services and resources to ensure patient safety. Beyond this minimum service set, however, there will be much greater diversity of service provision between local hospitals than has been the case under the old District General Hospital model.

Certain areas of planned care (e.g. uncomplicated elective surgery, diagnostics etc.) will see competition between local hospitals and other providers, with comparative advantages emerging between different institutions. Local clinical networks will need to respond flexibly to shifting patterns of routine care, and to ensure that urgent and emergency care networks are not destabilised by changes to elective care. Over time, key resources (such as specialised staff and crucial service-specific assets) might be increasingly provided by networks and collaborative ventures, rather than by individual hospital trusts, allowing greater flexibility in the deployment of fixed costs in response to changing local circumstances. Overall, the skills of collaboration and integration in effective networks will be every bit as essential to local NHS hospitals as will the ability to compete.

Some clinical staff may spend a growing amount of their time working across institutional boundaries and as part of increasingly formalised managed clinical networks. Similarly, local hospitals will conduct a great deal more of their business beyond the four walls of their hospital buildings. They will provide increasingly integrated support to primary and intermediate care partners – and a wider range of these partners may come to have a physical presence in the "hospital" site itself. Local people will have increasing confidence that as much of their need for urgent care as possible will continue to be met locally, while they will have a greater choice of providers (both community and hospital-based) in more specialised services and for routine surgery and diagnostics.

Achieving the Future Vision

We have developed a set of "**Design Principles**" which can be used by the local NHS to assist in developing service redesign and reconfiguration options, and as a shared tool for reviewing and debating such proposals. A set of system principles spells out the vital elements of a whole-system approach to hospital configuration questions – particularly important for commissioners, given their leadership role in this area. Care should be provided as locally and conveniently for the patient as possible, subject to the need to ensure that patient care is safe, effective, accessible, reliable, efficient, timely, equitable, and patient-centred. Patients require integrated services, and true service integration grows upwards from clinical practice and innovation, not downwards from organisational structures. Incentives must be aligned to support the objectives of care and care systems. Finally, models of care should reflect local conditions, and local commissioners, providers and partners must act flexibly, and should not attempt to enforce "one size fits all" solutions.

The design principles also address the need to adopt more flexible approaches to service design and staffing. New service models can be created by decoupling services, teams and individual professionals from buildings and institutions, and making them available to provide services locally in the most appropriate settings both within and outside hospital. This will require a far greater emphasis on well-defined and accountable networks of care. Multi-disciplinary teams will provide staff in flexible combinations appropriate to cover the full range of relevant competencies, rather than in a set combination of

professional disciplines. This will permit trained staff to provide service cover, allowing trainees to concentrate on quality training activities.

Accident & Emergency Departments in local hospitals will remain vital components of urgent care networks, delivering acute and emergency care, in close coordination with ambulance services, walk-in services, GP out-of-hours services, social care and other emergency intervention services. Wherever possible, emergency / assessment services should be "streamed" separately from elective services, i.e. a physical separation of facilities, resources, and personnel.

Our approach starts from the premise that *all* local hospitals will have to be active members of multi-hospital networks of care and we therefore propose that all local health communities need to ensure that such arrangements are in place, operational and have well understood accountability arrangements. Urgent care, emergency surgery and trauma (alongside specialist surgery, obstetrics and gynaecology, paediatrics etc.) will need to be provided via well-defined and accountable multi-hospital care networks, with mutual support and interdependence becoming essential as several key service areas become difficult to sustain on a 24 hour basis at every local hospital.

Only local innovation can provide sustainable solutions to the provision of local hospital services. We anticipate that different local circumstances will increasingly result in different service configurations. To underpin this growing diversity, **we have proposed a minimum set of acute services which are required on-site to support an Accident & Emergency Department** (see Table 1 in the report for full details). This represents the minimum level of acute care which must be provided on-site to ensure a safe Emergency Department – provided that emergency care networks can ensure prompt access to other important services at local partner hospitals.

In the emerging environment, providers will be required both to compete with each other for activity in some services, and to collaborate in others within commissioned and contestable networks and partnerships. **We have therefore proposed a number of innovative organisational vehicles through which the benefits of contestability can be realised alongside the benefits of cooperation**, and through which innovation and constructive change can reshape today's fragmented services into flexible, responsive and high-quality networks of care fit for the future. We propose three main vehicles by which to develop innovative integrated services: "principal provider" models in which a lead provider sub-contracts parts of the care pathways to partner organisations; "joint venture" models under which provider organisations share the risks, benefits and income from new service models and reconfigurations; and practice based commissioning as a tool by which clinical integration between primary and secondary care can be enabled

The establishment of networks of care is not just a matter for existing providers. PCTs, working with their practice-based commissioners, will have the key leadership role locally in specifying and contracting for services. Through their

commissioning decisions and system management role, PCTs will need to ensure sufficient local choice and competition, as well as service integration. In considering and helping to develop proposals for networks they will need to balance these objectives.

The new environment is likely to stimulate new approaches to the employment of clinical staff, especially given the growing need for staff to work in different settings and across organisational boundaries. Whilst not within our direct remit, we have suggested some options with which the local NHS might experiment to encourage innovative models of clinical employment. Similarly, we have identified a number of challenges within the area of clinical training, including the sustainability of traditional training models, the growing role of the independent sector, and future training needs in key disciplines; we have suggested that work needs to be initiated in good time in all of these areas to anticipate potential problems.

Main Recommendations

The *Local Hospitals* Project has identified a range of proposals for change, all focused on providing practical support for reshaping hospital services at a local level. We have not attempted to solve every problem that we have encountered in the course of our work; however, we have made a number of recommendations intended to feed into the Department's policy development and publication programmes as set out in Annex C of *Health Reform in England*. There are important implications for all aspects of work on system reform. Our main recommendations are as follows:

1. The Department may wish to consider defining a minimum set of services required on-site to support an Accident & Emergency department (as described in Table 1) as an appropriate basis for guidance on minimum service requirements for reconfiguration and service planning, and for relevant dimensions of future "market management" and regulation. The Department may wish to make further use of the NLN in engaging with other stakeholder interests, for example through its reference groups for the Department's workstreams on system reform.

2. The Department may wish to consider taking forward the *Local Hospitals* Design Principles as an appropriate tool for planning, benchmarking and assessing service reconfiguration proposals, suitable for use by both the local NHS and local OSCs

3. Through its leadership coalition, the National Leadership Network should engage with other stakeholder interests (e.g. the Independent Reconfiguration Panel) on the minimum service set and Design Principles with the aim of developing a broad consensus across the NHS to underpin their local implementation

4. The Department may wish to consider how best to encourage commissioners, providers ,partner agencies and the public to support innovative local models for service integration, including principal provider models and joint venture

services, alongside a concerted effort to deliver effective, well defined and accountable clinical networks of care. A requirement to foster choice and competition in appropriate areas should sit alongside the strengthening of integration and networks across local services.

5. The Department may wish to consider how best to stimulate and support the process of organisational development and culture change (for both managers and clinical staff) needed to produce the flexible and innovative organisations and networks required in the new NHS environment

6. The work of the *Local Hospitals* project on design principles and service models should be carried forward over coming years to support local services through the development of a “Compendium of Emerging Practice and Innovation”, to be led by an appropriate national agency. Support for both providers and commissioners will be needed to share best practice, innovation and learning

I. NHS Hospital Configuration: Pressures for Change

Creating a patient-led NHS: delivering the NHS improvement plan sums up how NHS services will be expected to adapt and improve to provide truly "patient-led" services:

"A patient-led service will require new ways of delivering services that are responsive to patients:

- fast, convenient services, often delivered very locally and shaped around people's needs and preferences
- high quality, integrated emergency, urgent and specialist services for patients wherever they are in the country"

The three core patient principles identified in *Keeping the NHS Local* still apply directly to achieving this vision – namely developing options for change with people, not for them; focus on redesign, not relocation; and taking a whole systems view. Achieving this overall system vision will pose far-reaching questions for NHS acute hospitals – alongside a range of important external challenges which must also be met in coming years.

The introduction of system reform (i.e. choice, payment by results, practice based commissioning, plurality of provision etc.) promotes greater contestability and competition; resulting shifts in activity between providers have the potential to create important pressures for change in service delivery. At the same time, considerable work continues throughout the NHS to improve service integration and collaboration and to strengthen the operation of managed clinical networks, especially in the area of urgent and emergency care, paediatrics and maternity services.

The White Paper *Our health, our care, our say: a new direction for community services* sets out a very clear policy to shift focus on improved prevention and health promotion activities, and to make major shifts in specialist ambulatory care (both outpatient consultations and diagnostics) out of acute hospitals and into community settings. To achieve these aims, it envisages an explicit and progressive shift of resources from acute hospitals to the community (5% of acute resources over a ten year period). The White Paper states:

"This means a shift in the centre of gravity of spending. We want our hospitals to excel at the services only they can provide, while more services and support are brought closer to where people need it most."

Meanwhile, the NHS will continue to face regional shortfalls in the supply of certain health professions for several years. Achieving compliance with the European Working Time Directive 2009 will require further redesign of service models and ways of working than was the case for WTD 2004, with less scope to employ additional staff to take up the slack. Combined with a more rigorous and comprehensive approach to ensuring patient safety, all acute hospitals (but especially smaller hospitals) will face renewed pressure to rethink their working patterns and to recognise the growing interdependencies between hospitals.

The implementation of *Modernising Medical Careers* will require new approaches to balancing training and service delivery, while improving the future base of skills to support acute care. Opportunities may also be created for a more fundamental rethink of the UK's traditional (and, compared with other countries, rather unusual) model of using junior doctors in training as the backbone of service provision.

A crucial challenge will be to ensure that the future vision for acute hospitals is financially sustainable, especially as the NHS transitions from its current period of expansionary funding growth to a "steady state" of lower annual growth. A proportion of NHS organisations already face significant challenges if they are to achieve long-term financial balance, while all face significant pressures in moving to a tariff based system.

There are also major threats to health in the future, from rising rates of obesity, alcohol consumption and high levels of smoking. These, combined with growing numbers of older people, could put significant burdens on services unless current trends are reversed. Sustained or increasing demand on health services is likely to be seen in major disease areas, such as musculoskeletal disorders, respiratory disease, heart disease, cancer, diabetes and renal disease. Meanwhile, health inequalities will continue to present a challenge to the NHS.

However, there are also important opportunities to provide better and more effective healthcare. Conditions which were once fatal can now be cured. Medical advance, supported by advances in information technology, will continue to improve health outcomes, but will also create budgetary pressures – as will rising public expectations of health and health services. Given the rate of change and uncertainty about the future, health care providers will need to be able to adapt their services continuously to this rapidly changing environment. Further details of the work of the Department of Health Strategy Unit on future health care trends are available at http://www.nationalleadershipnetwork.org and at www.nhsconfed.org/acutefuturereference.

II. The Need for Change

The Risks of Inaction

It is essential that acute trusts, Foundation Trusts and commissioners all acknowledge these multiple pressures for change, and that they consider the extent to which their own local services will need to change *before* such pressures become irresistible. Many of these pressures are already beginning to make themselves felt, while most will be exerting a clear and identifiable influence on the local NHS over the coming period. The critical choice to be made is whether to engage proactively with planned reconfiguration, or whether to "wait and see" how the new environment evolves. The risks of delay can be summarised as follows:

Unchanged Services	**Unpopular**	
risk becoming	**Unstaffable**	
	Unsafe	*resulting in*
	Unsustainable	**Service Failure**

While the unfolding of greater market pressures may inherently contain uncertainties, which cannot possibly be predicted fully, local health communities which have addressed the broad question of the sustainability of local service configurations are likely to find themselves in a much stronger position than those who choose to defer this debate. Staff, the public and local communities can at times resist change; complex interplays between services and education may inhibit apparently straightforward changes to service; and change typically requires the commitment of scarce financial resources to enable service redesign. The sooner these potential risks can be engaged with and solutions developed, the more likely a positive and sustainable outcome.

III. Defining a Sustainable Future Vision for the Local Acute Hospital

The future local NHS hospital will be an essential vehicle by which truly local access to most acute care services is maintained. The local hospital will serve as one key component of local urgent care networks - closely integrated with primary care, out-of-hours care, ambulance services, specialised hospital, social care and mental health services. Critically, trauma and emergency surgery (alongside a range of other services, for example, specialist surgery, paediatrics, obstetrics/gynaecology) will be managed across well-defined and accountable networks. Ambulance services will play an expanding role in providing immediate care and in making key decisions on appropriate routing of patients requiring further treatment. Where Accident & Emergency Departments are provided, they will need to be supported by a defined set of acute care services and resources. Beyond this minimum set of services, however, there will be much greater diversity of service provision between local hospitals than has been allowed for under the old District General Hospital model. Many local hospitals will offer a wide range of services and specialties, providing support to smaller local hospitals through well-developed clinical networks of services that may not be sustainable at every hospital (e.g. major trauma, emergency surgery and paediatrics) – but no single template will determine exactly which services are provided at each hospital. Commissioners will play a vital role in ensuring that effective, comprehensive and appropriate networks are available locally, in holding these networks to account for their performance, and in ensuring that patients have an appropriate choice of care.

Certain areas of planned care (e.g. uncomplicated elective surgery, diagnostics etc.) will see competition between local hospitals and other providers, with comparative advantages emerging between different institutions. Local clinical networks will need to respond flexibly to shifting patterns of routine care, and to ensure that urgent and emergency care networks are not destabilised by changes to elective care. Over time, key resources (such as specialised staff and crucial service-specific assets) might be increasingly provided by networks and collaborative ventures, rather than by individual hospital trusts, allowing greater flexibility in the deployment of fixed costs in response to changing local circumstances. Overall, the skills of collaboration and integration in effective networks will be every bit as essential to local NHS hospitals as will the ability to compete.

Some clinical staff may spend a growing amount of their time working across institutional boundaries and as part of increasingly formalised managed clinical networks. New models of professional practice and development are likely to emerge over time to reflect this straddling of organisational boundaries. Similarly, local hospitals will conduct a great deal more of their business beyond the four walls of their hospital buildings. They will provide increasingly integrated support to primary and intermediate care partners – and a wider range of these partners may come to have a physical presence in the “hospital” site itself.

Local people will have increasing confidence that as much of their need for urgent care as possible will continue to be met locally, while they will have a greater choice of community and hospital-based providers in more specialised services and for routine surgery and diagnostics. The public, commissioners and the local NHS will forge a “compact”, by which effective acute care is sustained locally, while certain services are provided at a more concentrated level to reap economies of scope and scale, and to ensure patient safety and sustainability.

IV. Design Principles to Guide Service Change

The *Local Hospitals* Project Board therefore felt that it was essential to define a series of design principles to guide service change locally. The purpose of the design principles is to provide a logical framework within which commissioners, providers and other stakeholders can consider service reconfiguration and change. The design principles can be used in any of the following ways:

- To benchmark current service configurations
- As a starting point for defining the objectives of service reconfiguration
- As a framework within which to generate and compare alternative options
- As a quality assurance tool to review and assess the appropriateness of service reconfiguration proposals
- As an aid to explaining service reconfiguration proposals to stakeholders and the wider public

The reference and resource version of our report provides details of and links to working examples of the application of each principle. Application of the principles will not provide automatic answers; they are intended to be an aid to planning and development, not a substitute for local thought and innovation. The principles should be used in tandem with systematic patient safety risk assessments of each affected service, to ensure that new solutions provide safe care. We recommend that the Department may wish to consider adopting these Design Principles as an appropriate tool for planning, benchmarking and assessing service reconfiguration proposals, suitable for use by both the local NHS, local Overview and Scrutiny Committees (OSCs) and the public.

System Principles

1. Care should be provided as locally and conveniently for the patient as possible, subject to the need to ensure that patient care is:
    a. safe
    b. effective
    c. accessible
    d. reliable
    e. efficient
    f. timely
    g. equitable
    h. patient-centred

2. System values need to be articulated clearly and frequently whenever service changes are under consideration, to ensure that service change is constructive and consistent across organisations; the whole health community must be engaged whenever service reconfiguration is contemplated, to ensure that solutions are appropriate and sustainable for the whole local system

3. The system's aim is to deliver care that meets the individual patient's needs in a manner which is systematic and managed, entailing:

a. Single assessment of patients
b. Support for patients to navigate the system to see the most appropriate professional / receive the most appropriate service
c. Use of formally agreed pathways, guidelines and protocols to reduce unwarranted variation, to form a basis for patient choice between alternative interventions where appropriate, and to allow effective and safe delegation of tasks where appropriate
d. Shared objectives of care by different teams, professionals and organisations
e. Promoting continuity of information at all times, and promoting continuity of relationships with particular care givers where possible (and where desired by patients)
f. Focusing on outcomes and high quality information on patients and their care

4. Safe and reliable services require all staff to be embedded in an organised system with predefined responses and protocols and appropriate clinical governance arrangements, which offers them professional back-up at all times, and which rewards them for communicating effectively and for seeking higher-level expertise when it is required

5. Patients require integrated services; true service integration grows upwards from clinical practice and innovation, not downwards from organisational structures

6. Service redesign and reconfiguration must be firmly embedded in a culture that places patient safety first at all times; systematic patient safety risk assessments must therefore always be an integral part of the process of designing and assessing new models of local care

7. All healthcare providers should engage proactively with “future” patients (via communication, education, active case-finding and case management etc.) to ensure that care can be commenced and managed before an acute episode emerges

8. Incentives must be aligned to support the objectives of care and care systems:
    a. Support integrated services based on pathways of care and not institutions
    b. Only do in a hospital what actually needs to be done in hospital
    c. Funding arrangements should reduce inappropriate bed utilisation, rather than rewarding unnecessary hospitalisation
    d. Personnel should be rewarded for entering and remaining in those disciplines and localities where skills are in short supply
    e. Personnel should be rewarded for working across organisational boundaries
    f. Empower patients to influence their care

9. Models of care should reflect local conditions (including needs, resources and capabilities); local decision-makers must be able to demonstrate that due

consideration has been given to local circumstances when proposing changes to the configuration of services (within the overall condition that patient safety and care quality must be maintained and improved by all service changes). SHAs and national agencies must empower local commissioners and providers to act flexibly, and should not attempt to enforce “one size fits all” solutions

10. Define the outcomes and objectives of new service models and reconfiguration in terms of patient and clinical outcomes

Service Models – Guiding Principles

11. New service models can be created by decoupling services, teams and individual professionals from buildings and institutions, and by making “hospital” staff (including specialists) and equipment available to provide services locally in the most appropriate settings both within and outside hospital. This will require a far greater emphasis on well-defined and accountable networks of care

12. Patients who are no longer acutely ill should be moved into an appropriate therapeutic and rehabilitative environment with an appropriate care and discharge plan at the earliest possible opportunity

13. Maximum use should be made of intermediate, home-based and nursing home care; specialised personnel should be as comfortable providing inputs to care in these settings as in an acute hospital setting

14. Subject to the tests of safety, effectiveness, accessibility and efficiency, key diagnostics (including radiology, pathology, echocardiography and respiratory function) must be widely available in primary care and the wider community, using near-patient testing to ensure that patients do not need to attend hospital for investigations or to wait for results; testing should take place in parallel, not in series; and results must be rapidly and readily available to avoid duplication of investigations

15. Build in spare capacity to allow for fluctuation in patient demand (including beds, diagnostic equipment, operating capacity etc.). A degree of spare capacity (especially in diagnostics) is a desirable outcome, not evidence of inefficiency

16. Do today’s work today and plan to achieve flow in system operation, instead of queuing and waiting

17. Treat day surgery as the norm for the majority of routine surgery

Staffing Principles

18. Develop integrated assessment services, based on “See and Treat” priniciples – single assessment by a highly-skilled professional, allowing rapid definitive diagnosis, early initiation of treatment, and appropriate delegation of

further diagnostic and treatment tasks to skilled professionals (as opposed to the patient seeing the most junior member of staff and then having their care escalated)

19. Maximum use is made of the day and the extended evening to provide diagnostic, treatment and rehabilitation services, and training activities, while a very different pattern of activity is supported at night, with staffing requirements varying accordingly

20. Access to specialist staff and services should be maintained over the weekend to reduce the risk of adverse events and to provide continuity of care

21. Multi-disciplinary teams provide staff in flexible combinations appropriate to cover the full range of relevant competencies, rather than in a set combination of professional disciplines

22. Trained staff provide service cover, allowing trainees to concentrate on quality training activities

23. The costs incurred in providing quality training and teaching need to be reflected in funding mechanisms in order to provide for a sustainable development of skilled personnel

Emergency Care Principles

24. Emergency Departments are vital components of urgent care networks, delivering acute and emergency care, in close coordination with ambulance services, walk-in services, GP out-of-hours services and other emergency intervention services

25. Emergency medicine requires rapid access to high-quality surgical advice, but not necessarily to on-site surgery

26. The ability to provide fully-staffed 24/7 critical care is likely to be a key determinant of the range and complexity of emergency services which can be provided on-site, including emergency surgery; critical care for key groups (e.g. paediatrics) will require networked provision across multiple providers

27. Wherever possible, emergency / assessment services should be “streamed” separately from elective services, i.e. a physical separation of facilities, resources, and personnel; personnel with emergency care responsibilities should be freed of elective / non-emergency commitments while on duty

28. While all local health systems (including local hospitals) should provide specialised support for the assessment, diagnosis and treatment of sick children in community and ambulatory settings, the provision of paediatric inpatient care will depend upon the availability of a critical mass of staff with the appropriate mix of competencies in paediatric care to provide adequate

cover. Paediatric care (including SCBU / NICU) will therefore require networked provision across multiple providers in most situations

V. Defining a Minimum Set of Acute Services to Support an Accident & Emergency Department

Local commissioners and providers will need to use the design principles to inform their thinking on viable local configuration options; local flexibility and innovation will be essential. However, discussions with NHS managers and clinicians have made it clear that one particular issue is often especially complex when acute service redesign is being undertaken at local level – namely, which services *must* be provided on an "acute" site. This problem can be formulated as follows: "If an Accident & Emergency Department[1] with 24 hour access is to be provided, what is the minimum set of supporting services which must be provided on the same site to ensure safe and effective patient care?" It is recognised that some local hospitals do not currently provide full Accident & Emergency services, and it is accepted that varying forms of Minor Injuries Unit require different levels of on-site support; however, the key question clearly revolves around the provision of an Accident & Emergency Department which accepts unselected medical emergencies.

Our approach starts from the premise that *all* local hospitals will have to be active members of multi-hospital networks of care. Urgent care, emergency surgery and trauma (alongside specialist surgery, obstetrics and gynaecology, paediatrics and so on) will need to be provided via well-defined and accountable multi-hospital care networks, with mutual support and interdependence becoming essential as several key service areas become increasingly impossible to staff or sustain on a 24 hour basis at every local hospital. A networked approach to care stands at the heart of the proposals developed by the *Local Hospitals* Project Board. For example, ambulance services will play an essential role in ensuring safe, reliable and speedy routing of patients to the most appropriate provider.

We recognise that this requires a shift of mindsets, and a potentially difficult process of accepting that diverse and innovative approaches must replace traditional "blueprints". However, we are equally clear that only local innovation can provide sustainable solutions to the provision of local hospital services.

The reference report and appendices provide further details of the local factors which will require consideration in determining the precise local set of acute services required in a given location, and some approaches to applying these criteria to different local scenarios.

[1] It should be noted that Accident & Emergency departments are likely to be renamed "Emergency Departments" in the next few years (reflecting professional developments in the Faculty of Emergency Medicine); this report uses the terms "Accident & Emergency Department" and "Emergency Department" interchangeably.

The most important local factors include:

- Population density and travel times
- Demographic characteristics
- Availability of alternative local providers
- Strength of network provision
- Strength of local primary care services
- Strategic importance of key services

The *Local Hospitals* project has therefore proposed a minimum set of acute services required on-site to support an Accident & Emergency Department, shown in Table 1 below. This represents the absolute minimum level of acute care which must be provided on-site to ensure a safe Emergency Department – provided that emergency care networks can ensure prompt access to other important services at local partner hospitals. As As such, we would regard this list as a minimum – and not as a positive "blueprint". It would always be preferable to have access to a wider range of services than the minimum set; but, in situations in which this is not possible, the minimum set of services can be safely operated, with appropriate support from local networks. For example, it is our expectation that a substantial majority of local hospitals should and will continue to provide 24-hour on-site emergency surgery – but network solutions can allow safe access for those hospitals in which 24-hour on-site surgery cannot be sustained.

Local determinations may include a significantly wider range of services than the minimum set – but any local definition which was narrower than that shown in Table 1 would, in the view of the *Local Hospitals* Project, not provide a safe or sustainable level of support for a local A&E department. All local proposals for specific service configurations and for the identification of which services are required locally to support an A&E department must include a detailed patient safety risk assessment as an integral part of the design process. Appendix 2 provides illustrative scenarios of the varying range of services which local hospitals might provide under different local circumstances. Commissioners will play the driving role in determining which services are provided in any particular setting, and in ensuring that local populations have effective and continuous access to networked services.

Table 1: Proposed Minimum Set of Acute Services Required On-Site to Support the Operation of an Accident & Emergency Department in a Local Hospital

Accident & Emergency Department
Supported On-Site By 24 Hour Access to: Acute Medicine Level Two Critical Care Non-Interventional Coronary Care Unit Essential Services Laboratory (ESL)[1] Diagnostic Radiology[2]
Supported by 24 Hour Local Multi-Hospital Network Access (not necessarily on-site) to: Emergency Surgery Trauma & Orthopaedics Paediatrics Obstetrics & Gynaecology Mental Health Specialised Surgery[3] Interventional Radiology

Notes:
1 ESL comprising rapid access to biochemistry, haematology, blood transfusion, basic microbiology, infection control and mortuary services
2. Comprising X-Ray, ultrasound and CT Scan
3. The same rationale of networked support in the identified services also applies to a wide range of other specialised services

Practical experience with different models of service configuration to support Accident & Emergency Departments is developing continuously across the NHS. We therefore propose that the Department and the National Leadership Network should ensure that a suitable national agency develop and maintain a "Compendium of Emerging Practice and Innovation", to provide an up to date source of intelligence available to the entire NHS. This resource should support local innovation and the evolution of new service models, by providing a source of ideas and evidence – but its aim should be to spark and encourage further local experimentation, rather than to provide ready-made answers.

We propose that the National Leadership Network should endorse the suggested minimum service set required on-site to support an Accident & Emergency Department (as per table 1), and that the Department may wish to consider its adoption as the basis for guidance on minimum service requirements for reconfiguration and service planning and for relevant dimensions of future "market management" and regulation. As such, through its leadership coalition, we would propose that the NLN takes forward the work of its *Local Hospitals* Project with other key stakeholders with the aim of developing a broad

consensus in this area. Attention will also need to be devoted to the process by which strong, effective and accountable managed clinical networks can be developed (see next section), and to changing managerial and clinical cultures away from an excessive identification with a single institution.

We also suggest that the Department, the NLN and other key stakeholders may wish to investigate how best to support commissioners and providers in the practical processes of service redesign and reconfiguration. Areas of practical support which might be of assistance to local health communities might include rapid dissemination of learning and good practice from successful reconfiguration exercises; tools for providing the public locally with feedback on how patients have been exercising choice, and the implications of these choices for local services; consideration of how to provide objective clinical assurance of the safety and sustainability (or otherwise) of local services, and of proposals for change; tools and support for local patient safety risk assessments; and providing information and briefing to MPs and local politicians on key issues relating to hospital reconfiguration.

VI. Cooperation, Competition and Choice

In the emerging environment, providers will be required both to compete with each other for activity in some services, and to collaborate in others within networks and partnerships. A simple model of competition and choice between institutions will be effective for easily commoditised, routine procedures (e.g. uncomplicated elective surgery, scheduled diagnostics). Other areas of care (for example, emergency care, chronic disease management, or rehabilitation following an acute episode) inherently require integration of services across organisations, and over time and geographical locations. The effective management of long-term conditions in particular may require a different mix of collaboration and competition than would elective care. The achievement of effective patient choice and competition in more complex areas of care will require more sophisticated forms of organisation and patient-provider interaction than that implied in the simple elective "choice" model. Maintaining the spare capacity required to provide real choice may prove to be both more difficult and more expensive to achieve in urgent and more complex care than has been the case for routine care, again requiring rather different organisational approaches to the challenge.

Crucially, given our clear finding that effective managed clinical networks will be the cornerstone of safe and effective new models of acute care, the benefits of competition in routine care must not be achieved at the expense of networks and integration – but neither must "integration" be used as an excuse for anti-competitive behaviour.

We have therefore examined a number of innovative organisational vehicles which would allow commissioners and local hospitals to operate flexibly to deliver a personalised patient experience through integrated services, while retaining an overall framework for contestability and choice. Our aim is to propose methods by which the benefits of contestability and choice can be realised alongside the benefits of cooperation, and through which innovation and constructive change can reshape potentially fragmented services into flexible, responsive and high-quality networks of care fit for the future.

NHS organisations are currently impeded in their ability to deliver integrated systems or care pathways, as organisational boundaries and PbR practice do not always encourage an integrated approach. This is especially clear in the management of patients with chronic diseases, which requires seamless management of care between primary and secondary care providers. The development of the **"Principal Provider"** concept is proposed as an option for commissioners to enable resources for the provision of services within an integrated care pathway to go to a "principal provider" Trust, which then is able to provide directly, or to sub-contract elements of the care pathway to other providers. This approach allows close integration of services, but allows for periodic contestability between principal providers, and between sub-contractors. A variant would allow a managed clinical network (especially in the case of Urgent Care Networks) to assume the role of lead contractor or commissioned body, sub-contracting with its members – but this would require networks to have

a much clearer status and accountability than is presently the case, within an effective regulatory framework to prevent anti-competitive behaviour.

NHS leaders will need to be supported in developing solutions which may involve significant reconfiguration and networking of services across organisational boundaries, which may currently be perceived as a "loss" to a particular organisation. The concept of a **"Joint Venture"** provides a meaningful vehicle for provider organisations to work together in a way which is not enabled by current PbR incentives. Joint Venture Services (JVS) will enable partner organisations to share risks, costs, benefits and income via "distributed ownership" of activity and income – and allow for contestability *between* JVS and/or other providers. It would also be possible for a managed clinical network to be established as a Joint Venture Service, giving the network a clear corporate and financial form from the outset, making it easier for the network to control and deploy key resources as required. Commissioners will need to ensure that patients have a realistic choice of providers where JVS are entered into.

Practice Based Commissioning (PBC) should enable local clinicians from primary and secondary care to work together to integrate clinical practice. There are dangers in focusing too narrowly on the vertical integration of organisations. A preferred approach is to focus on integration of clinical practice at individual service level which will yield better results, faster. PBC is likely to be particularly well-placed to develop and drive such bottom-up service integration and redesign. Concepts such as "principal providers" and joint ventures will also assist commissioners to develop service redesign between primary and secondary care.

One of the key themes of the proposed design principles is the fundamental importance of enabling staff to work across organisational boundaries if they are to be able to provide truly patient-led care. New employment models might offer one vehicle by which to remove key clinical staff from the direct employment of individual trusts and FTs, and instead to employ them via an overarching organisation. Developing specific models for the employment of clinical staff is beyond the scope of our work, but promising options might include:

- NHS Managed Clinical Networks could become employers of key staff in their specific fields, deploying staff across members of the network
- NHS "Clinical Staffing Trusts" which could employ and deploy staff across a broader range of service areas
- Specialist practices or "chambers" of clinical staff who could contract with the NHS in a manner analogous to GPs
- Social enterprises or independent sector companies could employ staff and contract with the NHS (and other IS providers)

New employment models will require significant development and testing, as they contain both potential benefits and potential risks. We therefore propose that the NHS (both locally and nationally) investigates the feasibility and desirability of such innovative approaches to the employment and deployment of clinical staff.

Overall, we propose that national policy should clearly enable and support innovative local models for service integration, and should recognise both the benefits of contestability and choice in certain routine services, and the essential importance of well-integrated urgent and emergency care networks in providing guaranteed access to high-quality acute care. Networks will need to develop greater organisational and financial "muscle", and the concepts laid out above provide an organisational vehicle by which to achieve this goal – but alongside this must sit clearer governance and accountability mechanisms for clinical networks. Care should be taken to ensure that future refinement of Payment by Results policy and guidance progressively supports the more effective operation of managed clinical networks in key service areas.

The establishment of networks of care is not just a matter for existing providers. PCTs, working with their practice-based commissioners, will have the key leadership role locally in specifying and contracting for services. Through their commissioning decisions and system management role, PCTs will need to ensure sufficient local choice and competition, as well as service integration. In considering and helping to develop proposals for networks they will need to balance these objectives.

Realising the opportunities offered by new approaches to collaboration and competition will require a three-fold approach to organisational development. First, these models set out above must be used and developed to transform today's clinical networks into stronger, more clearly defined and clearly accountable organisations. Second, a significant cultural shift will be required among managers and clinicians – from a traditional approach which values institutional independence, growth and expansion as ends in themselves, to a culture in which flexibility, managing organisations "down" to a smaller and more locally appropriate scale, and sharing "control" of resources with networks and partners are regarded as normal and desirable behaviours. Third, commissioners will need to acquire skills in coordinating and contracting with networks, as well as with individual provider organisations. These are all areas in which the National Leadership Network can play an important role in stimulating and supporting change and we are making recommendations accordingly.

Partners developing these or other approaches to strengthening clinical networks and improving clinical integration across organisations will need to ensure that their local solutions address a number of prerequisites needed to underpin successful networks. Networks and partnerships require clear governance and accountability mechanisms; they need clear operating rules, which must be honoured by all participants; educational networks should reinforce clinical service networks, not cut across them; and they need sustained and professional "back office" support, especially in the fields of Human Resources and finance.

VII. New Training Models

While making detailed recommendations on clinical training lies beyond the remit of the *Local Hospitals* project, we recognise that training is a vital influence (and,

frequently, a constraint) upon service delivery. We have identified a number of crucial issues at the intersection of training and service redesign which we believe must be addressed systematically by national policy. Important changes now underway in the organisation of postgraduate medical training present an opportunity to move away from the increasingly unsustainable traditional training model, towards one in which a more limited set of providers focuses on high quality training (in line with international practice), leaving others free to focus on service delivery. Clearly, many important factors require consideration in any such debate, including a realistic acknowledgement of the professional and organisational status that accrues to trainers and training centres, and of the potential downsides of change. In the interim, it continues to be important for all bodies to be sensitive to local service redesign needs and the likelihood of growing diversity in service models when considering training accreditation. The growing role of independent sector diagnostic and surgical providers will – in some parts of the country – make it imperative that mechanisms are found by which training can be conducted where the patients are – which, in some cases, will be in IS facilities. Dedicated funding mechanisms for training conducted in both NHS and IS facilities need to be fair, transparent, and must support well-coordinated training programmes – and not simply be an extra revenue stream.

More broadly, our work has identified an important need for "generalist" specialists – especially in specialties such as acute medicine, emergency medicine, general surgery, anaesthetics and critical care, and diagnostic radiology. This requirement swims against the prevailing tide of ever greater sub-specialisation. We consider that further work is required to develop a clearer picture of the extent of supply and need in these fields; and to consider how best to attract and retain personnel to these demanding disciplines, in a way which can be sustained both by the system as a whole and by the individuals concerned.

Our work has also shown clearly that the safe and effective operation of many promising new service models will require the development of advanced skills in airways management, resuscitation and stabilisation as a vital competency across several acute specialties – and should also include nurses and certain other disciplines working in a number of "expanded roles". A larger and wider cadre of personnel will need these skills to sustain service models under which an anaesthetist or critical care specialist may not always be available locally.

An exciting window of opportunity exists over the next year or two as the *Modernising Medical Careers* and PMETB accreditation processes require that the NHS "sign off" revised curricula for all specialties. This is a golden opportunity for the NHS to ensure that the future curriculum will produce clinicians with the right competencies to staff future service models successfully, and to ensure that acute care specialties share essential core competences (such as the question of airways management noted above). We recommend that the National Leadership Network should consider how best to mobilise its members to take advantage of this opportunity to align curricula with service needs, and for the NHS to spell out what it wants from clinical training.

VIII. Service Configuration and Public / Patient Involvement

In recent years, a number of problems have emerged in relation to the effective engagement of patients and the public in acute hospital reconfiguration and service change. While there is recent evidence of improved skills and performance by the local NHS, the likelihood of further service reconfiguration in many parts of the country means that these problems may become more prominent again if they are not dealt with. The most important areas of difficulty have been the following:

- Lack of effective communication and campaigning strategies by the NHS to galvanise public opinion in support of service change
- Lack of a clear investment framework for health gain
- Discussions dominated by buildings and institutions not services, despite the increasing trend towards networked service provision
- Bias towards 'centralisation' in NHS planning, when experience shows that patients value local services
- Sense of public/patients being 'done to' rather than genuinely engaged/involved in decision making process
- The fact that successfully concluding a consultation still leaves a long distance to travel to successful implementation

At the same time, a number of features of system reform policy provide a different type of challenge to the current PPI framework. Namely:

- Potential incompatibility between the current duty to consult on service change and the need for trusts to be able to respond promptly to changing conditions (e.g. by discontinuing services which are losing activity to competitors), and the danger that obligations to consult may prevent providers from taking timely corrective action
- The potential for conflict between the actions of patients exercising their choice to travel to alternative providers (taking funding with them) and the desire of other patients to have local access to services, especially where small changes in funding levels could threaten service viability
- The current position which leaves independent sector providers working on contract to the NHS outside the PPI framework

Accordingly, the Department of Health is reviewing both the mechanisms of public and patient involvement and the processes of statutory consultation regarding service reconfiguration. The Local Hospitals project is therefore making specific recommendations to the DH review team, as follows. Our work suggests that the following could enhance public engagement in service change:

- A requirement for the public to have access to local briefings or education about the key issues associated with proposed reconfigurations *prior* to formal consultation
- A requirement for genuine options to be put before Overview & Scrutiny Committees and the public for comment by the local NHS

- A requirement that individual OSCs, having previously agreed to form a joint OSC and subsequently being a party to a joint decision, should then be prevented (by regulation) after that decision from appealing individually to the Secretary of State

Drawing on many of our discussions with the local NHS over recent months, the following practical actions and strategies would help to ensure that future service change is handled more effectively at local level:

- Greater clarity over the role of PCTs, Foundation Trusts and SHAs in the handling of reconfiguration (and, specifically, that PCTs should have the primary responsibility and competence for initiating consultation with the public and OSCs over service change)
- Focusing on the patient's journey through the system to highlight which reconfigurations are actually of benefit, and on seeing things from the patient's perspective
- A more cohesive and competent communications strategy to celebrate NHS success and deal with failure more professionally, and to emphasise the importance of quality and patient safety
- Providing feedback to the public on how patients have exercised choice locally, and what consequences these choices may have for local services – so that local people understand and engage with some of the trade-offs that their choices may engender
- Appropriate use of "Citizens Juries" and active engagement opportunities to reach the public and win hearts and minds
- The development of clinical networks emphasising interdependence not independence of individual hospitals and institutions
- Working more closely with staff and local professional bodies from the outset to ensure "buy in" to service change with its members

We also feel that consideration should be given by the NLN to establishing a proactive process to assist the briefing of all political and community stakeholders across the local NHS, including Members of Parliament, local councils and OSCs, on the future vision for local hospitals set out in this report, to ensure that they understand the possible changes which might play out in services in their communities over coming years.

IX. Proposed Way Forward

The *Local Hospitals* Project has identified a range of proposals for change. We have not attempted to solve every problem that we have encountered in the course of our work. We have, however, made a number of recommendations intended to feed into the Department's policy development and publication programmes as set out in Annex C of *Health Reform in England*. There are important implications for all aspects of work on system reform.

Main Recommendations

1. The Department of Health may wish to consider defining a minimum set of services required on-site to support an Accident & Emergency department (as described in Table 1) as an appropriate basis for guidance on minimum service requirements for reconfiguration and service planning, and for relevant dimensions of future "market management" and regulation. The Department may wish to make further use of the NLN in engaging with other stakeholder interests, for example through its reference groups for the Department's workstreams on system reform.

2. The Department may wish to consider taking forward the *Local Hospitals* Design Principles as an appropriate tool for planning, benchmarking and assessing service reconfiguration proposals, suitable for use by both the local NHS and local OSCs

3. Through its leadership coalition, the National Leadership Network should engage with other stakeholder interests (e.g. the Independent Reconfiguration Panel) on these minimum "core" services and Design Principles with the aim of developing a broad consensus across the NHS to underpin their local implementation

4. The Department may wish to consider how best to encourage commissioners, providers, partner agencies and the public to support innovative local models for service integration, including principal provider models and joint venture services, alongside a concerted effort to deliver effective, well defined and accountable clinical networks of care. A requirement to foster choice and competition in appropriate areas should sit alongside the strengthening of integration and networks across local services.

5. The Department may wish to consider how best to stimulate and support the process of organisational development and culture change (for both managers and clinical staff) needed to produce the flexible and innovative organisations and networks required in the new NHS environment

6. The work of the *Local Hospitals* project on design principles and service models should be carried forward over coming years to support local services through the development of a "Compendium of Emerging Practice and Innovation", to be led by an appropriate national agency.

Support for both providers and commissioners will be needed to share best practice, innovation and learning

Areas for Further Consideration

7. The Department may wish to investigate how best to support commissioners and providers in the practical processes of service redesign and reconfiguration. Areas of practical support which might be of assistance to local health communities include rapid dissemination of learning and good practice from successful reconfiguration exercises; tools for providing the public locally with feedback on how patients have been exercising choice, and the implications of these choices for local services; consideration of how to provide objective clinical assurance of the safety and sustainability (or otherwise) of local services, and of proposals for change; and tools and support for conducting local patient safety risk assessments.

8. The Department may wish to consider how to develop and support the new workforce and training models needed to underpin the different shape for local hospitals set out in our report. This might include:
    a. Initiating concerted strategic work to examine the most appropriate and sustainable long-term strategy for the future relationship between post-qualification training and NHS service provision, and to examine options for reducing the dependence of local service provision on trainees
    b. Coordinating the process of matching future NHS service needs with the process of reviewing curricula across all specialties as part of *Modernising Medical Careers*, with an explicit focus on the need for strong generalist acute care skills
    c. A specific project to consider how best to expand the cadre of staff with advanced skills in airways management
    d. Developing a flexible framework for the provision, accreditation and funding of training in the independent sector should be developed
    e. Developing novel approaches to clinical governance to support new and emerging organisational and employment models

9. Consideration should be given by the NLN to establishing a proactive process to assist the briefing of all political and community stakeholders across the local NHS, including Members of Parliament, local councils and OSCs, on the future vision for local hospitals set out in this report, to ensure that they understand the possible changes which might play out in services in their communities over coming years.

Recommendations for consideration by the Local NHS

10. Local commissioners and providers should use the design principles set out in this report as a starting point for considering the need for service redesign and as a guide for planning service reconfigurations

11. The local NHS should ensure that local OSCs have access to this report and use its contents as a basis for developing a shared understanding of problems and possible solutions

12. Local commissioners and market managers should ensure that local discussions of the minimum set of acute services reflect the considerations and factors set out in Section V of this report – and should be empowered to use these resources as tools to generate locally tailored solutions

13. The local NHS should consider developing innovative organisational models, including strengthening of managed clinical networks, and the development of local variants of the "Principal Provider" and "Joint Venture Services" models set out in this report (while maintaining adequate choice for patients), without waiting for the centralised development of detailed models

14. The local NHS should similarly consider exploring novel approaches to the employment of key clinical staff, where such innovations hold real promise of improving service integration across organisational boundaries

15. The local NHS should consider devoting more effort and resource to gathering better real-time information on patient experiences and views – and ensure that staff every level are positively empowered to act on this information to improve systems and process

16. Commissioners, providers and bodies responsible for the accreditation of training should be encouraged to take a proactive and sensitive approach to reconciling training accreditation alongside local service needs so as to avoid inadvertently precipitating service failure in local hospital services.

17. Experience drawn from many of our visits across the NHS suggests that local managers and commissioners should address the following issues in order to maximise the prospects of achieving successful and effective service reconfiguration which is accepted as reasonable by local people:
    a. Ensure the debate focuses on the patient's journey through the system to highlight which reconfigurations are actually of benefit, and to help see change from the patient's perspective
    b. Develop a more cohesive and competent communications strategy to celebrate NHS success and deal with failure more professionally, and to emphasise the importance of quality and patient safety
    c. Make appropriate use of "Citizens Juries" etc. to engage the public and win hearts and minds

d. Explain clearly to the public why some services must be provided through networks, and why the provision of high-quality services may require interdependence between organisations and sites
e. Embrace the need to work more closely with staff and local professional bodies to ensure that all staff (including “young clinicians” and junior personnel) are positively involved in service redesign and change processes

Appendix 1

Terms of Reference – *Local Hospitals* Project

Under the aegis of the National Leadership Network, a seminar was held on the future of the acute hospital on 27th January 2005. Following this seminar and the publication of *Creating a patient-led NHS: delivering the NHS improvement plan*, a project on the "Future of the Acute Hospital" has been established under the leadership of Mike Deegan. This project has the following objectives:

a. To articulate a vision for the future of the acute hospital which is cognisant with the different demands placed on general and specialist hospitals; supports a networked approach to unscheduled care; and helps understand the interdependence of different specialties to support complex care so that as many services as possible continue to be provided locally

b. To identify the managerial / clinical behaviours required to support delivering a future vision for the acute hospital, and in particular to highlight the policy incentives to help deliver such change

c. To consider how – drawing on previous experience – the NHS can begin to engage far more effectively with public, patients and staff in delivering such change on the ground, with particular reference to a more "campaigning" approach on a local basis