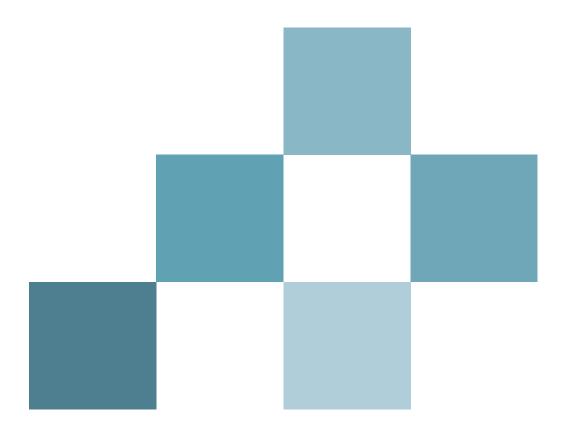# Background to the Next Stage Review

Background

In July 2007 Professor Lord Ara Darzi, a surgeon and health minister, started a wide-ranging review of the NHS in England – described by the Secretary of State for Health Alan Johnson as a 'once-in-a-generation opportunity to ensure that a properly resourced NHS is clinically led, patient-centred and locally accountable'. This followed a review of London's NHS that Lord Darzi conducted in 2007 before becoming a health minister in June 2007 and undertaking his national review.

Lord Darzi's *Next Stage Review* has been charged with developing a vision for the health service over the next decade by engaging with patients, staff and the public on four key challenges:

- ensuring clinical decision-making is at the heart of decisions about the design and future of the NHS

- improving care by increasing quality and making services more joined up

- making care more convenient, easier to access, delivered in the right place and integrated across primary and secondary care

- building a service that is based around patient control, choice and local accountability and less on central direction.

The final report is due to be published before the 60th anniversary of the NHS on 5 July 2008. This should provide a much clearer picture of the future direction of government health policy under Gordon Brown's leadership. The government's recently announced draft legislative programme for the autumn (May 2008) includes an NHS Reform Bill to implement any proposals requiring legislation. This briefing examines the key issues that will be covered in the review.

Informing the review

The review has been informed by consultation exercises with patients, staff and the public and by the work of a series of local, regional and national working groups. The review has held consultation events in each of the nine strategic health authorities (SHAs) outside London and an international summit, which included presentations from other countries;it also provided an interactive website – www.ournhs.nhs.uk – that has encouraged individuals and organisations to give their views.

LOCAL AND REGIONAL WORK

Eight 'clinical pathway groups' comprising local NHS staff and stakeholders were set up in each of the nine SHAs outside London in October 2007 and asked to develop a plan for 'world-class quality care' in their area. The groups were organised around eight clinical areas:

- maternity and newborn care
- children's health
- planned care
- mental health

- staying healthy
- long-term conditions
- acute care
- end-of-life care.

Drawing on the work of these groups, each of the nine SHAs has developed a document outlining their 'vision' for health care in their respective regions for the coming decade. These documents are being published in May and June 2008, in advance of Lord Darzi's final national report.

NATIONAL WORK

Five groups were charged with identifying the changes required at a national level to enable the proposed local and regional changes to be implemented. These groups have focused on:

- primary and community care
- quality improvement
- innovation
- workforce
- leadership.

Additional work was being undertaken by the Department of Health on:

- systems and incentives
- informatics
- NHS constitution.

EARLY INSIGHT INTO LORD DARZI'S PLANS?

An interim report was published in October 2007 – in this report, Lord Darzi made clear that the current set of NHS reforms, such as patient choice, Payment by Results and reforms to regulation, must be allowed to continue. The report's headline recommendations focused on patient access to family doctor services and increasing the capacity of primary care services in under-doctored areas.

Lord Darzi recommended 100 new GP practices in the 25 per cent of primary care trusts (PCTs) with the greatest need – the government has since announced funding for 12 new practices and a further £100 million for investment in existing GP practices. He also recommended that 150 new 'polyclinic-style' health centres should be built throughout the country – these would provide a range of services, such as minor surgery, 8am–8pm, 7 days a week. Since the interim report was published, the government has introduced a new financial incentive (recycling existing incentive monies for GPs) for practices that provide on average three hours of additional appointment time in evenings or at weekends.

The interim report also recommended the introduction of MRSA screening for all planned hospital admissions in 2008 and all emergency admissions by 2010; and the establishment of a Health Innovation Council charged with being 'the guardians of innovation, from discovery to adoption'.

What will the final national report recommend?

The final report has been described as a 'framing' or 'enabling' document, which will identify the national policy changes required to help managers take forward changes to local health services. The national review team has recently published a set of rules to govern such changes to allay public anxieties over changes to local services – they must be to the benefit of patients; clinically driven and locally led; involve consultation with patients and the public; and existing services should not be allowed to close before new services are in place and delivering benefits.

The following pages outline the key issues each of the national working groups are likely to be grappling with.

PRIMARY AND COMMUNITY CARE

This team has a particularly wide remit, and recommendations relating to primary care are likely to play a significant part in Lord Darzi's final review. It has been asked to consider:

'the models of care being developed locally, and [to] develop a vision of world-class primary and community care services, capable of tackling existing challenges of access and inequality, and focusing ever more strongly on promoting health, encouraging self-care, predicting and preventing ill-health and managing long-term conditions'

Integrating care

A major challenge for primary care is how to integrate services around the needs of the patient. This means improving not only accessibility, but also communication between different parts of the health service. This is especially important in the management of long-term conditions, where patients may use services frequently and where a failure to identify and treat a minor problem can result in an emergency admission to hospital, which is bad for patients and costly for the health service.

The focus is now on helping different parts of the health system to work better together. This could be done through developing clinical networks or establishing clearer pathways, both of which could be supported through the development of polyclinics. The term 'polyclinic' has been used to describe a variety of different approaches from very large super surgeries, which involve closing current GP practices and moving their services into the new unit, to the so-called hub-and-spoke model, under which clusters of GP practices create formal links with one another and draw on a common set of community-based diagnostic and specialist resources. Polyclinics could bring together family doctors and specialists alongside a range of other services, such as diagnostic testing and minor surgery. They could also bring more outpatient work out of hospitals and provide other 'one-stop shop' facilities such as blood tests and x-rays.

Lord Darzi's review of London's NHS recommended that polyclinics be introduced across the capital. He described them as 'new facilities that would offer a far greater range of services than currently offered in GP practices, while being more accessible and less medicalised than hospitals'. Lord Darzi's proposals for London, which have now been consulted on, would see the polyclinic as the place where most routine health care needs are met in the capital. Although polyclinics are being considered as part of the national review, Lord Darzi has distanced himself from the models of large polyclinics that locate GP and other services in a single, centralised building and has expressed an interest in the hub-and-spoke model.

The King's Fund supports the hub-and-spoke model over those which centralise GP care, but urges commissioners to focus on developing new care pathways, technologies and better joint working across teams and professions. Developing new facilities may be part of the strategy, but buildings should be a means to an end, not an end in themselves (Imison *et al* 2008).

Choice

Extending patient choice in primary care is also in the review team's remit, specifically identifying the changes required to make it easier for patients to change GP practice and to be able to register near their workplace. In addition to making services more convenient to patients, this is intended to introduce competitive pressure on GPs (similar to that introduced in the hospital sector) to respond to patients' preferences.

In theory patients can already choose their GP practice, but in practice lists may be closed (or 'open but full') or new registrations may be restricted to people living within certain geographic areas. Some GP funding arrangements act as disincentives for practices to take on new patients. For example, the Minimum Practice Income Guarantee (MPIG) – introduced with the new GP contract in 2004 to safeguard practices against any loss of income resulting from the move to a new funding formula – protects practices' existing income levels. Also, under the General Medical Services contract if a patient moves practices, the new practice receives less than 70 per cent of the funding for that patient and additional 'premise' funding stays with the original practice. The government intends to review these arrangements.

New providers

The introduction of Alternative Provider Medical Contracts (APMS) in 2004 opened up the provision of primary care services to commercial and voluntary sector providers without NHS links, but use of these contracts has been slow (Walsh *et al* 2007). The review team will need to identify what can be changed to encourage providers and commissioners to use existing routes more effectively, or to consider whether new contractual mechanisms are required. Any new organisations must be subject to the same regulatory standards as traditional providers.

Encouraging new providers and patient choice could conflict with maintaining continuity of care. As the Royal College of General Practitioners has pointed out, increasing flexibility in access to primary care may be desirable to young and relatively healthy service users who prioritise convenience, but those with long-term conditions and co-morbidities are more likely to benefit from a consistent relationship with a GP.

QUALITY IMPROVEMENT

This team, led by the Chief Medical Officer, has been tasked with developing a strategy for:

> 'speeding and embedding quality improvement across the health and social care delivery system', to include drawing on international evidence of best practice in 'standard setting, data collection in clinical practice, inspection and review of health care services, and supporting quality improvements'

The Health and Social Care Bill currently in Parliament deals specifically with the reform of regulation in health and social care, including the establishment of a new Care Quality

Commission (House of Commons Bill 2007–08). The regulation of health professionals was the subject of a recent White Paper, and implementation of its recommendations is being considered separately. The focus of the review team is likely to be the day-to-day delivery of care in hospitals and elsewhere.

Despite concerns about variability in the quality of clinical care in different parts of the health service and occasional scandals revealing poor practice, a lack of systematic data on care processes and outcomes for patients makes it impossible to benchmark standards of clinical practice.

There have been recent developments on this. The new 'Standard NHS Contract for Acute Services' introduced this year requires all hospitals providing services for NHS patients to publish patient-reported outcome measures for a limited number of procedures from April 2009. Together with the Society for Cardiothoracic Surgery in Great Britain and Ireland, the Healthcare Commission has also developed a database and accompanying website showing survival rates for heart surgery at different surgical units across the United Kingdom (Healthcare Commission 2008). Enabling data on clinical processes and outcomes to be comparable across different units and different clinicians requires the information to be risk-adjusted to take into account the differences in the conditions of patients needing care.

This team is also likely to draw on international evidence to make recommendations in relation to whether certain types of specialist services, such as trauma and stroke care, ought to be centralised into specialist centres. Research to date has found that for some types of treatments, higher volumes of patient throughput are required to maintain institutional and individual competence and are associated with improved health outcomes for patients.

One option apparently being considered in relation to primary care (Lakhani 2008) is to recommend some form of national accreditation scheme which would grade services or institutions giving them the equivalent of a kite mark of quality – the accreditation standards would be above the basic level required by the new regulator the Care Quality Commission.

The government has also indicated that it plans to make payments to NHS hospitals adjustable according to patient satisfaction and health outcomes (*see* Systems and Incentives).

INNOVATION

This group must develop a strategy for 'speeding up and embedding innovation' across health and social care services in relation to medical devices, pharmaceuticals, clinical practice and delivery models and management. The term 'technologies' is used to refer to these areas collectively.

The United Kingdom is traditionally slow to adopt advances in medical technologies. While the government has not introduced targets or wide-ranging initiatives in this area, they have established a number of new organisations and initiatives intended to speed up the process of adopting and implementing innovative technologies.

Evidence on the value of new technologies is generally poor, making it very difficult to estimate the scale of potential benefits and the costs of achieving them. While some technologies may reduce unit costs, it has been predicted that as a whole new technologies will put upwards pressure on health spending as they deliver quality improvements (Wanless 2001).

In contrast, improvements in service design and delivery may lower costs and improve quality. There has been a sustained drive since 2000, first through the Modernisation Agency and now its successor the NHS Institute for Innovation and Improvement, to deliver services more effectively. This has achieved a number of successes, such as reducing waiting times for diagnostics and for treatment. But such improvements are not replicated quickly enough across the service as a whole.

The challenge for this part of the review will be in identifying novel solutions to longstanding structural and cultural barriers to technological innovation of all kinds in the service.

WORKFORCE

This team has been asked to develop a long-term strategy for workforce planning which will ensure that education, training and planning processes produce a workforce of the right size and structure, which is suitably skilled to deliver a high-quality service. The terms of reference add that the workforce must also be sufficiently flexible and sustainable to meet the changing needs of patients and the service and that the future roles of clinicians and their career pathways should be clearly described.

The immediate concern for the team should be the lack of connection between workforce planning and financial and service planning. For example, the policy of shifting care out of hospitals into community settings will require retraining and redeployment of existing staff; as yet no details have been published on how this might be achieved. At both regional and national level, the importance of workforce planning both in its own right and in relation to service and financial planning must be better recognised through organisational structures and skills development. Workforce planning is often demoted to a secondary concern after service and finance strategies have been agreed.

The team will also have to consider the longer term. As Sir John Tooke recommended in his report of the Inquiry into Modernising Medical Careers, this requires the development of 'common and shared understanding(s)' of professional roles within health care teams (Tooke 2008) and how they will develop in future. Education and training then ought to follow on from the establishment of these roles, which Tooke recommended should be developed in consultation with all major stakeholders and should take 'due account of public expectations'.

Sir John Tooke is now working with a range of organisations to define the role of the doctor in the 21st century with a view to reaching consensus by the end of this year.

A major challenge will be in identifying how education, training, career paths and regulatory structures can be organised so that they can respond to changes in individual skills and

health care teams and evolving service demands. A further challenge will be to work out how professional roles and job definitions can be changed so as to make the workforce more productive.

The team will also have to make clear the extent to which national workforce planning has a future and how far planning should be devolved to a local level – indications thus far are that Lord Darzi would prefer to see local solutions.

LEADERSHIP

Work on leadership is being supported by three working groups. The first is examining 'the leadership model' and is tasked to define 'what excellent leadership in the NHS looks like and what needs to be done nationally to encourage the behaviours we are seeking.' This will produce specific recommendations in relation to appointment, assessment and promotion. The second group is focusing on 'getting the right people', which includes consideration of increasing diversity among NHS leaders, recruiting more women and people from ethnic minorities. Finally, the 'leadership development' group is examining how developing leadership skills can form a part of all professional training in the NHS. These three streams are each being managed by senior representatives from strategic health authorities who lead on workforce planning.

One recurring tension in the development of leadership strategies is whether the NHS should (in this context) be thought of as a single business, like Tesco, or as an industry, in which a collection of organisations are working for a common purpose within a regulatory framework. The 'single business' model allows central mandates to be issued about best practice and would permit 'talent' to be managed centrally and moved around the system without the requirement for recruitment processes. The industry model makes it more difficult for individual organisations to be mandated to take actions and requires appointment processes to be followed when individuals move roles or organisations. In grappling with this issue, the group will need to define clearly national, regional and local responsibilities in the development of leadership.

This group's recommendations will almost certainly emphasise the importance of 'clinical leadership'. This presents an opportunity to better unite clinicians and managers in the pursuit of national policy objectives and to engage clinicians in considering the economic implications of their actions. It also allows those with frontline knowledge to feed back on whether policies are achieving (or are likely to achieve) their objectives.

In the context of frequent structural reorganisations and leadership investment programmes that have to date focused on rectifying failure, a new leadership strategy for the service ought to focus on valuing and positively investing in existing leaders, rather than solely on bringing in new talent.

ADDITIONAL AREAS

Systems and Incentives
There is no published information on the scope of the work the Department of Health is

undertaking here. It could include: reviewing whether existing systems of financial incentives in primary care are helping or hindering the achievement of policy objectives; considering how staff contracts could be used to encourage greater productivity (Williams *et al* 2006, Buchan *et al* 2007); exploring what incentives could be used to encourage healthy behaviours (*see* King's Fund 2008).

The Prime Minister has announced that payment for NHS hospitals will be adjusted according to patient satisfaction and health outcomes (Hansard 2008). This could entail making a particular proportion of the national tariff payable only on the achievement of particular quality standards.

The King's Fund has commissioned an expert working group to contribute to this strand of Lord Darzi's review. The resulting report will include recommendations for the strengthening of PCT commissioning through the appointment of independent clinical advisory panels to assist commissioners; SHAs devising incentives to reward strong commissioning; and the development of national quality indicators which PCTs can use in contracts with providers. This report will be published in June 2008.

Informatics

NHS Chief Executive David Nicholson commissioned a review of informatics to examine how the collection and sharing of information in the NHS can be improved, minimising the burden of collection on organisations while maximising the use of the information that is collected; and how to align the aims of existing and future information projects with NHS priorities. This will include reviewing the National Programme for IT and better integrating decision-making on informatics in the Department of Health with policy-making across other areas of health care.
By 2014 the National Programme for IT is intended to deliver an integrated electronic patient records service; an electronic prescribing system; a digital images communications and archiving system; an electronic appointment booking system; an NHS email and directory system; new IT systems for GPs to enable them to easily transfer records; and an IT infrastructure to support all these systems.
All of these programmes have begun to be implemented, though some are behind schedule.
In addition to delays in implementation, the programme has also been criticised for failing to demonstrate that its investment represents value for money. The planned spend on ICT in the NHS in 2006/7 was almost £3 billion (Wanless *et al* 2007).

Sir Bruce Keogh, formerly NHS Medical Director, has been appointed to the new role of Chief Information Officer. Given Sir Bruce's previous interest and pivotal role in the development of a database of risk-adjusted heart surgery outcomes (*see* Quality Improvement section above), his appointment could signal a new focus in the Department of Health's informatics strategy on collecting and making available data on care quality.

NHS Constitution and Local Accountability

The Prime Minister recently confirmed that the government intends to establish an NHS 'constitution', which 'sets out what patients can expect to get from the health service, including entitlements to minimum standards of access, quality and safety'. This will be a key issue in Lord Darzi's review.

In his interim report, Lord Darzi asked the NHS Chief Executive David Nicholson to consider how a constitution could: help secure the enduring principles of the service; establish a stronger framework for accountability and legitimacy at both local and national levels; establish the responsibilities of all organisations working for NHS patients; include an open and accountable process for arbitration and decision making where decisions on the shape and delivery of local

services cannot be resolved locally; review the process for NHS appointments; strengthen the opportunity to work in partnership with other organisations; and create a stronger focus on rights and responsibilities for patients, the public and staff 'based on evidence of what matters'.

The Department of Health has already developed a 'statement of principles' for the NHS (Department of Health 2006a, Department of Health 2006b), to which the Conservative Party has given its support. The model NHS contract for 2007/8 required organisations to 'have regard for' the statement of principles, though it is not clear how this might be enforced.

A constitution could set out minimum standards of service – for example, a guaranteed maximum waiting time or the promise of a choice of hospital. However, these could change quite often, making it inappropriate to enshrine them in primary legislation. And there is a risk that a legally enforceable set of rights and responsibilities may lead to disputes over entitlements being resolved in the courts rather than in PCTs or the National Institute for Health and Clinical Excellence. On the other hand, a constitution must be more than a set of aspirations.

The King's Fund has argued (Dixon *et al* 2008) that a constitution could be useful in setting out the roles and relationships of key players in the health system, including the Department of Health, making it clear how the NHS is governed and who is responsible for which types of decision. However, the Department of Health will have to balance this against the dangers of issuing hollow rhetoric and over-specifying things which will either lock-in the status quo or open the NHS to legal challenges.

The constitution might also specify mechanisms for local accountability. The Prime Minister has recently said that the government plans to strengthen public involvement in commissioning arrangements. PCTs already have a legal duty to consult the public and are subject to scrutiny by Local Involvement Networks (LINKS) and local authority overview and scrutiny committees. However, some have argued for strengthening the role of the public by allowing directly elected PCT boards or instituting membership arrangements similar to those of foundation trusts. Stronger local democratic influence over PCT commissioning could be expensive to set up and could lead to a conflict between central government policy and locally driven decisions.

What happens next?

Lord Darzi has made it clear that his final report will be 'no national blueprint' but will be about *enabling* the local visions of SHAs to become reality. On the other hand, the government is committed to both value for money and best clinical practice so there may be more support for some types of local changes than for others. For example, Lord Darzi has (outside of London) expressed interest in hub-and-spoke models of polyclinics in which GPs stay in their existing practices but have access to new resource centres providing diagnostic tests and other specialist services.

Many local plans for reconfiguring services were put on hold following the announcement of Lord Darzi's review. The publication of the review, together with the nine SHA 'vision' documents, will signal the re-launch of plans for reconfiguration. That means the thorny issue of local service change will be firmly back on the political agenda.

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Further reading

Detail about the Darzi review, including membership of the working groups, events and publications can be found on the Our NHS, Our Future website, at: www.ournhs.nhs.uk

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