NHS

High Quality Care for All

Our journey so far

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High Quality Care for All
Our journey so far

Foreword by the Secretary of State for Health

From the cradle to the grave, the NHS is there for all of us. It supports people at those moments in life when they find themselves at their most vulnerable, providing a service to everyone that is free at the point of need. It is not just an organisation, but a cherished and ingrained part of life in our country.

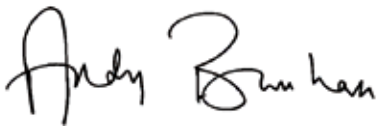
Over the last decade, the substantial investment in clinicians, staff, facilities and equipment was life-saving treatment for an NHS in critical condition. Huge improvements have been made as a result – a massive reduction in waiting times, faster access to care and more choice for patients. But, just as stabilised patients are moved out of intensive care and into rehabilitation and other treatments, so too did the course of NHS reform need to change and adapt once these initial investments and changes had taken their effect.

That is why, in 2007, the Prime Minister, Chancellor and Secretary of State for Health asked Lord Darzi to lead the NHS Next Stage Review to work with patients, public and NHS frontline staff to develop a vision of an NHS fit for the 21st century. The review was a first of its kind, involving 2,000 clinicians and carried out in consultation with 60,000 people across the country. It developed regional visions that reflected local needs and one national vision: that the NHS should deliver high quality care for everyone.

One year on from the publication of *High Quality Care for All*, I am delighted to see the progress that has already been made towards embedding quality at the heart of the service. Lord Darzi has followed the implementation of the vision with as much diligence and effort as he did with its design. The achievements being made in the NHS are testament to this and the work of thousands of people who also share the same passion for improving the quality of service that their patients receive.

We all recognise that many things have changed since the launch of *High Quality Care for All*, in the NHS and healthcare, not to mention the wider economy and society. However, the one thing that has remained constant is our aspiration to make quality the organising principle for everything we do. It is a focus on quality that will make services more efficient; it is a focus on quality that will drive and inspire people to think of new ways to provide care through innovation; and it is a focus on quality that will move the NHS towards concentrating on prevention as well as cure.

I want to thank Lord Darzi and everyone in the service for already doing so much to make the NHS a place which truly does provide high quality care for all. It is testament to the spirit of those working in the service that you came together to set yourself such an ambitious goal, and it is clear that you are well on your way to achieving it.



The Rt Hon Andy Burnham MP
Secretary of State for Health

Dear Prime Minister, Chancellor of the Exchequer and Secretary of State for Health

One year ago, through the combined efforts of 2,000 frontline clinicians, and the energy and creativity of the 60,000 people engaged in the NHS Next Stage Review, we published our final report, *High Quality Care for All*. We recognised the substantial improvements that have been made in the NHS over the past decade and agreed that achieving high quality care for all should be the ambition that we all share. Placing quality at the heart of the NHS has sparked an uprising of energy, enthusiasm and creativity across the service, which cannot be extinguished.

Patients are already noticing the difference. It is easier to see a GP than ever before, with three-quarters of practices now open in the evenings or at the weekends, 50 new GP-led health centres open from 8am to 8pm, and 65 new GP practices open in areas that for generations have had too few doctors. We are approaching an end to the postcode lottery, ensuring that the local NHS everywhere can fund National Institute for Health and Clinical Excellence (NICE)-approved drugs and treatments and speeding up the approvals process.

Improvements have been made in each aspect of quality – experience, effectiveness and safety. Over 9 million people with long-term conditions now have personal care plans, with care organised around their individual needs and so they don't need to repeat their story. There have been radical changes to the care of stroke patients, using the FASTrack pathway which is proven to save lives. Sustained focus on patient safety is showing results as rates of *C. difficile* and

meticillin-resistant *Staphylococcus aureus* (MRSA) have fallen by over a third in the last year alone.

Quality is the silk thread that is being stitched into the very fabric of the NHS. That is why I am delighted with the launch of services that will enable this to happen. A good example of this is NHS Evidence, a new internet portal managed by NICE which ensures that professionals have the best available knowledge at their fingertips.

Clinical teams up and down the country are now measuring the quality of care that they provide to their patients, and all acute trusts are recording this information so that they can publish the first ever set of Quality Accounts alongside their Financial Accounts for the year 2009/10. This will make the NHS the first health system in the world to systematically measure, record and openly publish the quality of

Local solutions led by NHS staff will always be the most effective way to deliver high quality care.

While central government has an important role in setting priorities and standards, it will never have the ability to make the changes that are needed at local and individual level. High quality care can only be delivered if NHS staff are given the freedom to use their talents and lead the improvements to services themselves. That is why this chapter will address empowering clinicians to lead change, giving greater freedom to the front line, equipping staff with the skills they need, aspiring for excellence and investing in training and development.

The common purpose of NHS staff is clearly laid out in the draft NHS Constitution, currently making its way through Parliament. The Constitution provides a powerful statement of the shared purpose and values of the NHS, as well as bringing together the rights and responsibilities of all NHS patients and staff. We all have a part to play if we are to fulfil the pledge made in the NHS Constitution that: *"All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients."*

Empowering clinicians to lead change

We have invested significantly in developing our leaders in the last year, recognising that it is only through strong leadership that we can deliver our vision for patients. It is our clinical leaders who will empower their own teams to improve the quality of care that they provide. In March the National Leadership Council, created to champion leadership across the NHS, met for the first time. Dr Mark Goldman, who has responsibility for clinical leadership on the council, makes the case for clinical leadership:

"Promoting clinical leadership is a key ambition which I have been asked to lead. My sense is that the timing is right. It arrives at a point when the NHS is moving forward from the 'push' of performance to the more enlightened 'pull' of patient quality and safety. Managers and clinicians at last feel at ease on the subject material if not yet the language. Aligned ambition across professional and managerial groups is the only way to deliver for the future…

"Even in its infancy, it feels like a movement. It has more than the ministerial thumbprint upon it. It has heart and soul, it is about people and what they need to deliver the most complex and important public service at the most complex and important time since the inception of the NHS."[19]

Across the country, programmes have been put in place to support clinicians to take on leadership roles – from early on in their professional careers to very senior roles at board level. NHS London, for example, is working with the London Deanery to establish a cohort of clinical leadership fellows. Fellows are seconded to the roles of Medical Directors/ Professional Executive Committee Chairs of trusts for a full year, during which they complete an accredited leadership programme and lead projects designed to accelerate new ways of working in their trusts and local communities.

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Dr Mark Goldman, Chief Executive, NHS Heart of England Foundation Trust and Clinical Leadership Champion, National Leadership Council

Clinical leaders in control

The support for clinical leadership is being put in place and it is now our responsibility to create a culture where all clinicians feel able and obliged to step up and lead the changes required to improve quality for patients. The next step is to shift the balance of control of services further, giving clinical leaders of services ownership of budgets and accountability for the quality and financial performance of services.

In primary care this shift has been under way for some time, with Practice Based Commissioning offering GPs and practice staff the opportunity to take more control over millions of pounds of NHS commissioning expenditure to achieve better outcomes for the local population. There is increasing support for this among GPs, and earlier this year we published a vision for Practice Based Commissioning to re-engage the primary care community.[20]

We now need to grow the appetite and ambition to do the same in the acute sector. Some trusts are already developing service line management – putting budgets in the hands of clinicians – within their organisations and Monitor, the independent regulator of Foundation Trusts, has advocated this approach for Foundation Trusts.[21] At Heart of England NHS Foundation Trust, clinical directors have been in charge of their services and budgets for some time.

> It is our clinical leaders who will empower their own teams to improve the quality of care that they provide.

Its Chief Executive, Dr Mark Goldman, is leading a major piece of work on developing clinical leadership on behalf of the new National Leadership Council. As part of this programme, I have asked him to work with Sir Bruce Keogh, the NHS Medical Director, to consider how we can embed the principles of service line management across the NHS.

Allowing clinicians to run their own services unleashes a new entrepreneurship – liberating a team's creativity to innovate in the way it delivers services – within clear boundaries. Clinical leaders will be able to make more decisions without deferring upwards. They will be able to make bids for investment to drive quality improvement and will be able to shape their services around the needs of their patients.

Greater freedom for staff to focus on quality

National targets play an important role in driving up the quality of care in priority areas. Without targets we would not have achieved dramatic results in reducing waiting times or reducing healthcare associated infections. National priorities will always have a legitimate role in any tax-funded health system, to continue to drive progress and delivery.

But if we are serious about giving staff more freedom to improve quality for their patients, we must give them more freedom to set their own clinical priorities. In my career I have achieved success by setting my own targets. National targets should only ever be seen as the minimum that patients can expect. I strongly believe that clinical teams, if empowered, will set their ambitions much higher than system-level expectations.

That is why the Secretary of State for Health, Andy Burnham, set out his intention to minimise the burden on frontline staff by reducing unnecessary data collection and removing obsolete targets and commitments. We will start by removing the redundant 13-week outpatient and 26-week inpatient performance targets and will commission a review of other targets and data collection commitments to ensure that they are necessary and fit for purpose.

Our aim is that data should only be collected if it is clinically relevant and important to patients. The review will be reflected in the 2010/11 Operating Framework.

High Quality Care for All also gave staff more freedom to run their own community services. In November last year, we gave community staff the 'Right to Request' to set up social enterprises – organisations with social objectives whose profits are reinvested to serve local communities and can be more innovative and responsive to patients' needs. This has generated considerable interest and we will announce the first wave of social enterprise projects in the autumn.

High Quality Care for All also gave staff more freedom to run their own community services.

Making it happen – equipping staff to improve quality

As discussed in chapter 2, good progress has been made in taking forward the quality agenda. Local teams are more consistently measuring what they do as a basis for improvement. However, measurement alone cannot be enough. Without the skills to improve, teams will not be able to systematically move the care they provide to a higher level. We need to give NHS staff the tools and the time to improve the quality of care based on what they measure.

The science of quality improvement within health services can appear to be forbidding territory. There are many methodologies, from evidence-based care to LEAN and the Institute for Healthcare Improvement's Plan, Do, Study, Act (PDSA) cycle.[22, 23] However, there are fundamental principles applicable throughout – a systematic, team-based, problem-solving process to continually move up the level of care provided – to implement and test the effects of ideas on quality outcomes.

This is not just theory. There are some excellent examples of quality improvement initiatives happening right across the country. The NHS Institute for Innovation and Improvement's Productive Ward initiative is increasing the amount of time nurses spend on direct patient care by implementing simple, standard changes.[24]

Salford Royal Foundation Trust is taking a 'whole systems' approach, embedding quality methods at all levels of the organisation and working towards excellence in clinical systems.[25] Bolton has implemented the Bolton Improving Care System, based on LEAN methodology, to improve the quality of care offered to patients and has notable successes in reducing the mortality rate for trauma. Many of these initiatives are inspired by pioneers such as Virginia Mason Medical Centre in the US and Jonkoping County in Sweden. We need to do more to spread these insights.

Collaboration is essential and should be the obligation of all those who subscribe to the quality agenda. Professionals and providers can learn from each other more efficiently and quickly than they can learn on their own. Quality Observatories and Health Innovation and Education Clusters will play an important role here and there are many other examples of collaborations, such as the Patient Safety First and Clinical Audit programmes.

"One of the rewarding things about the science of quality improvement is how egalitarian it is. Anyone can play a role in making meaningful changes given the time, the right tools and motivation." [26]
Don Berwick, President and CEO, Institute for Healthcare Improvement

Aspiring to excellence: the role of accreditation

Our aspiration for quality in the NHS should be nothing less than excellence, and clinicians should constantly compete with one another to find new and better ways to care for their patients. Their successes should be recognised and celebrated by the whole of the NHS. While we have robust systems in place to ensure that minimum standards of care are met through regulation, there is no coherent or comprehensive approach to recognising leading teams that are providing excellent standards of care. One way of recognising the teams that meet such levels of excellence is through greater use of accreditation. This has the potential to unleash healthy competition among clinicians across the country to provide the best care.

Accreditation schemes are already being used in different parts of the NHS, enabling clinicians to lead the way in healthcare quality. We now need to develop a new common approach to accreditation with a clear purpose, to recognise excellence. It should complement wider efforts to improve quality, while reducing the burden of assessment. It should build in an element of peer review to provide a holistic view of services.

The Royal Colleges have already started to work together to move towards a common approach. Over the next year, the Royal College of Physicians will examine the case for accrediting stroke service. Working with the Royal Colleges we will develop a consistent accreditation approach, beginning initially with a limited number of services and building up to extend this across every NHS service. The National Quality Board will play an important role in the development of this work.

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Fostering a high quality workforce

Improving the health and well-being of NHS staff

The NHS is on a mission to transform itself from a service focused on treating sickness to one that also promotes health and well-being. As the largest employer in the country, there is no better place to start with this agenda than with our own staff. Not only is a healthy workforce important for our own well-being and productivity, but it will also make NHS staff the best ambassadors for promoting healthy living to the patients they care for and the public with whom they engage. We are committed to this agenda and it is therefore essential that we all start to role-model healthy behaviours ourselves.

Therefore, just as we are increasing our focus on more preventive measures for our patients and the wider public, so too should we reconsider our approach to the health of NHS staff.[27] Rather than relying solely on occupational health services, we need to move towards a broader commitment to improving health and well-being across the workplace. That is why Steve Boorman's ongoing review into the health and well-being of NHS staff is of such importance. The review will report in the autumn and I want to encourage as many people as possible across the NHS to get involved as the recommendations are finalised, as they will go on to inform the 2010/11 Operating Framework.

Investing in training and development

Radical developments in the shape of primary care and community services, together with the shift of care from hospitals into the community, require different thinking about how those services are staffed. Since last year, care pathways, designed by clinicians to set out what the future of care should look like in each NHS region, are being actively used to determine the numbers and types of professionals we need for the future.[28] The East Midlands has adopted a systematic, dynamic approach – involving clinicians and service managers to model the consequences for the NHS workforce of major changes to stroke, trauma and maternity care. To support the NHS locally, a new Centre for Workforce Intelligence will begin its work in December. It will work closely with NICE to assess the impact of new developments and standards in clinical care to ensure that we plan the NHS workforce we need for the future.

The quality and safety of patient care depend on the quality of staff treating patients. This is why we have focused on improving the quality of healthcare education and training. Delivering a wholesale change in this area will not take place overnight, but in the last year important steps have been taken. Medical Education England (MEE) has been established to provide professional leadership of workforce planning and education. This clinical input to education is both important and essential, particularly in the face of new challenges. By the end of 2009, we will have set up similar bodies to ensure that nurses, midwives and allied health professionals have the same input.

We must invest in nurturing talent at every level and across the entire workforce. *High Quality Care for All* committed to doubling our investment in apprenticeships by 2012/13, and the Prime Minister has subsequently announced 5,000 additional apprenticeships this year. They will cover traditional apprenticeship roles such as estates and maintenance, but many of them will also be in clinical support roles such as healthcare assistants.

High Quality Care for All committed to doubling our investment in apprenticeships by 2012/13.

We spend £4.6 billion a year on education and training. Ensuring value for money from this investment has never been more important. Our reform of funding – replacing the historical funding for Multi-Professional Education and Training (MPET) with a tariff-based system – will be implemented by April 2010. The tariff will bring greater transparency to funding. Money will now follow the trainee professional – which will help drive up the quality of education.

But these incremental steps are not enough. We must have greater ambition – to become global leaders in healthcare education. In December we will announce the first wave of **Health Innovation and Education Clusters** – new alliances between the NHS, the higher education sector and industry. Building on our strong tradition of medical education in Britain, they will harness creativity and innovation, giving professionals in training access to the breadth and depth of expertise to ensure excellence. Along with AHSCs, they have the potential to attract the best clinical minds from across the world. For patients, this is set to accelerate the pace at which innovative treatments and medicines become available for their treatment.

References

[1] Since July 2008 NICE has published six pieces of technology appraisal guidance developed through its fast track Single Technology Appraisal process, of which 50% were available in draft within six months of the drug's market authorisation. This compares with 17% of all the Single Technology Appraisals published before July 2008.

[2] See the Marie Curie Delivering Choice Programme – http://deliveringchoice.mariecurie.org.uk

[3] Department of Health, *End of Life Care Strategy: Promoting high quality care for all adults at the end of life*, July 2008.

[4] *High Quality Care for All* committed to piloting personal health budgets in the NHS as a way of giving greater control to patients over the services they receive. Pilot sites will initially offer notional budgets or budgets held by a third party but the patient would be able to choose how they are spent. When new legislation currently going through Parliament comes into force, some pilots will also test direct payments, where an individual will receive money directly and pay for their own services as agreed in their care plan.

[5] Figures from the 2009 GP Patient Survey, published 30 June 2009.

[6] £330 million is invested within PCTs' baselines for the period 2008/09–2010/11.

[7] A stroke in the UK happens every five minutes and 30% of those affected die. The condition is also the leading cause of disability in this country and devastates the lives of an increasing number of patients every year. Thrombolysis is a treatment which can drastically improve outcomes for people suffering from stroke or transient ischaemic attack (TIA). Around 80% of strokes are caused by a blood clot which can be treated by thrombolytic (clot-busting) drugs – but time is of the essence. Thrombolysis has to be administered within three hours of the onset of symptoms to achieve the best possible outcome for the patient.

[8] National Audit Office, *Reducing Healthcare Associated Infections in Hospitals in England*, 12 June 2009.

[9] In line with the work being done as a result of *High Quality Care for All*, Professor Jimmy Steele has just published his independent review of NHS dental services, which recognises the importance of preventive measures.

[10] Vascular diseases include heart disease, stroke, type 2 diabetes or kidney disease.

[11] NICE Monthly Report on NHS Evidence, 30 April to 31 May 2009.

[12] A Clinical Dashboard is a toolset developed to provide clinicians with the relevant and timely information they need to inform daily decisions that improve the quality of patient care. See www.connectingforhealth.nhs.uk/systemsandservices/clindash

[13] All providers that provide NHS acute healthcare services are to prepare a Quality Account in respect of the financial year 2009/10. When primary care providers, including GPs, dentists and some optometrists, are required to register with the Care Quality Commission, they will be brought into the Quality Accounts regimen by way of further regulations. Depending on the outcome of this work on registration, it might therefore be possible for these groups of providers to be ready to produce Quality Accounts in 2012.

[14] www.advancingqualitynw.nhs.uk

[15] www.ic.nhs.uk/services/measuring-for-quality-improvement

[16] The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice.

[17] Alberti G, *Mid Staffordshire NHS Foundation Trust: A review of the procedures for emergency admissions and treatment, and progress against the recommendation of the March Healthcare Commission report*, 29 April 2009; Colin-Thomé D, *Mid Staffordshire NHS Foundation Trust: A review of lessons learnt for commissioners and performance managers following the Healthcare Commission investigation*, 29 April 2009.

[18] In January, the Prime Minister announced the establishment of the Office for Life Sciences (OLS) to look at how the life sciences sector can contribute to ensuring that the UK has a strong economy when we come out of the current downturn. The NHS is a key component to delivering on this work. Lord Drayson, Minister of Science at the Department for Business, Innovation and Skills, aims to publish a blueprint of the OLS work before the summer recess.

[19] www.hsj.co.uk/home/clinical-leaders/mark-goldman-on-clinical-leaderships-tipping-point/5001060.article

[20] Department of Health, *Clinical commissioning: our vision for practice-based commissioning*, 4 March 2009.

[21] Service line management has been practised in businesses for many years. Each service line becomes a business unit in its own right, with profit and loss reported at that level rather than aggregated for the whole organisation. A clinical leader typically has accountability for the budget.

[22] LEAN is an organisational approach to improve flow and eliminate waste that was developed by Toyota. LEAN is about getting the right things to the right place, at the right time, in the right quantities, while minimising waste and being flexible and open to change.

[23] The Plan, Do, Study, Act (PDSA) cycle is shorthand for testing a change in the real work setting – by planning it, trying it, observing the results and acting on what is learned. This is the scientific method used for action-oriented learning.

[24] www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

[25] www.srft.nhs.uk/news-media/publications/quality-improvement-strategy-2008-11

[26] Donald Berwick, MD, MPP, FRCP, President and CEO, Institute for Healthcare Improvement, is one of the US's leading authorities on healthcare quality and improvement issues. He is also Clinical Professor of Pediatrics and Health Care Policy at Harvard Medical School.

[27] This will be aligned with the work we are doing at a national level to promote health and well-being. As part of our Healthy Weight, Healthy Lives strategy we have established the Change4Life movement: 'eat well, move more, live longer'. Physical inactivity is also estimated to cost an average of £5 million per PCT each year. In response we launched *Be Active, Be Healthy – a plan for getting the nation moving*.

[28] Each SHA considered eight clinical pathways of care as part of the NHS Next Stage Review (maternity, children, staying healthy, long-term conditions, end of life, mental health, acute and planned care).

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