

# » Briefing

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## High Quality Care For All

### Overview

The final national report of the year-long NHS review led by health minister and surgeon Lord Darzi was published on 30 June 2008 (Department of Health 2008b). *High Quality Care for All* confirms a shift in the government's approach to health policy: where previously the speed of care was the principal measure, 'quality' is now being broadened to encompass patient outcomes and experiences and clinical outcomes.

This improvement in quality is going to be achieved principally through the publication of new comparable performance data, which will be used by clinicians to improve their practice and systems. Although Lord Darzi's report does not dismantle any of the existing market-inspired reform policies – indeed it continues to expand patient choice – it places a new emphasis on professionals' innate desire to improve services. Competition is secondary to professionalism and personalisation in the rhetoric of the report.

The report also develops the government's plans to move away from centrally imposed targets towards greater local flexibility in service delivery. A commitment to enable all trusts to become foundation trusts is reiterated, and the report promises there will be 'no additional top down' targets, although national 'minimum standards' will still be required and the distinction between these and targets is not clear. The report proposes giving the NHS greater local flexibility to modify existing financial incentives, including possibly for the Quality and Outcomes Framework and proposes new policies to reward good patient outcomes and to withhold funding for avoidable, adverse events in hospitals; the content of these policies can be tailored to reflect local priorities.

This briefing outlines and analyses the main recommendations made in *High Quality Care for All*. For more information on the background to the review and the details of the 'visions' produced by strategic health authorities as part of the review see The King's Fund website ([www.kingsfund.org.uk](http://www.kingsfund.org.uk)).

### Improving quality

Improving the quality of care for NHS patients is the guiding principle of Lord Darzi's review, on the basis that higher-quality care is both beneficial for patients and offers better value for money for the taxpayer.

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Quality is defined in terms of three criteria:

- patient safety (doing no harm to patients)
- patient experience (care should be characterised by compassion, dignity and respect);
- effectiveness of care (to be measured using survival rates, complication rates, measures of clinical improvement, and patient-reported outcome measures).

The collection and publication of information on the quality of care and the use of this information by clinicians to improve their performance is central to the report. Financial incentives still have a role to play alongside personalisation, innovation, clinical leadership and regulation as drivers of improvement.

## Information

A national set of comparable quality indicators for acute care will be developed under a new 'National Quality Framework'. An equivalent framework for community services will be piloted in 2009. The implication is that these indicators should cover all of the three areas of quality identified above, though this is not explicitly stated.

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, enabling data on clinical outcomes to be comparable across different units and clinicians requires the information to be risk-adjusted to take into account the differences in the severity or complexity of illness of patients accessing different services. Darzi acknowledges that this is a 'complex task' and that a number of previous attempts have been unsuccessful. He recommends that the answer is to develop 'acceptable methodologies' for collecting and collating the information. However, details on how these methodologies have yet to be established, by whom and for which clinical areas have yet to be set out, as have the costs of data collection and analysis. In selecting indicators experience from other countries should be carefully examined. Quality indicators have been developed to measure whether patients have received recommended care (for example, stroke patients receiving thrombolysis within three hours). This is a process measure rather than an outcome measure, but it has the potential to significantly improve quality and avoids the problem of risk adjustment.

The costs of data collection must also be considered. 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 are due to be announced in December 2008.

Comparable information on quality for patients will continue to be available on the NHS Choices website, which will be expanded to include more information on primary and community services, and the new Care Quality Commission will publish periodic assessments of comparative performance. *High Quality Care for All* also sets out plans for the government to explore developing internationally comparable quality measures together with other OECD countries. It is important that all this data is made available in a such a way that patients will be able to understand and use it.

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 strategic health

authority 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'. Local organisations are encouraged to supplement the national quality indicators with local measures of quality. The report also calls for 'Clinical Dashboards' to be developed in 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'.

All data on quality performance will be available publicly but it is its use by staff to improve their own performance that provides the central lever for change in Lord Darzi's report. He argues that providing transparency about performance across the NHS 'will facilitate meaningful conversations between teams and members of teams about how they can continuously improve the quality of care they deliver' and that 'providing high quality care leads to professional pride, and focusing on improving it energises and motivates all NHS staff'.

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, which should be set by the National Institute for Health and Clinical Excellence, and will make an annual report on the state of quality in NHS care in England using the newly agreed international comparator measures. It is not clear how this report will relate to existing reports, such as the Healthcare Commission's state of health report, the NHS Chief Executive's annual report and the Chief Medical Officer's annual report. The new Board will be chaired by the NHS Chief Executive, with a membership drawn from people working on care quality in a range of national organisations, and is intended to 'align and agree quality goals' for the NHS. It is due to make its first report in June 2009. It will be important that the relationship of the Board to the new Care Quality Commission, the National Institute for Health and Clinical Excellence, the Department of Health and others is set out clearly if it is to provide an effective co-ordinating role as opposed to complicating or confusing responsibilities and lines of accountability relating to quality assurance and improvement.

### Financial incentives

Additional financial incentives (and penalties) for hospitals are also announced. 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 Strategic Health Authority and would form a 'simple overlay' to the Payment by Results system in contracts between providers and commissioners. The details of the system have yet to be set out, but the report states that the scheme will reward improved outcomes from 2010, be funded by money that would otherwise have been used for the national tariff (national NHS price list) uplift and will be 'flexible to suit local circumstances'. The same risk-adjustment challenges that face the development of the national quality indicators also apply here.

Proposals to pilot 'Best Practice Tariffs' within the Payment by Results system are also announced. The NHS tariff details how much money hospitals will be reimbursed by commissioners for providing a particular treatment. The prices are currently based on the average actual costs of providing the treatment in the NHS. Under these new proposals, some prices would instead be based on the cost of providing the treatment if 'best practice' is followed. 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. The methodology for calculating the new tariff prices has not yet been detailed.

In addition, the report instructs 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 in the United States. Here, the National Patient Safety Agency has been asked to develop a menu of such events, from which PCTs can select a priority list for their operating frameworks in 2009.

The existing Quality and Outcomes Framework in primary care is to be adjusted using a new 'independent and transparent process for developing and reviewing indicators', with a view to replacing some organisational and process indicators with new indicators on prevention and clinical effectiveness. The report also commits the Department of Health to exploring the possibility of developing a national menu from which PCTs and the GP practices in their area can select additional local indicators to reflect local health priorities. This was requested in the strategic health authority reports for the West Midlands and the South West.

### Personalisation and integration

The existing right of patients to choose their GP is confirmed explicitly in the draft constitution (see below). Although this right to choose has always been present in principle, in many parts of the country 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. 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 GMS providers to offer services and pledging to guarantee patients access to open lists.

In 2006 the White Paper *Our Health, Our Care, Our Say* pledged that patients with long-term conditions, including mental health problems, would be able to have personal care plans by 2008. Lord Darzi's report confirms this commitment and extends the original pledge by specifying that the plans must be agreed by a named lead professional from the team of people who help to manage a patient's care. In addition, patients with complex long-term conditions will be provided with a named lead professional, such as a community matron or case manager, who will be responsible for advising them on how to access the services in their plan (Department of Health 2008c). More than half of the strategic health authority vision documents proposed the introduction of similar 'care co-ordinator' roles for patients with long-term conditions (King's Fund 2008).

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 exploring their introduction. It suggests that in some cases the budget would be held by the professional on behalf of the patient, but also commits to piloting direct payments 'where this makes most sense for particular patients in certain circumstances'. The introduction of direct payments would require legislation. The report adds that personal budgets would be voluntary, accompanied by tailored support, that no one would ever be denied treatment as a result of having a personal budget and that 'NHS resources will be put to good use, with appropriate accountability'. Establishing the correct initial payment level for personal budgets will prove particularly challenging, unless it is only to cover routine, predictable care. There is the potential for direct payments to open up the opportunity for individuals to enhance their allowance with their own money (co-payment), which risks creating a two-tier service. There is also the potential for NHS funds to be spent on non-health or ineffective treatments, although the report's assurance that the resources will be put to 'good use' suggests there may be restrictions on how the money can be spent.

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). The proposal of this model seems to allude to the fact that GPs have not always been successful in co-ordinating patient care and this would be more effective with input from other professionals. It is worth noting that this proposal to address the problem of fragmented services further blurs the distinction between providers and commissioners of care and has the potential to reduce patient choice. It also has potentially major implications for the current drive to develop world-class commissioning in primary care trusts.

## Innovation

The review team for this area was tasked with developing a strategy for ‘speeding up and embedding innovation’ across the health service in relation to medical devices, pharmaceuticals, clinical practice and delivery models.

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 currently take up to two years for guidance to be published following the licensing of a new drug. The report pledges that in the majority of cases this will be reduced to ‘a few months’. In 2005 the Department of Health and NICE introduced a new, faster process for assessing certain life-saving drugs called the ‘single technology appraisal’ process. It is not clear whether this new reform is about expanding that system to cover more drugs, or beginning the assessment process earlier (ie, before licensing).

NICE is also being tasked with extending 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. It will be important that these standards are linked to the measurable indicators developed by the National Quality Board. The cost of this expanded role for NICE is not set out.

At a local level, PCTs are to be encouraged to enable the development of ‘flexible, responsive’ community services. The Department of Health is set to publish advice on a range of organisational options that PCTs might adopt for the community services they have traditionally provided. These will include the development of arms-length provider organisations, which remain responsible to the PCT board, or the creation of new foundation trusts. This provides a way for the Department of Health to encourage primary care trusts to separate their provider and commissioning functions rather than appearing to force PCTs to divest themselves of their provider function, a policy that provoked considerable hostility when it was suggested in 2005.

Measures to encourage the development of social enterprises to provide community services were also announced. Where former PCT provider staff establish a social enterprise and continue to work wholly for NHS services, they will be allowed to retain their NHS pension. This would remove a significant obstacle to the creation of new forms of organisation, although as yet there is no mention of extending this right to the independent sector. The report also states that all PCTs will be obliged to consider



requests by their staff to establish social enterprises, 'and if the PCT board approves the business case, support the development of the social enterprise and award it a contract to provide services for an initial period of up to three years'. It is not clear if the same rights would be extended to private sector provider models.

Strategic health authorities are to have a new legal duty to promote innovation, to be realised by administering 'substantial' new funds for innovative projects and awarding prizes for innovations which directly benefit patients. New 'Health Innovation and Education Clusters' will be encouraged to emerge locally, comprising health care professionals, and individuals from the education sector and industries who will be tasked with running 'joint innovation programmes'.

### Clinical leadership and workforce planning

The report announces that in addition to being practitioners, all clinicians should have the opportunity to be a 'partner' – collaborating with other organisations as well as taking responsibility for the management of finite resources – and a 'leader', working with other clinicians and managers to change systems where it will benefit patients.

Clinical and non-clinical leadership has, the report says, 'been the neglected element of the reforms of recent years'. A series of initiatives aimed at developing leadership skills and supporting leaders is proposed, including reviewing the undergraduate curriculums for nursing and medical students and training programmes for other health care professionals to ensure they reflect the skills required for leadership; introducing a 'Leadership for Quality' certificate as a way of assuring the quality of development programmes; establishing Clinical Leadership Fellowships, which provide protected time for clinicians to focus on developing their leadership skills; establishing a Clinical Management for Quality programme for clinicians managing the provision of particular types of service, 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; encouraging the development of Master's levels programmes relevant to the health sector; and establishing an NHS Leadership Council, chaired by the NHS Chief Executive, with a budget to commission leadership programmes.

The report's proposals for greater local control and fewer top-down targets in relation to services could also be used as a model for leadership development. It is important that the new Council should focus on collating and sharing existing examples of best practice and not prove a new centralising force. It is also important that in focusing on clinical leadership, the management task, which is much less attractive than leadership but highly important to improving service quality, is not overlooked or undermined.

In addition to policies already introduced under the world class commissioning programme, the report recommends that clinical engagement in commissioning ought to be enhanced by establishing 'interviews between the PCT board and a panel of independent experts, one of whom will be a clinician'. Practice-based commissioning should be 'redefined and reinvigorated' through involving community and specialist as well as primary care staff in the policy and distinguishing more clearly the role of commissioning from enhanced GP provision, though it is not clear what this might mean in practice.

More broadly in relation to workforce education and training, the report recommends replacing the current funding arrangements for the education and training of clinicians, under which a Multi-Professional Education and Training (MPET) levy is allocated to strategic health authorities, with a tariff-based system where money follows the trainee. The details of how this would work are due to be developed over the next few months.

Investment in apprenticeships for health care support staff are due to be doubled over the next four years and while continuing professional development will remain the responsibility of individual employees the government intends to 'strengthen the arrangements to ensure staff have consistent and equitable opportunities to update and develop their skills' (Department of Health 2008a). The draft NHS constitution (see below) also includes a pledge to 'provide all staff with personal development, access to appropriate training for their jobs, and line management support to succeed' (Department of Health 2008e).

Following the recommendations of the Tooke report on medical training published earlier this year (Tooke 2008), this report commits to establishing an independent public body, Medical Education England (MEE) to advise the Department of Health on higher specialist training for doctors, dentists, pharmacists and health care scientists which needs to be organised at a regional or national level. This body is due to be established by the end of the year.

A regional 'advisory machinery' (Department of Health 2008a) will also be established to provide input from clinicians and other health care professionals on workforce planning at the SHA level. The report commits to ensuring that 'workforce is able to meet the needs of patients by developing workforce elements of service plans, using the eight pathways of care of the review as the basis for identifying what patients need, now and in the future'.

The report also proposes the establishment of a 'Centre of Excellence' hosted by a university (or group of universities) to support national and local bodies by developing technical planning assumptions, performing long-term horizon scanning activities and – somewhat ambiguously – 'enabling the capacity and capabilities to make the SHA wide workforce planning, education and training system work' (Department of Health 2008a). It is not clear how this service will relate to the existing functions served by the National Workforce Review Team and National Workforce Projects.

## Regulation

The government recently consulted on the details of the new regulatory system due to come into force next year. Two weeks after the close of this consultation, two of the proposals appear to have been adopted in this report: registration requirements relating to health care acquired infections will be introduced in April 2009, a year in advance of the full registration system, and all GP and dental practices should be incorporated into the regulatory system in some form, in order to remove unwarranted variations in care quality.

## Constitution

A draft constitution has also been published alongside the review. It consists of the constitution document itself, which is relatively short (six pages) and a 'handbook' designed to add the detail. The constitution contains a set of statements categorised as principles, rights and pledges: only the rights have legal force, which is set out in detail in the handbook. 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 fails 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 principles also include a commitment to the NHS being accountable to the public, communities and patients. A statement of NHS accountability, 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 (Department of Health 2008e). The constitution also pledges that patients, the public and staff should be involved in decisions that affect them – either direct or through representatives. The consultation document accompanying the constitution states that the government does not intend to make changes to existing formal accountability structures, but encourages primary care trusts 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.

The 'rights' section pulls together the existing legislation that relates to health care, equalities and 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. There are some gaps: the legal duty on NHS organisations to consult the public on services (especially service charges) is not presented as a 'right' for patients to be consulted on the planning and delivery of NHS services. It is possible that this will be included in the forthcoming statement of accountability.

There are 'rights' to choice, which received considerable attention in the media for their novelty. There are three versions of choice. The first two – the right to choose a GP and the right to express a preference for using a particular doctor within a practice – are based on existing law. They are accompanied by potentially broad caveats: the right to choose a GP can be refused on 'reasonable grounds' and the preferences for a GP have to be 'reasonable'. The third, a right to wider (not specified) choice – 'choices about NHS care' – has yet to be clarified by the Secretary of State, and will also require secondary legislation.

Overall, the NHS constitution provides a useful distillation of law from a patient's point of view; however, it is not clear what sort of impact this will have on the NHS: many of the actions available under 'redress' involve patients either complaining through the existing channels (NHS complaints procedures or to their PCT) or even seeking judicial review. It is not clear how many patients will use the NHS handbook to find out either the legal details or the basis for the many pledges, for instance what the current waiting times should be for treatments.

## Health

Although much of the review looks at how to improve the quality of NHS treatment for those already ill, it also summarises some centrally driven initiatives, which have already been announced, to improve the quality of preventive care. The usual array of future health challenges are identified in the review – demographic change, more lifestyle-driven illnesses – but there's an admission that the NHS in general and GPs in particular have been poor at meeting these challenges so far. The review cites evidence from its own research, in which more than 54 per cent of patients reported that their GP had failed to offer them advice about diet and exercise.



The review repeats the commitment, made in April 2008, to provide health checks to everyone aged between 40 and 74 to screen for vascular disease, adding that the first checks will begin next year and be gradually rolled out until 2012, when they should be offered to about 3 million people a year. A Coalition for Better Health, already announced in May 2008, will be launched 'shortly', which will consist of voluntary agreements between the NHS and the private and voluntary sector, initially focusing on obesity.

Although the review states that every PCT will now have to commission services to tackle obesity, alcohol and drug abuse, smoking and improving mental and sexual health, there's a lack of detail about how the government will ensure that organisations make the investment in this area. Preventive and other public health services have, in the past, been subjected to cuts when PCTs have come under financial pressure.

The review also promises action to encourage employers to keep people healthy in the workplace, working with other government departments to ensure that 75 per cent of FTSE 100 companies report to their boards on their employees' health 'by 2011' and introducing an unspecified number of new 'fit for work' services in primary care to ensure that services for common mental health or back problems can be accessed more quickly.

## Conclusion

*High Quality Health Care for All* offers a new vision for improving quality in the NHS, one that places an emphasis on the desire of NHS staff to drive this improvement, based on enhanced information about quality. The report begins to develop a more sophisticated view of managerial and clinical motivation – central to this is a belief that organisations will be self-improving where they can see their own performance in relation to others and where they accept the accuracy and fairness of the comparisons being made. Many clinicians will welcome this new emphasis on professionalism and autonomy.

There is a question about how clinicians and health care workers feel about taking on more responsibility for management and for improving the system. The significant increase in quality data collection indicated by *High Quality Health Care for All*, and in particular the requirement to use it to inform practice, has the potential to involve clinicians in a greater range of non-clinical activities, which they may not welcome. The time this collection and analysis entails will also have cost implications.

The review process involved considerable amounts of work at a regional level and this report has been presented as making the national changes necessary to enable these local visions to be realised. The final report also emphasises introducing local flexibilities to some national policies and continuing the government's policy of encouraging all trusts to become foundation trusts, thus giving them more autonomy from central government control. The extent to which any local freedoms might be enjoyed is in part contingent on how many 'must dos' continue to be issued by the Department of Health. Each year, the annual list of instructions from the Department of Health to the NHS contained in the Operating Framework has been extensive: this year's (the fourth) will be awaited with interest.

In the year leading up to the launch of the Darzi review, the reconfiguration of health services – in particular the centralisation of some specialist services posing a threat to the sustainability of local hospitals – was an incendiary (and unresolved) political issue. In the course of this review, the government appears to have succeeded in extricating itself from involvement in these local debates. A short document was published as part of the review process setting out the principles against which local decisions on service change should be judged, stating that they must be of benefit to patients; led locally; clinically driven; involve patients, the public and other stakeholders; and that no existing

services should be withdrawn until new 'and better' services are available to patients (Department of Health 2008d).

The Department of Health could have published firm guidance on, for example, the necessity of centralising stroke care, where the evidence is fairly unequivocal. However, they have chosen to defer these decisions to strategic health authorities and primary care trusts. A 'statement of accountability' setting out which organisations are responsible for what in health care is due to be published alongside the final version of the NHS constitution and the government has encouraged PCTs to experiment with new mechanisms to enhance their public accountability. The extent to which decisions by SHAs or PCTs will seem more palatable to local people than decisions by central government will depend at least in part on how successfully SHAs and PCTs consult their local populations and communicate the case for change.

Whether professionalism is intended to replace competition as the principal driver of quality improvement in the service, or whether the NHS will continue to support and implement patient choice and make greater use of the private sector, remains to be seen.

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