

High Quality Care For All

BRIEFING ON NHS NEXT STAGE REVIEW FINAL REPORT

Overview

Lord Darzi's report (Department of Health 2008b) attempts to open a new chapter in the story of 'quality' in the English NHS: how to move on from a centrally driven performance management regime – with its focus on driving activity and meeting targets – to a more sophisticated strategy that will strengthen the capability and capacity of local NHS leaders to deliver higher quality and more effective patient care. Behind the review lie two vital devices to drive up standards: more and better information about clinical performance and a strengthening of existing incentives. In addition, a draft constitution for the NHS was published which, among other things, enshrines the right of patients to choose where and how they are treated.

This report could bring a radical change in what the NHS delivers in England and how it delivers it. It opens up a vision of a service in which quality improvement is driven by local clinicians, armed with better data on the effectiveness of their own work, spurred on by financial incentives and by the choices of well-informed patients rather than by top-down targets. However, it is a vision that has to be classed as 'potential' rather than real because of uncertainty about how it will be implemented: has the centrally driven reform agenda been adapted enough to let locally led change thrive? Are the resources there to innovate and support the necessary changes in information-gathering? Will patients understand the information and be persuaded to act on it? And, above all, will local NHS staff drive improvement on a big enough scale and be as enthusiastic as the 2,000 clinicians and other staff who fed their views into the review?

This briefing provides The King's Fund's analysis of the key themes explored in the review.

Improving the quality of care

Quality is the dominant theme of the report, but the report does not specify what a high-quality service in an individual clinical area – for example, maternity or child health services – would look like. This has been left to the local SHAs to articulate. The decision not to define the details is welcome and entirely necessary in order to support genuine local action, but leaves uncertainty, particularly where quality has been absent in the past. For example, the report makes the task of preventing ill health a key aspect of quality. Every primary care trust (PCT) will now have to commission services to tackle obesity, alcohol and drug abuse, smoking and improving mental and sexual health, but there is a lack of detail about how the government will ensure that PCTs will do this, particularly as preventive and other public health budgets have proved vulnerable in times of financial pressure.

Beyond prevention, high-quality care is broadly defined as care in which patients have control, have access to the most effective drugs and receive care that is safe. The report goes into most detail about how quality of care should be defined and measured, going beyond current measures such as mortality rates for surgery (still relatively rare occurrences) to include patient-reported outcomes and patient experience of services. Many of the new initiatives that relate to quality are contained under the heading of 'information'.

Higher quality information

High Quality Care for All significantly expands the scope and volume of information being collected in the NHS, to help clinicians and commissioners to improve services and patients to make informed choices. If it can be achieved, expanding the evidence base on such a scale would be an enduring legacy and of immense benefit to the NHS.

A national set of comparable quality indicators for acute care will be developed under a new 'National Quality Framework'. The NHS standard contract already commits hospitals to publishing patient-reported outcome measures for a limited number of procedures from April 2009 (Department of Health 2007). Expanding this programme to include data on clinical outcomes is a welcome development given the current paucity of systematic data. However, ensuring the data is adjusted to take into account risk remains a challenge if trusts dealing with the most unwell patients are not to be penalised.

The costs of data collection must also be acknowledged alongside the benefits. A report to the Department of Health at the end of last year identified that the cost of collecting data on patient-reported outcome measures for planned surgery ranged from £3 to £11 per patient (Browne *et al* 2007), which means that for high-volume procedures total costs would run into hundreds of thousands of pounds per operation type. The first set of indicators is due to be announced in December 2008.

A National Quality Board will be established to oversee work on improving quality metrics, advise the Secretary of State for Health on priorities for clinical standards and report annually on the state of quality in NHS care in England using newly agreed international comparator measures. The effectiveness of the new Board will depend on the clarity of its relationships with the new Care Quality Commission, the National Institute for Health and Clinical Excellence, the Department of Health and others, to avoid complicating or confusing responsibilities and lines of accountability relating to quality assurance and improvement

At a local level, the report proposes that all organisations providing services for the NHS should be required by law to publish annual 'Quality Accounts' detailing their performance in relation to patient safety, experience and outcomes. Each SHA is also instructed to develop a formal 'Quality Observatory' to 'enable local benchmarking, development of metrics and identification of opportunities to help frontline staff innovate and improve the services they offer'. The report also calls for 'Clinical Dashboards' to be developed within each organisation to provide easy-to-understand, graphic representations of performance against national and local quality measures 'as a tool to inform the daily decisions that drive quality improvement'.

Collecting and publishing data on the quality of care, on patient outcomes and experience has the potential to drive up standards if the measures are right and clinicians are engaged. It should help to encourage a culture of self-improvement as well as giving commissioners the data they need to have meaningful conversations about the quality of care. Greater transparency on clinical quality will flag up variations in performance and should put pressure on organisations providing care to improve. Outcome data should also help patients to make informed choices, although they will need help navigating these new types and sources of information if they are to be of use.

More personalised and integrated care

The report also includes a few concrete proposals to improve care from the patient's perspective. A high priority is the extension of choice of GP, which is enshrined as a right in the new constitution (see below). Greater choice of GP and genuine freedom of movement between practices is of clear benefit to patients, many of whom have discovered that real choice has been limited due to closed or 'open but full' lists.

The report pledges to extend choice in primary and community services by channelling money currently used to fund GP practice income guarantees to fund allowances for expanding practices. It also promises to enhance the NHS Choices website to include more information on primary care and to allow patients to register for their GP online. Whether these incentives are strong enough to increase supply and to encourage patients to move is not yet clear. This is not the first time that the government has tried to enhance choice in general practice: previous efforts included introducing new contracts allowing non-NHS or General Medical Services providers to offer services and pledging to guarantee patients access to open lists, none of which have yet delivered widescale choice of GP.

Other initiatives are aimed at patients with long-term conditions, including mental health problems, who are to receive 'personal care plans' by 2008. An expanded version of this idea has proved popular locally: more than half of the SHA vision documents proposed the introduction of similar 'care co-ordinator' roles for patients with long-term conditions (King's Fund 2008). Delivering this will require leadership and perhaps some regulation (care plans were originally promised in 2006) to ensure that they actually happen, deliver tangible benefits to patients and avoid becoming an additional layer of NHS bureaucracy.

The introduction of personal budgets for patients with long-term conditions also featured in five of the SHA vision documents; in response, *High Quality Care for All* commits to piloting them. In principle, personal budgets represent the most direct way of creating personalised services by responding to different, individually expressed needs. However, despite some success in social care, their replication in health generates additional challenges.

The report suggests that in some cases the budget would be held by the professional on behalf of the patient, but it also commits to piloting direct payments. Both approaches have drawbacks: if the payment goes direct to the clinician then there is a danger the patient will not get the final say in the treatment chosen. However, if the budget is held by the patient it could allow the better-off to enhance their allowance, thereby creating a two-tier service. There is also the potential for NHS funds to be spent on non-health or ineffective treatments. Pilots must be fully evaluated and not used as a routine precursor to national roll-out.

The report also announces the launch of a series of pilots to establish how primary, community and hospital care services might be better integrated in an attempt to co-ordinate care better for patients. One of the proposed models – an ‘integrated care organisation’– would involve ‘multi-professional groups based around groups of GP practices who would manage the health care resources for their local populations and decide how best to use these resources to shape services around individuals and promote healthy lives’ (Department of Health 2008c). It is worth noting that this proposal to address the problem of fragmented services could mean reversing the purchaser–provider split and has the potential to reduce patient choice by channelling patients into pre-arranged care pathways.

More innovative services

One of the headline recommendations of the report is an expanded role for the National Institute for Health and Clinical Excellence (NICE), the body in charge of evaluating the effectiveness of interventions for use by the NHS. The report pledges that the process by which NICE produces guidance on whether the NHS should fund newly licensed drugs will be speeded up for ‘significant’ drugs. It can take up to two years for guidance to be published following the licensing of a new drug. The report says that in the majority of cases this will be reduced to ‘a few months’. Speeding up the process is good news for patients, provided that rigour is not compromised on the way.

The changes to the approval process announced in the review should go some way towards reducing the postcode lottery in access to NICE-approved drugs, but the main area of dispute occurs when some PCTs are reluctant to fund drugs that have a licence but are yet to be evaluated by NICE. Dealing with this source of variation is more difficult and may well require central guidance to ensure consistency across the NHS, as will the proposal that PCTs need to explain their local judgements regarding funding of drugs yet to be evaluated by NICE. Another source of variation in access to care arises from differences in the clinical decisions of doctors about who to treat, when and how. Rates of the most common operation in the NHS – cataracts – can vary more than four-fold across England, for example.

NICE will also extend its scope to establish recommendations on quality standards across all aspects of care provision, ‘either by selecting the best available standards (including the adoption of relevant parts of the National Service Frameworks) or by filling in the gaps’. This is presented as a knowledge synthesis and dissemination role – a new portal called NHS Evidence will be established for use by professionals. The cost of this expanded role for NICE is not set out.

Greater financial incentives

The report envisages higher quality and innovation being driven partly by staff being committed to self-improvement, but financial incentives (and penalties) also play a supporting role. For hospitals, a new payment-for-performance scheme will make a small percentage of a hospital’s income contingent on outcomes for patients. This scheme, called ‘Commissioning for Quality Innovation’, draws on plans already developed in the North West SHA and would form a ‘simple overlay’ to the Payment by Results system in contracts between providers and commissioners from 2010.

There are also proposals to pilot ‘best practice tariffs’ within the Payment by Results system. This would mean that some prices would be based on the cost of providing

the treatment if 'best practice' were followed rather than following the current system in which the price is based on average cost. The pilot will begin in four high-volume areas in which there is significant unexplained variation in practice – cataracts, fractured neck of femur, cholecystectomy, and stroke care.

In addition, the report enables PCTs to withhold payment for treatments in the case of serious, avoidable adverse events occurring in hospitals. This policy of so-called 'never events' draws on practice from the United States. The National Patient Safety Agency has been asked to develop a menu of events, from which PCTs can select a priority list for their operating frameworks in 2009.

The report is right to consider how financial incentives can support the overall search for improved quality (especially in the light of evidence gathered for the report that badly aligned incentives can hinder quality, see [Making It Happen](#)). Much work now needs to be done to add detail to these new initiatives, but the government must also recognise that continual vigilance, feedback and adjustment is needed to maintain the existing incentive schemes in primary and acute care.

Clinical leadership

A series of initiatives aimed at developing clinical and non-clinical leadership skills and supporting leaders is proposed, including reviewing the undergraduate curriculums for nursing and medical students to ensure they reflect the skills required for leadership; introducing a 'Leadership for Quality' certificate to assure the quality of development programmes; establishing Clinical Leadership Fellowships, which provide protected time for clinicians to develop their leadership skills; establishing a Clinical Management for Quality programme for clinicians managing services, especially clinical directors and primary care professionals running practice-based commissioning groups; identifying the 'top' 250 clinical and non-clinical leaders in the NHS and providing them with (unspecified) support; and establishing an NHS Leadership Council, chaired by the NHS Chief Executive, with a budget to commission leadership programmes.

The commitment to secure and maintain high-quality leadership by creating a Leadership Council to identify and support the top 250 leaders is welcome, as is the assurance of continued investment in leadership development, with a particular focus on clinical leadership. There are two notes of caution here: the management task, regardless of whether it is done by clinicians or non-clinicians, still needs to be done. Management is much less attractive than leadership; running a complex service like the NHS, and doing so in a way that is responsive to patients and drives up quality in the way the report aspires to, will require effective high-quality management. It is right that clinicians should be engaged and involved in leadership, but care needs to be taken to ensure that the management task is not neglected and that managers are not undermined, overlooked or vilified. Equally, clinicians cannot have all their time diverted to tasks that could be done as well, or better, by professional managers.

The implementation of these changes also needs to ensure a balance between central and local drivers for change. There is rightly some caution about launching a further national programme. The last three attempts to secure a national approach to developing the most senior leaders has been marked by less than impressive outcomes. Confidence in the ability of the NHS to deliver high-quality services locally is undermined if the message is that identifying and developing the very best leaders can only be undertaken centrally.

Constitution for the NHS

A draft constitution has been published alongside the review - it contains principles, rights and pledges but only the rights have legal force, (details are set out in an accompanying handbook). The constitution provides a positive statement of patients' rights and how they can exercise them, as well as what services the public can expect to receive. It enshrines the right of patients to choose where and how they are treated and will help people take greater control of their own health care. However, it is not clear what sort of impact this will have on the NHS. Many of the sections available under 'redress' involve patients either complaining through the existing channels (NHS complaints procedures or to their PCT) or even seeking judicial review.

The 'principles' of the NHS contain no surprises and consist of a series of broad statements that describe the NHS as a tax-funded system delivering care free at the point of need. It chooses not to pin down the scope of the NHS, leaving open whether it is no more than a guarantee of free, state-funded care (provided by any type of organisation, bound by the principles of the constitution) or a more extensive set of state-owned commissioning and provider institutions that can have a relationship with other sectors, including private and third sector.

The 'rights' section pulls together the existing legislation that relates to health care, equalities, human rights law and employment law. No new legislation is promised, but it raises the profile of certain aspects of existing law for patients, for instance the right to seek treatment elsewhere in Europe if faced with 'undue delay' in the NHS or to access NICE-recommended drugs and treatment (with a doctor's approval). Some modifications of existing law are promised about which drugs and treatments PCTs should fund where these are not covered by NICE guidance. Patients are given the right to expect local decisions by PCTs on these cases to be made 'rationally'. The Secretary of State will spell out the 'process to be adopted when making these decisions' in secondary legislation, using powers under the 2006 NHS Act. In the past there has sometimes been a lack of transparency in PCT decision-making, and greater clarity should be of benefit to patients and the public.

The government does not intend to make formal changes to existing local accountability structures – this is a relief given the near-universal wariness about unnecessary structural reorganisation. Instead, PCTs are encouraged to try out new ways of taking into account local views when they make decisions. The four options proposed are: creating a local membership system (albeit one without the formal status of foundation trust membership); inviting local councillors or mayors onto PCT boards; developing joint planning processes with local authorities; and experimenting with other approaches to linking PCT and local authority work, such as appointing joint senior executives and using pooled budgets. All are reasonable suggestions but not all are without costs: thorough evaluation is needed, which will need a clear statement about the objectives of local accountability, which is often missing.

A statement setting out 'the system of responsibility and accountability for taking decisions in the NHS' will be published by the government alongside the final version of the constitution following a consultation period (Department of Health 2008d).

Next steps – making it happen

High Quality Care for All is not accompanied by the usual implementation guide that follows most other government reports of this size and magnitude – this is both a virtue and a weakness. It is a virtue because the report genuinely attempts to liberate local decision-making in the NHS: an overly detailed, prescriptive implementation plan would encourage local clinicians and managers to continue to look up to the centre to see if they were delivering the right amount of improvement in the right time.

But it risks being a weakness from a public accountability perspective as the lack of detail about implementation will make it hard to establish whether the bold vision contained in the report is being implemented and is actually improving patient care. One approach would be to scrutinise the SHA plans. Successful implementation of these plans would, of course, bring greater variation in NHS services – something that has always existed but which will now be made more explicit. The issue for the future will be how to balance what is acceptable variation to meet local needs and what is unacceptable variation in terms of quality of care.

What is clear is that delivering this agenda will demand cultural change at all levels – the performance management arrangements of the past decade have conditioned a whole system to operate within an environment in which goals have been set elsewhere and accountability through the national chain has been paramount. If there is to be a new performance regime it will make new demands on leaders at local level who will need to be innovative, creative and willing to take risks. Organisations accustomed just to doing what needs to be done to survive will fail to turn round poor or average performance.

Many NHS organisations have the right leaders in place but years of command and control will have left some without the right skills and approach. The review promises significant investment in leadership skills and that will be essential – all high-performing health systems indicate this is the case. Genuine cultural change on this scale takes time – however, the report is silent on the question of how much time organisations should be given to change from within and at what point change should come from outside - perhaps through mechanisms such as competition, merger and acquisitions or consultancy.

Finally, one issue that receives little attention in the report is how local NHS organisations will handle potentially contentious changes to services. This was subject to earlier guidance by the Department of Health (2008a) which stated that any future changes must be clinician led, with the needs of patients paramount and the interests of local people taken into account. Where the evidence is strong those responsible at a local level should move forward with confidence – where it is weaker, there must be a commitment to pilot and evaluate new ways of delivering care. Balancing arguments about quality, access and cost, reconciling different interests and taking account of local people's views will be vital if local services are to maintain the engagement and trust of their communities in improving services and quality overall.

The next decade should be about transformational change. Lord Darzi's review has made the right start by going with the grain of reform. His review may not live up to its 'once in a generation' billing but it does what it does what it set out to – it takes us to the next stage in NHS reform.

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