The NHS Plan and clinicians

Deirdre Cunningham

Deirdre Cunningham
FFPHM, Director of Public Health and Health Systems, Lambeth, Southwark and Lewisham Health Authority

Clin Med JRCPL 2002;**2**:134–8

ABSTRACT – The NHS Plan issued in July 2000 is being implemented and is fundamentally trying to modernise the NHS using new organisational arrangements. At its heart is the desire to make the NHS more responsive to what the public wants and sensitive to individuals' needs and rights. National clinical priorities and targets have been identified, including emergency care, time to elective treatment, cancer, coronary heart disease, mental health and care of the elderly. Clinical standards will be increasingly under scrutiny since the Bristol Royal Infirmary and Alder Hey inquiries, and clinicians will expect their performance as individuals, and increasingly as team players, to be in the spotlight. There may be a tension between achieving safe standards and increased activity levels if shortfalls of staffing are not addressed, but ultimately clinicians will need to safeguard their standards.

KEY WORDS: Bristol inquiry, clinical pathways, clinical staffing, clinical standards, modernising, national priorities, NHS Plan, partnership, patient centred

This article provides an overview of national guidance and developments from July 2000 to the end of 2001. It is intended for busy general physicians who have little time to consume the details or think about the implications of such important documents or changes.

Main themes since July 2000

The government and the population want a modernised NHS which will be safe, high quality, patient oriented and comprehensive. How can the government achieve this?

The government's strategy for the NHS

It all started with the NHS Plan[1], first published in July 2000 after an all too brief consultation process with Medical and Nursing Royal Colleges, leaders of NHS and local government bodies, professional groups, unions, leading charities and leaders of patient and carer associations. The document set out a framework for the NHS and laid out its core principles (Table 1).

The government had reaffirmed that the NHS would be comprehensive, funded out of taxation, a national service and available to all citizens on the basis of need. What is more, the patient would be truly at the centre. There was a recognition that the NHS was chronically underfunded. So far so good. What happened next?

Implementation of the NHS Plan: modernisation boards

A modernisation board was set up nationally and one was also set up for each regional office of the NHS. A rapid implementation programme was planned and issued[2]. It included 'provisional milestones and key targets for 2001/2002'. These were to be 'reviewed by the modernisation board on a regular basis'.

The overall vision of the NHS Plan was

> *to create a service designed around the patient or user. It recognises that this will require investment and reform.*

The next steps would include the modernisation board reviewing the implementation plan and updating it to include firm milestones and plans for 2001/2002. For London, for instance, there emerged 58 targets and 55 planning milestones for the NHS. There was also guidance for health and local authorities on service and financial frameworks.

More targets followed thick and fast. The previous year had seen a surplus of health circulars. Ministers put a stop to those. Now it was the time for targets.

Implications for clinicians: first, to be patient centred

A patient-centred service will meet the needs and wishes of patients rather than of the system. Clinicians will be expected to communicate with patients and carers[3] and design services and treatments around them. Long waits for outpatients, in accident and emergency (A&E) and for elective procedures are unacceptable to the government and to the public. Ministers have given a high priority to these targets. However, clinicians may be frustrated to find locally that the resources are not there to meet all these targets.

One NHS

The government wants one NHS and, as far as possible, that the same evidence-based, appropriate treatments should be given for the same needs to patients around the country. To that end, it has set up bodies such as the National Institute for Clinical Excellence (NICE) to advise on the evidence of effectiveness of treatments, and ultimately to advise what treatments should be provided on the NHS. Advice to clinicians to listen to what patients want may appear to conflict with the guidance from NICE because patients sometimes cannot have what they want: beta interferon, for example. In a recent analysis of published guidance from NICE on 22 technologies (up to March 2001), only three technologies were initially not recommended[4]. One judgement (zanamivir) was subsequently reversed.

Clinical pathways and partnership

Partnership is here to stay. It is no longer enough for a clinician or a trust to be an island, entire unto him or herself. Patients should follow smooth care pathways; for this to happen there has to be close collaboration between professionals and institutions. Formally, cancer care started it with the Calman-Hine Cancer Framework which has been implemented in this country for about six years. The NHS cancer plan[5] was published in September 2000 to provide further impetus. It set out a comprehensive strategy for implementation over the next five years. At its heart is the aim of defining patient journeys, the clinical networks and service standards which produce the best results for patients. More clinical networks will be defined and operate as we work through how to get better results and a more patient-centred service.

National clinical priorities

By ascribing priority to services, the government is favouring some services possibly at the expense of others. Clinicians working in one of the priority areas such as coronary heart disease (CHD) (National Service Framework for CHD) or emergency medicine (in A&E) will find that their specialty is recognised as important. They may be the recipients of new resources and interest, but this may not apply to clinicians not working in a priority area. However, there have to be priorities. We have to start improving services in some areas and cannot possibly tackle all areas with equal priority. What is learnt from a successful and completed strategy, like cancer care, could be translated to other priority areas.

League tables of the performance of clinicians and organisations

Clinicians should expect their practice and that of their organisation to be scrutinised. Annual appraisals will be the norm. If doctors' practice or conduct is a cause for concern, they could be referred to the newly set up National Clinical Assessment Authority[6] for assessment or to the General Medical Council,

Table 1. NHS plan core principles and key implications[1]

	Core principles	Key implications
1	The NHS will provide a universal service for all, based on clinical need not ability to pay	'Unlike private systems the NHS will not exclude people because of their health status or ability to pay'
2	The NHS will provide a comprehensive range of services	Comprehensive care to include 'intermediate care, information services, health promotion, disease prevention, self-care, rehabilitation and after-care' and 'clinically appropriate cost-effective services'
3	The NHS will shape its services around the needs and preferences of individual patients, their families and their carers	'Patients and citizens will have a greater say in the NHS and the provision of services will be centred on patients' needs'
4	The NHS will respond to different needs of different populations	'Health services will continue to be funded nationally and available to all citizens of the UK'. 'Efforts will continually be made to reduce unjustified variations and raise standards'
5	The NHS will work continuously to improve quality services and to minimise errors	'Quality will not just be restricted to the clinical aspects of care, but include quality of life and the entire patient experience'. 'The NHS will continuously improve its efficiency, productivity and performance'
6	The NHS will support and value its staff	'The strength of the NHS lies in its staff'
7	Public funds for healthcare will be devoted solely to patients	'Public funds will be devoted solely to NHS patients, and not be used to subsidise individuals' privately funded healthcare'
8	The NHS will work together with others to ensure a seamless service for patients	'The NHS will develop partnerships and co-operation at all levels of care ... to ensure a patient centred service'
9	The NHS will keep people healthy and work to reduce health inequalities	'The NHS will focus efforts on preventing, as well as treating, ill-health'. Recognising determinants of health 'it will work with others to reduce inequalities'
10	The NHS will respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	'Patient confidentiality will be respected throughout the process of care' and 'new technologies (to be) harnessed and developed in the interests of society as a whole and available to all on the basis of need'

which is endeavouring to become more rigorous. (It is certainly busier.) The previous relative autonomy of clinicians will not be the same as the government and institutions respond to the NHS Plan and to the reverberations from a number of high profile media incidents and enquiries. Alder Hey is one: the enquiry into organ retention at Alder Hey Hospital has had major implications for practice, including implications for seeking consent[7].

Implications of the Bristol Royal Infirmary public inquiry

Things will never be quite the same again after the publication on 18 July 2001 of the recommendations of the Bristol Royal Infirmary public inquiry (the Kennedy Report)[8]. This inquiry was set up to investigate the management of the care of children receiving complex cardiac surgical services at Bristol Royal Infirmary between 1984 and 1995 and 'to make recommendations which could help to secure high-quality care across the NHS'.

As the report stressed:

The story ... is not an account of bad people. Nor is it an account of people who did not care ... It is an account of people who cared greatly about human suffering, and were dedicated and well-motivated.

This could be you or me. So what went wrong?

Sadly, some {people} lacked insight, and their behaviour was flawed. Many failed to communicate with each other, and to work together effectively for the interests of their patients. There was a lack of leadership and of teamwork.

– a familiar story, with tragic consequences.

There are 198 recommendations, organised to reflect the patient's journey under seven headings (Table 2). These are familiar themes, familiar problems. It is already acknowledged that the events at Bristol have been 'a major catalyst for change'[10]. Duties of quality and requirements of clinical governance have been placed on NHS organisations. In addition to the Commission for Health Improvement (CHI), the government has set up the new National Patient Safety Agency (NPSA)[11] which is running a single reporting system for all adverse health events.

What next? Learning from the Bristol Royal Infirmary inquiry

The government response to the Bristol inquiry report has just been published[12]. The government accepts the analysis, and seeks to develop an NHS in which there is a culture of openness and honesty, where all who work in and for the NHS share the common purpose of delivering high quality, safe healthcare, and where patients and staff work in genuine partnership.

The key tasks which the Department of Health (DH) sees lying ahead are the following:

- to put patients at the centre of the NHS
- to improve children's health services
- to set, inspect and monitor the standards of care, through the roles of CHI, NICE and NPSA.

The DH wants to ensure the standards of care, develop a health service which is well led and managed, improve regulation, education and training of all healthcare professionals, and improve information. Above all, it wants to involve patients and the public in healthcare.

We hope, and the government intends, that it should 'build a new culture of trust, not blame, within the NHS', and one in which safety for patients always comes first.

Implications for clinicians are that safety, learning and patients are central, but there may be issues about what activity and productivity they and other NHS staff are required to achieve to meet government targets. One aspect of the NHS Plan which still poses a problem is shortage of staff: not enough doctors, particularly in certain specialties, and not enough nurses. This has been acknowledged in the government response, and commitments to remedy this are reiterated.

Also, there are restrictions on what doctors can do. The European Working Time Directive already applies to juniors[13] and in a couple of years could apply more broadly. There is a potentially dangerous trade-off between the workload compatible with high regard for quality and patient safety and the workload required to meet ever more stringent activity targets. There may also be a trade-off between the high priority placed by the government on safety and the even higher priority it apparently places on achieving waiting time targets. That is frequently where the resources go.

The implications for clinicians of the main recommendations from the Bristol Royal Infirmary inquiry are listed in Table 2.

Where to start: making the best use of NHS resources

Underfunding of the NHS has been acknowledged and more money invested, but resources still feel extremely tight, partly because increases in resources have been accompanied by even greater increases in targets and performance indicators, and partly because of the steady increase in new technologies which have to be funded, especially drugs. Funding NICE recommendations is now not optional.

Nevertheless, all health authorities have undertaken Local Modernisation Review baseline assessments of risks to achieving targets in their local health economies. They have also identified local modernisation projects where services are to be transformed into modern services, often at low cost because resources are tight.

Modernising and reorganising

The government is also reorganising and modernising management[14]. Gone is the NHS Executive, the regional offices in England are being wound up, and four new directors of social care for England have been appointed. All English health authorities will be disestablished at the end of March 2002 and

virtually all their powers, responsibilities and resources, will transfer to primary care trusts (PCTs).

There were nearly 100 health authorities; there will be nearly four times as many PCTs. By April 2001, there were 164 PCTs, and a further 237 primary care groups will become trusts by April 2002[15]. PCTs will hold almost 75% of the NHS resources and be responsible for health improvement, developing and delivering primary care, and commissioning secondary and tertiary healthcare for their populations. Welsh health authorities are also abolished.

What this will mean to clinicians is unclear. As a leader in the *British Medical Journal* points out[16]:

> *the government's NHS reorganisation is an evidence free zone, with no research cited to suggest that the changes will improve the performance of the NHS.*

Clinicians in England will find that from 1 April 2002, where they previously looked to the health authority to sort out problems or to address cost-pressures such as funding new drugs or new technologies, they now have to look to PCTs. PCTs will also be responsible for providing the resources for specialist commissioning of what the DH defines as 'specialised services'. Examples include neurosciences, renal replacement therapy, services for haemophilia and rare cancer services. It is likely that lead PCTs will represent their colleague PCTs to commission services for them. From October 2002, but in effect from 1 April 2002, all trusts will be performance managed by the new 28 strategic health authorities in England. They already have chief executives elect who are preparing their franchise plans.

Table 2. Recommendations from the Bristol Royal Infirmary inquiry and their implications for clinicians[8]

Category	Specific elements include:	Implications for clinicians
Respect and honesty	Partnership: involving patients; keeping patients involved with treatment and care; communicating with patients; support services for patients; consent to treatment; feedback to patients and responding to patients when things go wrong	Patients must be communicated with, informed and supported. Treatment must be properly consented to. Guidance issued[9]
A health service which is well led	Regulation of the quality and safety of healthcare; management of the NHS at the local level	Regulation of quality and standards is a top priority. Many changes are recommended to management and reward systems for doctors, including distinction awards, incentives to involve patients, and incorporating codes of professional practice into employment contracts
Competent healthcare professionals	Broadening the notion of professional competence. Leadership: the skills and capacity; the systems for assuring competence; managers; clinicians who hold managerial positions. Acquisition and development of new clinical skills and discipline	Much wider assessment of competence will be required in future, with competence in communicating with patients at the heart. Assurance, CPD, training, appraisal and revalidation may also require wider skills. Managers will need enough time to manage and should not carry on professionally unless they can prove their continuing competence. A Council for the Regulation of Healthcare Professionals is being set up to strengthen arrangements
The safety of care	A national reporting system; incentives to encourage the reporting of sentinel events; the system of clinical negligence; designing for safety and incorporating a concern for safety into systems and policies	NPSA set up; recording sentinel events and analysis of root causes
Care of an appropriate standard	Standards of care for NHS organisations; monitoring standards and performance	NICE is likely to issue clinical standards to the NHS, which CHI will monitor, possibly also in the private sector. Swift action will follow if patient safety is compromised
Public involvement through empowerment	Involving the public in all aspects of care	The NHS plan requires CHCs to be disestablished. New public involvement bodies are being set up, including PALS. Public involvement planned in selection of those entering training as healthcare professionals
The care of children	Responsibility for children's services; setting standards for children's healthcare services, planning and staffing of children's services and communication between healthcare professionals, children and their parents or carers	A national director has been appointed. An NSF for children's services may follow, with clear standards against which providers are inspected

CHC = community health council; CPD = Continuous Professional Development; NICE = National Institute for Clinical Excellence; NSF = national service framework; NPSA = National Patient Safety Agency; PALS = Patient Advocacy and Liaison Services.

Overall impact of the developments from July 2000

It is absolutely clear that the direction which the government and the public, and indeed the media, wish us to take is towards greater public accountability. The government, the public and the media want treatment when they need it without waiting unduly. They want to be able to rely on getting the right standards of healthcare and treatment wherever they live. They also want better outcomes in areas where we are lagging behind other countries, such as cancer.

The tensions lie in how healthcare is resourced, both with money and staff. Although this year, from 1 April, commissioners are anticipating the biggest ever increase in healthcare funding, there are 20 national priorities to achieve as a minimum and almost all the growth money is likely to be used in achieving those. The scope for achieving 'one NHS' outside those targets is limited, particularly as the government wishes more patients to have choice and to be treated in the private sector at public expense if the NHS cannot achieve those standards.

What the patient wants and needs: the most significant implication for clinicians

Clinicians are accountable for the standards of their practice, the extent to which they involve and seek consent from their patients, and for their communication with patients. For these, they are accountable through their management, elaborate arrangements for clinical governance and performance assurance. They are also accountable through new regulatory bodies, professional regulatory bodies, and ultimately through the courts.

Activity versus standards?

Clinicians are also accountable managerially for achieving the level of activity which their managers feel is required to meet the ever more stringent targets imposed by central government, whilst the support they receive from junior doctors is reduced due to working time and training changes.

Clinicians may feel they are between a rock and a hard place. However, if there is a trade-off between responding to the duties imposed in relation to quality and standards and the duties imposed by the government to increase throughput, clinicians could be forgiven for deciding that their standards are ultimately more important to their patients and to their future career, and that it is no longer safe for clinicians to respond to pressure by compromising the quality of their practice.

A high quality well-staffed NHS

A way will have to be found to modernise the NHS, and to meet the demands of the public for treatment within a reasonable time, without compromising safety and standards. More professional staff would be a good place to start. There are indeed commitments in the NHS plan to increase staffing levels. It is hoped that ways can be found to make this happen in the near future.

Conclusion

There are ambitious plans to reform the NHS and to provide the high quality patient centred care which we would all like to see. We hope that the government is able to put in place the resources which this programme needs.

Acknowledgements

I should like to thank Jamie Ferguson and Hiten Dodhia for their helpful advice.

References

1 Department of Health. *The NHS plan. A plan for investment. A plan for reform.* London: DH, July 2000.
2 Department of Health. *Implementation programme for the NHS plan*. London: DH, December 2000.
3 Cunningham D. The challenge for medicine *Clin Med JRCPL* 2001;**1**:194–6.
4 Raftery J. NICE: faster access to modern treatments? Analysis of guidance on health technologies. *Br Med J* 2001;**323**:1300–3.
5 Department of Health. *The NHS cancer plan. A plan for investment. A plan for reform*. London: DH, September 2000.
6 Department of Health. *Addressing poor performance in the NHS: the National Clinical Assessment Authority*. London: DH, 2000.
7 Department of Health. *Report of a census of organs and tissues retained by the pathology services in England*. London: DH, 2001.
8 Department of Health. *Learning from Bristol. The report of the public enquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995*. CM5207. London: DH, 2001.
9 Department of Health. *Reference guide to consent for examination or treatment.* London: DH, July 2001.
10 Department of Health. *CMO's Update 31: a communication to all doctors from the Chief Medical Officer*. London: DH, October 2001.
11 Department of Health. *Building a safer NHS for patients*. London: DH, 2001.
12 Department of Health. *The Department of Health's response to the report of the public enquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995.* London: HMSO, January 2002.
13 Pickersgill T. The European working time directive for doctors in training. *Br Med J* 2001;**323**:1266.
14 Department of Health. *Shifting the balance of power within the NHS*. London: DH, 2001.
15 Department of Health. *NHS: primary care*. www.doh.gov.uk/pricare/pcts.htm
16 Smith J, Walshe K, Hunter D. The 'redisorganisation' of the NHS. *Br Med J* 2001;**323**:1262–3.