How we build an NHS that's there for every member of society

This feels familiar: it seems like it was only a week ago I was on a stage in Manchester making a speech about the biggest hospital building programme in a generation – I'm assuming you all saw it?

Well, if you didn't, one of the highlights of my last trip was going to North Manchester General Hospital with the Prime Minister to see one of the 40 hospitals we're building or upgrading over the next decade.

We met with Raj Jain (CEO) and his brilliant leadership team, and we met with some of the patients being cared for by the brilliant doctors and nurses there.

But as we were looking around, it became abundantly clear that those facilities, built in 1876, aren't fit for the modern age. It's like one of the staff there said: asking Premiership footballers to play on a ploughed field.

All I can say: it's a good job Solskjaer isn't running an NHS trust – or Man United would be in special measures by now.

But poor facilities are not something that you should have to accept for your teams.

The right leadership is so important to the health of the NHS, but what's even more important is that our NHS leaders have the right support.

That you're not trying to operate with one arm tied behind your back.

As health secretary, I've listened to you about what support you need to do your jobs, and what I've seen is that the best chief execs, with the best-run trusts, all talk in the long term.

Of course, we all face short-term challenges, day-to-day pressures, but good leadership is about looking ahead, being able to anticipate and plan, think about the resources, the changes and innovation that you're going to need to meet the demands of tomorrow.

One of the most pressing demands is for more people – and that is what most of the £33.9 billion extra funding will be spent on.

There will be more on that in the People Plan later this year. Today, I'd like to talk about 3 other things that are going to be integral to the future of every NHS trust: the Long Term Plan, capital and tech.

And I'd like to take a moment to focus on each one.

First: the Long Term Plan Bill.

Simon Stevens, and his team, have consulted with you, and colleagues from across the NHS, to develop proposals collaboratively for an LTP Bill.

We want any legislative changes to have widespread support, and to ensure they help speed up delivery of the plan.

At their heart, the proposals, which I'm considering carefully, will empower you to work collaboratively with other providers and commissioners, so you can reduce bureaucracy and procurement costs, and so we can improve care and get the best possible return for taxpayers.

The proposals set out how the NHS is moving from competition to collaboration as the main driver for service improvement.

So more joint working. Choice for patients must remain, and competition should be encouraged where it can lead to better outcomes, but it doesn't have to be done in a bureaucratic, crass way. It isn't the organising principle for NHS services.

On mergers: trusts need to be able to make merger decisions in the best interests of patients – and patient interest should be clearly defined.

But the Competition and Markets Authority merger review process adds an unnecessary layer of bureaucracy that's time consuming and costly with knock-on effects for staff and patients.

So the proposals recognise that while the CMA has an important public interest role to play, when it comes to things like pharmaceutical pricing, proposed trust mergers are better assessed by the NHS.

They're better placed because quality of care, and best use of NHS resources, should be the guiding principles when it comes to deciding on mergers, tariff-setting and licence conditions.

And on tariffs, the Long Term Plan sets out how we're moving away from activity-based payments to population-based payments.

Why?

Because we need more flexibility to spur innovation and to remove perverse incentives. We're already doing it with blended payments for emergency care and multi-year tariff setting, but we can go much, much further.

Fair, transparent, locally-set prices will make it easier to redesign care across providers, support preventative care models and reduce transaction costs.

And on procurement, you know there are too many complexities and costs with little added value for patients in return.

So we hear what you're telling us and it's clear: we need simpler, more refined procurement, that reduces bureaucracy when you're developing competitive tender bids, that makes it easier for you to work with

commissioners to develop innovative clinical models.

And this new procurement model should cover commissioning of all healthcare services not just arrangements with NHS statutory providers.

So, we hear you, the voices of the NHS.

Second: let’s talk capital.

Last week, here in Manchester, we launched the Health Infrastructure Plan: the biggest, boldest hospital building programme in a generation, properly funded – not painful PFI deals – and properly planned so the NHS is ready for the 2020s and beyond.

Now, you all know the topline figures: 6 new hospitals, ready-to-go now, will start immediately, and another 34 new hospitals, in the pipeline, have been given the green-light, and seed funding, to develop their plans.

But the Health Infrastructure Plan (HIP) isn’t just about building new hospitals: it’s about capital to modernise diagnostics and tech, modernise our primary care and mental health buildings, and help address critical safety issues in the NHS.

It’s about the capital system as a whole.

You know better than anyone the challenges we face – that capital is too stop-start, the disjoint between the national allocation and local decisions, and the last-minute nature of some approvals.

This new regime will provide indicative, multi-year planning envelopes that will be confirmed annually.

To balance control and delivery, we’re proposing 2 sets of changes: one, to offer more assistance to providers in developing their business cases, and 2, to streamline the approvals process.

To ensure that funding reaches the frontline as soon, and as efficiently, as possible, all national organisations will need to work together more closely to manage NHS capital expenditure, through greater budget transparency and improved forecasting.

Under this new system, providers will remain responsible for maintaining their estates, and for setting and delivering their organisation’s capital investment plans. But local providers must work much more collaboratively to plan capital investment. After all, if one trust breaches capital spending limits, then clearly that’s going to have a knock-on effect on others and their capital plans: we all share the same national pot.

Integrated care systems (ICS) will have primary responsibility for spending within their capital envelopes – covering both types of acute trusts, mental health trusts, community trusts, primary care – and of course linking in with ambulance and specialist trusts.

I want to see more capital and estates collaboration through ICSs. I want to see providers who think they can better use local assets currently owned by NHS Property Services (NHSPS) to take over these assets and used them for the very best of the local health system. We've seen some early examples of use of the new powers for trusts to request ownership of NHSPS assets – starting in my own patch with Newmarket Hospital. And I will in principle be open to all such transfers, within the accommodative rules we've set out.

Trusts need to think of their physical assets as working for the ICS, and ICSs need to work to make the most of all the assets there are locally, and everyone needs to focus on using our physical assets to bolster the most important asset: the health of the population who we serve.

That is the new vision – and I need you to help me make it a reality.

The role of regions will be advisory: to support ICSs with advice to deliver their plans, to ensure ICSs in turn work with each other, and to make the relationship between the centre and local systems tractable.

And then we need more integration at a national level too. There will be one capital sign-off nationally: a Capital Committee including NHS England, NHS Improvement and DHSC. I want the national sign-off to be spectacularly more straightforward. We will be guardians of the national capital expenditure limits, and strategic in allocations of central capital, and encourage planning for the future through the HIP process. But the bureaucracy around sign-offs will be radically simplified.

The system must be fair to everyone: NHS trusts and foundation trusts alike.

We want to make sure capital better flows to where it's most urgently needed, while still rewarding trusts for strong financial performance, preserving the autonomy trusts have while ensuring the whole system uses capital as strategically as possible.

It's about building a more equitable, fairer system, where every constituent part of the NHS lives up to its responsibilities by acting in a collaborative way – and that, collectively, we all act in the best interests of patients and taxpayers.

And I want to say a word about what I mean by integration. This isn't superficial. I want trusts to be bold when it comes to integration.

It's very easy to point at real or perceived barriers and say: 'let's just do the bare minimum'.

Primary care, community care, mental health and adult social care should all be looking at ways, including structural ways, in which they can properly integrate to provide a more seamless experience for the patient.

Engaging and inspiring the workforce is critical to achieving this.

Empowering frontline staff to own the integration and find all the myriad ways to break down barriers and make things work better.

And that means investment in wider health and care infrastructure, such as genomics, prevention and public health, life sciences, and the wrap-around care and support we provide to elderly people and people with physical or learning disabilities.

The whole of the NHS is moving towards system-level working – and you are a vital part of that system.

Which brings me to the third – and final – thing I want to talk about: tech.

Now, I'd like to think since last year's conference we've got to know each other a bit. I've made my case for tech passionately and repeatedly, and to give a lot of providers credit, you've listened and responded.

We're axing the fax, purging the pager, and I've set up NHSX to drive digitisation across the whole of health and social care.

And the team at NHSX is getting the right architecture in place: common standards on privacy, encryption, inter-operability and data.

And not just the right technical architecture but shared standards on governance, procurement and contracts, so that you can buy whatever you want, from whoever you want, as long as it's safe, inter-operable and does the job.

This standards-led approach, open to innovation from outside the NHS, is the only way to go for an organisation as large and as complex as the NHS.

And this approach is already bearing fruit.

Just under a third of the population (26%) are now registered for a GP online service: that's more than 16 million people.

By the end of this year, every member of staff at Imperial College, and Chelsea and Westminster trusts will be using a single shared electronic patient record (EPR) system. Around 17,000 staff will have only one EPR to learn and patient records will be available across organisational boundaries.

We trust you to do your job so we're going to mandate tech standards for providers, like we've done with GPs.

We don't want to micro-manage you: we want to empower you to make the right decisions for your communities and their care needs – but they must fit standards so everyone's systems can fit in with each other.

But the truth is that getting the right architecture in place and mandating shared standards isn't going to be enough – it's also about cold, hard cash.

Let me be clear: it's not about getting the latest gadgets and gizmos into the NHS, it's about ensuring we upgrade slow, outdated – and often dangerous – systems so we can save lives, and save time for staff.

As I've seen in Salford and Addenbrooke's – and it's happening in Birmingham and Southampton – they're investing in the right tech to support their staff

and make their patients’ experiences better.

The driving force should be meeting a minimum set of core digital capabilities, but without the necessary spend, that’s impossible.

How can we unleash the potential of our national NHS AI lab if hospitals are still printing off X-rays and sending them by courier to be analysed?

So we need the right architecture and standards, the right innovation culture and the right tech spend.

This is about seizing the once-in-a-generation opportunity that the record £33.9 billion we’re putting into the NHS offers us to build a health service that is truly fit for the future. And with our multi-year full capital budgets to be set at the next capital review.

So a Long Term Plan that looks to the next decade and beyond.

A Health Infrastructure Plan that takes a strategic future-focused approach to capital.

And a new tech priority, properly mandated and properly funded, across the NHS to save lives and save time.

That’s how we ensure you get the right support to do your jobs.

That you can build up your organisations and back your teams.

That you can lead with confidence and optimism about the future.

And that’s how, together, we build an NHS that’s there for every single member of our society, for generations to come, whoever they are and wherever they live.