King's Fund response to Health Select Committee inquiry on NHS Next Stage Review

1. Introduction

1.1 This paper is a response by The King's Fund to the Health Select Committee inquiry into the NHS Next Stage review. The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help shape policy, transform services and bring about behaviour change. Our work includes research, analysis, developing leaders and improving services. We also offer a wide range of resources to help everyone working in health share knowledge, learning and ideas.

1.2 Niall Dickson, Chief Executive of The King's Fund has been invited to present oral evidence to the Health Select Committee on 10th July 2008.

2. Overview

2.1 It is always difficult to live up to a 'once in a generation' billing, but in general we feel the report provides a sensible set of measures to improve quality and equity, and a clear signal that responsibility for shaping and leading health services lies with staff at local level. The report suggests that in the near future patients will be able to access a wide range of information about the quality of the services they are being offered, from infection levels to success rates following operations. It is anticipated that this will support patients to make informed choices and put pressure on those providing the care to improve. It should also be useful to commissioners and GPs who purchase services or advise patients on where to go for care.

2.2 In order to secure high quality care that is responsive to patients it is important that local organisations are given greater freedom to innovate, are subject to less central control, but are clearly accountable for quality and value for money. While services provided by the NHS are far from uniform, increasingly devolved decision-making could result in significant regional variations in the care provided to patients. This will be a challenge for the government to communicate to the public.

2.3 There are two significant omissions in the report– there are no estimates of cost and no indication of just how different the government expects the quality of health services to be in five or ten years time. Some of the answers lie in the regional plans but an overall view of how far and how fast the government expects the NHS to change would be helpful.

3 King's Fund contributions to the Review

3.1 The King's Fund has been involved in the NHS Next Stage Review in a variety of ways:

a. We provided an analysis of the London review and presented evidence to the London Joint Overview and Scrutiny Committee.
b. We published a research report examining polyclinics and out-of-hospital care, drawing on international experience and the experiences of UK LIFT projects: *Under One Roof: Will polyclinics deliver integrated care?*
c. Niall Dickson, Chief Executive and Dr Anna Dixon, Director of Policy, participated in the work to develop the draft constitution for the NHS.
d. We commissioned an Expert Working Party to examine the systems and incentives involved in the current NHS reforms in England, and their state of play, as a contribution to Lord Darzi's NHS Next Stage Review: *Making it Happen: Next steps in NHS reform.*
e. We published the report of SeeSaw, a simulation-based project led by The King's Fund in partnership with Loop2, and commissioned by the Department of Health's

Shifting Care Closer to Home policy team. Its purpose was to better understand how a shift in care from hospital to community settings could be achieved.

f. We published two research papers examining national and local accountability:
   - *Governing the NHS: Alternatives to an independent board*
   - *Should Primary Care Trusts be Made More Accountable?*
g. Niall Dickson, Chief Executive, chaired a cross-party Commission for the Local Government Association, also examining local accountability for health services, and a number of the recommendations from that report appear in the Review.
h. Prof John Appleby, Chief Economist, and Dr Nick Goodwin, Senior Fellow, presented written and oral evidence to an inquiry by the All Party Parliamentary Group on Primary Care and Public Health – this was submitted to Lord Darzi's Review team. A final report from the inquiry is expected to be published on 8 July.
i. Our work on medical professionalism, while not undertaken explicitly for the Review, has been quoted in the Review documents

4. Commentary on the Review

4.1 As this was an extensive and wide-ranging Review, comprising multiple documents and strategies, we have attempted in this evidence to outline our response to the main points of the Review that we would wish to draw to the Committee's attention. We will be undertaking a more detailed analysis in the coming months.

4.2 The NHS draft constitution

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. The constitution 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. For choice not to be meaningless patients will need robust information to ensure they can make informed choices. The NHS constitution also reinforces the deal between taxpayers, patients and the state. It underlines the reality that the letters NHS no longer describe a state-run business – instead the NHS is a commissioner of comprehensive health care, free at the point of delivery.

4.3 Local accountability

While welcoming the emphasis on local accountability in the report, we believe it is critical to ensure that devolving decisions to local organisations does not lead to devolved power without devolved accountability. There is also a need to be clear about what kind of accountability is being promised. PCTs need to take more account of local views and give a clearer account of their decision-making to the people they serve. In order to hold PCTs to account we need to build on the existing mechanisms the NHS already has in place, such as strengthening the role of Overview and Scrutiny Committees. Politicians need to be clear about what kind of accountability they are seeking to achieve when they talk about different measures to increase 'local accountability' in the NHS.

4.4 Regional SHA plans

There have always been regional variations but the difference with this series of plans is that these differences are made are more explicit. There is an inherent tension in the government's desire to establish national guarantees and standards and the pledge to get rid of the "postcode lottery" over PCT provision of NICE approved drugs while at the same time SHA plans and devolution to PCTs mean that some regional variation is inevitable. 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.

4.5 Individual health budgets

The more we can tailor treatment the more likely it is to be responsive to individual needs but we need to look carefully at the implications of extending personalised budgets into the health service. Although direct payments are being used in social care, their effective use in health care presents more challenges,

4.5.1 Patients will need support in making informed choices about how to plan their own care, there also needs to be clarity about what exactly patients will be allowed to spend their allotted money on. Other challenges include - getting the initial payment level right and deciding who holds the budget; if it 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 directly by the patient it could allow the better off to enhance their allowance thereby creating a two-tier service.

4.5.2 This is a reform that is worth piloting and evaluating but it should not follow the government's usual pattern of using pilots as a prelude to national roll out - it should be carefully assessed and all the implications understood before any decisions are made about its use in the NHS.

4.6 NICE approval process

NICE is recognised world-wide as a real success for its cost effectiveness evaluations. Although its work is both rigorous and transparent there have been concerns that its decisions take too long. Moves to speed it up are good news for patients, however, NICE needs to be careful not to sacrifice rigor for speed. The changes to the approval process announced in the review should go some way to 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 which 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 well as the proposal that PCTs need to explain their local judgements regarding funding of drugs yet to be evaluated by NICE.

4.6.1 However, an even more important 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. The Department of Health and the NHS need to put much more effort into understanding why such variations exist and what needs to be done to ensure more equitable access.

4.7 Public health

The call for comprehensive well-being and prevention services with local authorities suggests a welcome direction of travel in primary care towards managing health rather than simply treating illness. This will require significant changes in the way primary care is managed and organised with greater multi-disciplinary working and tailored support for patients in a way that has not previously been seen. We welcome the Review's commitment to a new emphasis on preventive services. If we do not make significant strides on tackling unhealthy lifestyles, especially with regard to obesity, smoking, alcohol and sexual health, then we will have to spend substantially more on the NHS than would otherwise be the case – so much so that it could threaten the long-term viability of the service. We have seen many well meaning initiatives before – it remains to be seen whether the Coalition for Better Health will have the authority needed to make a difference and whether there will be a firm commitment to increase spending on public health at local level. The health service cannot solve all the nation's social problems but it can do more in the key areas identified by the Review.

4.8 Leadership

The commitment to secure high quality leadership of the NHS and maintain this as a priority by creating an NHS leadership council which will identify and support the top 250 leaders is a welcome one, as is 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 which is responsive to patients and drives up quality in the way the report aspires to, will require effective high quality management. In the rush, rightly, to ensure clinicians are engaged and involved in leadership, caution needs to be taken to ensure 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 which could be done as well, or better by professional managers - these too are skilled and values driven individuals whose work in the NHS should be recognised. The crucial thing is to get the right people, using the right skills, at the right time.

4.8.1 Secondly the implementation of these changes needs to ensure the balance between central and local drivers for change is realised; how the balance between national and local activity and control is secured, is as important in leadership development as it is elsewhere in this report. The creation of 'Leadership for Quality Certificates' will not be seen as a universally positive step forward if the time, effort and money that will inevitably need to be invested to make it happen is seen as detracting from good progress already being made at local level.

4.8.2 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. Securing the development of the top 250 leaders across the NHS as a central responsibility is a brave move. Confidence in the NHS to deliver high quality services for its populations is undermined if the message on identifying and developing the very best leaders is that this work remains the responsibility of the Centre. The welcome move to realising local control and autonomy over the development of services, and the move away from top down imposed targets could well be seen as a model for leadership development. Many of the SHAs have now established, or are on their way to establishing, creative and intelligent approaches to locally developing talent. The role of the Centre in leadership development needs more thought, and establishing a council who will capture and nurture what is already working well, as well as develop new approaches, is an appropriately measured response.

4.9 Primary and Community Care Strategy

If the vision for primary and community care is realised it would be a real step change in the nature of primary care towards managing health and providing enhanced continuity of care. However, while more prominent in this Review, such sentiments have been a regular theme in previous efforts at reform which have had limited impact. It is an essential move in the right direction but the agenda is challenging. It will require strong leadership, the support of professionals, and the right mix of incentives. That will mean appropriate governance arrangements, commissioning and pay for performance mechanisms.

4.9.1 Choice of GP

GPs are in a unique position being given in effect contracts for life, with little or no competition for patients and a guaranteed income stream - their strength is that they are small businesses that on the whole provide good value and are much loved by their patients. But the government is right to say it must be easier for patients who want to change their GP to do so- indeed every patient should know that it is their right to do so and that the system will make it easy for them to switch.

4.9.2 This is unlikely to lead to large numbers of patients switching GP but for some who feel uncomfortable, for whom trust has broken down or the relationship is not working the chance to move easily and still be able to access out of hours care will be of real benefit. The vast majority of excellent GPs will welcome that.

4.9.3 Community services

The spotlight on community services is welcome - this is an area which has been neglected for too long and which would benefit from close examination of working practices, levels of expertise and staff deployment. Extending the same kind of evaluation and regulation to the work of health visitors, district nurses and those who attend to patients in their homes that is applied to other parts of the health service, is absolutely necessary as part of the new drive to improve quality

4.9.4 Payment to GPs

Moving standards of the quality of practice management out of the Quality and Outcomes Framework (QOF) and into an accreditation scheme is a sensible move. It will strengthen incentives within QOF that relate to health outcomes and disease management. It may also mean that smaller practices may need to coordinate or merge their management functions with others in order to obtain accreditation.

4.9.5 The Minimum Practice Income Guarantee (MPIG) remains an anomaly in the payment system to GP practices and the government is right to begin moves to remove it. Some practices that could be adversely affected in the short term are likely to be protected from any reduction in income as rises in practice payments accrue.

4.9.6 Out of hours care
Out of hours care has not been addressed in the review. This is a major omission given the poor way it has been handled in recent years. Patients should not have to wait for another 'once in a generation review' to see this tackled.

4.9.7 Polyclinics
The government is right not to present a one size fits all model for the delivery of GP services. Polyclinics may be the right answer in some areas, they will not be right for others. That should be a matter to be decided locally on a case-by-case basis using the best clinical evidence available together with a full assessment of the costs and the impact on patient access.

4.9.8 Integrated care organisations
'Integrated care' should mean improved continuity of care, removing the artificial divide between health and social care services and enabling health professionals in different organisations to work together to provide more personalised and efficient care to patients. If this is what the government is aiming for then that is to be welcomed.

4.9.9 However, there is a tension between integrating care across community, primary and secondary care on the one hand whilst on the other promising patients in the draft constitution the right of greater choice not only over treatment but over providers. If 'integrated care organisations' are also commissioners of care there is a potential conflict of interest which could reduce patient choice rather than increase it.

4.9.10 Practice-based commissioning
Current evidence shows an overall lack of progress with practice-based commissioning and lack of active GP involvement in the scheme. The evidence suggests GPs are more interested in providing services rather than commissioning them and some PCTs are less supportive of practice-based commissioning. Whilst the strategy will hold PCTs to account for the quality of their support, our research has found that PCTs themselves need more capacity to provide such a role effectively. In particular the quality of data on which to give GP commissioners real budgets is in some cases so poor this would not actually be possible. Better articulation of the practice-based commissioner's dual role as commissioner and provider is essential to manage inherent conflicts of interest. Until practice-based commissioning really gets off the ground the jury is still out on whether it can achieve all its objectives.