

Our NHS, Our Future – Next Stage Review (The Darzi Review)

Background Briefing

**Lord Darzi**

Ara Darzi holds the Paul Hamlyn Chair of Surgery at Imperial College London, and is an Honorary Consultant Surgeon at St Mary's Hospital and the Royal Marsden Hospital.

His main clinical and academic interest is in minimally invasive therapy ("keyhole" surgery), including the use of surgical robots and image-guided surgery.

Prof Darzi was knighted in December 2002. In June 2007 he was made a member of the House of Lords and appointed Parliamentary Under Secretary at the Department of Health, as part of Prime Minister Gordon Brown's "government of all the talents" initiative.

***Healthcare for London: A Framework for Action (The London Darzi Review)***

In December 2006 NHS London, the Strategic Health Authority for the capital, asked Prof Darzi to develop a strategy for the NHS in London for the next five to ten years.

His report, *Healthcare for London: A Framework for Action*, was published in July 2007. It took as its starting point the following principles:

- Services should be focused on individual needs and choices.
- Services should be localised where possible, or regionalised where that improves the quality of care.
- There should be joined-up care and partnership working, maximising the contribution of the entire workforce.
- Prevention is better than cure.
- There must be a focus on reducing difficulties in accessing health and healthcare across London.

On this basis, the report proposed the following changes in the pattern of service delivery:

- centralisation and the creation of networks for the treatment of major trauma, heart attacks and strokes;
- a shift of routine diagnostic procedures and outpatient appointments out of large hospitals and into new "polyclinics";
- increased use of the day-case setting for many procedures;

- centralisation of more specialised in-patient care into large hospitals.

A London-wide public consultation was conducted from November 2007 to March 2008. An analysis of consultation responses will be published on 6 May 2008. London Primary Care Trust Boards will then consider the proposals and in June 2008 a Joint Committee of PCTs will meet in public to agree recommendations for health strategy in London over the next 10 years.

A paper that was recently put before the Board of NHS London suggested that there may be "insufficient leadership capacity and capability in primary care trusts and allied NHS organisations" in London to deliver Lord Darzi's recommendations.

### **Polyclinics**

Lord Darzi argued that there was a need for a new kind of community-based care at a level between that of current GP practice and conventional acute hospitals – a need that could be filled by the creation of what he termed "polyclinics".

A polyclinic is a relatively small healthcare facility, serving a local community and hosting a wide range of health services – including some that have, within the NHS, traditionally been provided in acute (district general) hospitals.

Polyclinics have long been major features of healthcare systems in some countries. In the Soviet Union, the greater part of healthcare was provided through polyclinics that combined the role of a hospital outpatients department with that of a general medical practice and served populations of several thousand. This system (known as the Shemasko system) was a model for healthcare in other Communist countries. In Cuba, polyclinics serving populations of around 30,000 provide GP services and a range of specialties, as well as diagnostic services. Germany has some 400 polyclinics. These are mostly a legacy of the health system in the former East Germany – but new polyclinics have begun to be established as part of far-reaching healthcare system reforms.

The polyclinics envisaged by Lord Darzi could provide the following:

- GP services;
- community services;
- outpatient services;
- minor operations;
- urgent care;
- diagnostics;
- community mental health care;

- management of long-term conditions;
- pharmacies; and
- other primary care services, such as optical and dental services.

They could be combined with local authority services and leisure facilities; and they could be co-located with a hospital or free-standing in the community. Their size could allow them to offer extended opening hours.

On this model, polyclinics would become the site of most GP care. Those practices remaining separate from polyclinics could be networked with a polyclinic, allowing patients to use their extended facilities.

Lord Darzi envisaged that between five and 10 polyclinics would be established in the capital by 2009. He did not spell out the contractual arrangements under which they would be commissioned.

### ***Our NHS, Our Future – NHS Next Stage Review, Interim Report***

When Lord Darzi became a minister in June 2007 he was asked by the new Secretary of State for Health, Alan Johnson, to undertake a review of the NHS across the whole of England, with a view to producing a strategy for the next decade (effectively following on from the NHS Plan of 2000). He was tasked with producing an interim report within four months and the final report in 12 months (to coincide with the sixtieth anniversary of the creation of the NHS).

In October 2007 *Our NHS, Our Future – NHS Next Stage Review, Interim Report* was published. In it, Lord Darzi stated that the NHS should be:

- fair;
- personalised;
- effective;
- safe.

He thought the NHS needed to:

- focus on quality of care as well as capacity;
- be ambitious in responding to the aspirations of patients and the public for a more personalised service;
- ensure that change was animated by the needs and preferences of patients;
- support local change from the centre, rather than handing down instructions;

- make best use of resources to provide the most effective care, efficiently.

Lord Darzi advocated that certain immediate steps should be taken ahead of his final report:

- 1) implementing a comprehensive strategy for reducing health inequalities, as announced by the Secretary of State;
- 2) embedding patient choice within the full spectrum of NHS-funded care, going beyond elective surgery into new areas such as primary care and long-term conditions through:
  - a. the investment of new resources to bring new GP practices (provided by traditional independent practitioners or by new private providers) to local communities where they are most needed, starting with the 25% of PCTs with the poorest provision
  - b. newly procured health centres in easily accessible locations, offering a range of convenient services for all local people, whether or not they are directly registered with GPs in these centres
  - c. the introduction by PCTs of new measures to develop greater flexibility in GP opening hours including the introduction of new providers – so that, over time, the majority of GP practices will offer services in the evening or at the weekend;
- 3) the establishment of a Health Innovation Council, to be the guardians of innovation;
- 4) support for the National Patient Safety Agency in establishing a single point of access for frontline workers to report incidents (“Patient Safety Direct”); and the following measures to reduce further rates of healthcare-associated infections:
  - a. legislation to create a new health and adult social care regulator (the Care Quality Commission) with tough powers
  - b. powers for matrons to report concerns on hygiene direct to the new regulator
  - c. the introduction of MRSA screening for all elective admissions in 2008, and for all emergency admissions as soon as practicable by 2010;
- 5) ensuring that any major change in the pattern of local NHS hospital services is clinically led and locally accountable by publishing new guidelines to make clear that:

- a. change should only be initiated when there is a clear and strong clinical basis for doing so
- b. consultation should proceed only where there is effective and early engagement with the public
- c. resources are made available to open new facilities alongside old ones closing.

Lord Darzi announced that groups of health and social care staff (over 1,000 people in total) would be established in every region of the country to discuss how best to achieve this vision across the following areas of care:

- maternity and newborn care;
- children's health;
- planned care;
- mental health;
- staying healthy;
- long-term conditions;
- acute care;
- end-of-life care.

Lord Darzi also asked the Chief Executive of the NHS, David Nicholson, to chair a national working group of experts to consider the scope, form and content of a possible NHS Constitution.

### **Equitable Access to Primary Medical Care programme**

Following the interim report, the government declared its intention to implement Lord Darzi's proposals on access to Primary Medical Services through the "Equitable Access to Primary Medical Care" programme. This is an initiative to procure:

- over 100 GP practices in the 25% of PCTs that are the most under-doctored (38 in all – the only one in the South East Coast area is Medway PCT);
- the development of at least one "GP-led health centre" in each PCT area (there are 152 in total).

The health centres (which are being referred to as "Darzi clinics" or polyclinics) must:

- be in easily accessible locations;

- deliver core GP services;
- maximise opportunities to integrate and co-locate with other community-based services, including social care;
- be open between 8:00am and 8:00pm, seven days a week;
- offer both bookable GP appointments and walk-in services;
- provide services for both registered and non-registered patients.

The government has stated that additional funding for this procurement exercise (both GP practices and GP-led health centres) will be provided to PCTs from a new £250 million Access Fund, with the GP-led health centres costed by the DoH at around £790,000 each. Funds will be added to PCTs' allocations, on a weighted capitation basis – apparently with ringfencing.

It is being emphasised that this funding is for new capacity – not the expansion or replacement of existing surgeries or health centres. Investment must be for additional clinical capacity (i.e. extra GPs, nurses and support staff). And the procurement is for new and innovative services, not necessarily for new buildings or facilities.

PCTs will most likely be using the Alternative Provider Medical Services contracting route for this procurement, meaning that contracts could mostly, or entirely, go to corporate providers – although the DoH says that existing GPs must be able to compete on a “level playing field” with the independent sector.

Alliance Boots have said they could host all 152 of the GP-led health centres. Lord Darzi has reportedly held meetings with at least 15 potential private and voluntary sector providers of primary care services, including private healthcare providers such as BUPA, Netcare UK and Care UK, and High Street chemists Alliance Boots and Lloydspharmacy – with non-healthcare commercial organisations, such as Tesco, also “welcome to attend”.

The DoH will not scrutinise individual plans or specifications but will ask Strategic Health Authorities (SHAs) to provide the necessary assurances. Progress will be monitored by the DoH on a monthly basis against “key milestones” deadlines – on an extremely demanding timescale for PCTs.

The DoH expects all the health centres to become operational between January and March 2009.

It has recently been reported in the *Health Service Journal* that Lord Darzi's final report will include a proposal that GPs should be charged whenever their patients access primary care through non-emergency use of an A&E department, or through a walk-in centre or minor injuries unit. GPs' representatives have argued that this would merely act as a disincentive for GPs to practice in areas with high levels of inappropriate A&E use – which tend to be socially deprived and underdoctored areas.

## Individual budgets

Individual budgets for social care (now called “personal budgets”), in addition to direct payments, were first mooted in a January 2005 paper by the Prime Minister’s Strategy Unit. The government announced that it would proceed with the development of individual budgets in the Green Paper *Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England* (March 2005).

While direct payments only cover local authority social care budgets, individual budgets combine this money with that available from other public funding streams.

Service users eligible for these funds have a single transparent sum, equivalent to their total entitlement, allocated to them. They can then choose to take this money as a direct payment in cash, as provision of services, or as a mixture of both cash and services, up to the value of their total budget. As with direct payments, the social care element is subject to the usual policies regarding means-testing and charging. Unlike direct payments, individual budgets can be used for services provided in-house by local authorities.

In Lord Darzi’s interim report he stated:

*I have also been impressed by what I have heard about the introduction of individual budgets in social care linked to direct payments and individual budget pilots, which have clearly transformed the care of some social care users. From this, we need to learn how to support and allow eligible service users increasingly to design their own tailored care and support packages. This could include personal budgets that include NHS resources. As a first step, we will encourage practice-based commissioners to use NHS funds much more flexibly to secure alternatives to traditional NHS provision where this would provide a better response to an individual’s needs, e.g. through respite care or support, installing grab rails to help maintain independence, self-monitoring equipment for people with long term conditions, supporting carers of terminally ill patients, and so on.*

In November 2007 this was explicitly endorsed by the NHS Chief Executive, David Nicholson, when he addressed the King’s Fund:

*I think we will see a move to more and more individual budgets involving allocation of resources - either yearly resources or episodic resources - to people, and what we will see coming with that is the need for a kind of brokerage, bringing people together and then buying on their behalf or commissioning on their behalf. I think we will see that. I think we should encourage it and develop it.*

In December 2007 *Putting People First* made explicit reference to Lord Darzi’s comments on individual budgets in the NHS.

In January 2008 the Prime Minister, speaking to an audience of health professionals at King's College London said:

*During 2008 we will bring forward a patient's prospectus that sets out how we will extend to all 15 million patients with a chronic or long-term condition access to a choice . . . Real control and power for patients, supported by clinicians and carers. And where it is appropriate, just as with personal care budgets for the 1.5 million social care users, it could include the offer of a personal health budget.*

In an interview with the *Sunday Telegraph* on 30 March 2008 Alan Johnson clearly stated his support for the idea of individual budgets in the NHS for patients with chronic conditions.

Given all of the above, it seems highly likely that proposals on individual budgets in the NHS will be contained in Lord Darzi's final report when it is published in early July 2008.

The extension of individual budgets to the NHS has been strongly advocated by a number of academics (including Prof Julian Le Grand, who was health policy adviser to Tony Blair during the latter's premiership), as well as by the Social Market Foundation and the Conservative Party.

It is argued that individual budgets in the NHS would:

- lead to greater personalisation of services;
- help overcome capacity constraints in the NHS;
- allow better coordination of care for individuals using multiple services;
- mean more transparency in the allocation of NHS funds;
- foster equity by allowing personalisation of services for NHS patients as well as private patients;
- deliver better value for money;
- lead to innovation and service development; and
- possibly improve health outcomes by helping people manage their own health better.

Individual budgets are in line with the government's introduction of market-style mechanisms into the NHS, through means such as Patient Choice.

The following have been identified as areas of NHS care in which individual budgets could be piloted:

- services for people with long-term conditions;
- mental health services;



- maternity services;
- expensive out-of-area placements;
- continuing nursing care (for instance, in the case of a patient with Alzheimer's Disease, an area that has been the subject of a legal test case about the limits of NHS funding, the Pointon case) – there are indications that this is the most likely candidate for a pilot of individual budgets in the NHS;
- services for learning disabled people (although, where such services are still within the NHS, they are increasingly being transferred to local authorities).

A radical version of individual budgets might go beyond this, with patients able to use sums of money, allocated to procedures under a national tariff, to choose from a range of providers.

It is unclear how exactly commissioning of services by patients using individual budgets would relate to other elements of NHS "system reform", particularly Practice-based Commissioning by General Practitioners and "world-class" (strategic) commissioning by Primary Care Trusts.

There are also questions around the possible impact of individual budgets on the work of the National Institute for Health and Clinical Excellence (NICE). NICE has a remit to evaluate the effectiveness and cost-effectiveness of clinical interventions and to issue guidance accordingly, helping to ensure that the NHS achieves value for money. Allowing patients to choose to spend NHS funds on treatments that have not been approved by NICE would appear to risk undermining the role of the Institute.

Some critics fear that individual budgets could actually work to compound the Inverse Care Law (that those who most need care are least able to access it) – contrary to claims made in support of the idea.

According to this view, market-type mechanisms tend most to empower those who have always done best out of the NHS and social care (the better off and less sick). At the same time, such mechanisms place service provision more in the hands of independent providers, who will want to concentrate on those communities, patients, conditions and procedures that yield the highest rate of return. The poorest and sickest will be least able to work the system to their advantage (especially without adequate "support brokerage" and "care navigation"); and they could suffer the most from the undermining of publicly-provided services.

Individual budgets also raise the possibility of breaching one of the NHS's core principles – that NHS money is never used to subsidise the purchasing of private care by the better off. Under Patient Choice, NHS patients can choose independent providers, but their care is still entirely on the NHS, wholly purchased by the NHS at its tariff price, with no "co-payments" by patients. A voucher system, such as individual budgets, could allow better off patients to

take NHS cash and use it, topped up with their own money, to buy private care not available to other NHS patients.

Allowing “co-payments” in this way could further be seen as potentially allowing *de facto* extensions of patient charging in the NHS (patient charges are currently confined to prescriptions, and to primary-care optical and dental services) – as indicated in *Our health, our care, our say*.

### **David Cameron’s speech to the King’s Fund**

On 22 April 2008 the Leader of the Opposition, David Cameron, gave a speech to the King’s Fund in which he criticised government health policy, including the proposals that are emerging from the Darzi Review.

He argued that “The plan for a national network of polyclinics is the biggest upheaval in primary care since the creation of the NHS” and accused the government of wanting to “make GPs salaried employees of the state, and abolish small practices in favour of large multipurpose centres”. Mr Cameron continued:

*The Government says that in London, most patients will be within a mile and half of a polyclinic. The people who need GPs the most are the elderly, those with small children and those with long-term conditions. Those are the people least able to get to a polyclinic, and least comfortable in a large impersonal institution. They like to rely on the doctor they know, at the end of their street, often in a building not much bigger than a house. They have a human relationship with their GP that they simply won't have with a member of staff at a polyclinic.*

He stated that, whilst not objecting to polyclinics in principle, he objected

*to the principle of imposing them on local communities without public support and against the wishes of GPs themselves. Where they occur, they should occur naturally, as the voluntary combination of free agents - not as the latest structural re-organisation of the NHS. Lord Darzi, the health minister behind the polyclinics plan, has admitted that doctors will, effectively, be forced into polyclinics using the GP contract. It is quite wrong.*

*If the Darzi plan is implemented a thousand GP surgeries are likely to close in London alone - that's three quarters of the total. Another 600 local surgeries will close across the country.*

### **House of Commons Opposition Day debate**

On 23 April 2008 an Opposition Day debate took place in the House of Commons around an Opposition motion expressing concern “about the lack of empirical and clinical evidence for the establishment of polyclinics in every primary care trust” and opposing “the central imposition of polyclinics against local health needs and requirements”. The Opposition argued that the government’s plans on polyclinics entailed the imposition of a “one-size-fits-

all” template across the country, threatening the future of family doctor services and undermining continuity of care.

The Secretary of State responded that “There is no national policy for replacing traditional GP surgeries with health centres or, indeed, polyclinics. There are no plans to herd GPs against their will, or the will of patients, into super-surgeries.” Mr Johnson argued that the investment of £250 million in additional primary care for underserved areas should be welcomed. He stated that Lord Darzi’s polyclinic plan for London was “not a blueprint for the rest of the country”.

David Turner  
(Research Officer, Health Overview and Scrutiny Committee)  
30 April 2008