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Memorandum submitted by Bliss (HS 03)

1. INTRODUCTION

1.1 Bliss is the UK charity dedicated to ensuring that premature and sick babies survive and go on to have the best possible quality of life. We provide practical and emotional support to families, provide specialist study days and training to support doctors and nurses to develop their skills, and campaign for essential change within government and the NHS.

2. SUMMARY

2.1 This written evidence sets out Bliss’ position on the key aspects of the Health and Social Care Bill relating to neonatal services. Our concerns relate to:

— The new commissioning structures, which we believe could lead to a serious fragmentation in the delivery of care for vulnerable babies.

— Whether clinical and lay representation is taken into account in the commissioning of neonatal services.

— The need to ensure integration between neonatal and maternity services so that services for women and babies are delivered in a safe and seamless way.

— The arrangements required to ensure a smooth and planned transition to the new NHS structures, including the continuation of the work of neonatal managed clinical networks.

3. COMMISSIONING OF NEONATAL SERVICES

Clause 11—power to require the Board to commission certain health services

3.1 The Command Paper Liberating the NHS: Legislative framework and next steps sets out that the NHS Commissioning Board will be directly responsible for commissioning specialised neonatal services. The definition of specialised neonatal services, as set out by the NHS Specialised Services Definitions Set includes all levels of neonatal care: special care, high dependency and intensive care (please see section 7 of this paper for more information on this).

3.2 However, there is a lack of clarity about whether it is the Government’s intention that the NHS Commissioning Board commissions all three levels of neonatal care. Evidence gathered by the System Alignment in Specialist Neonatal Care Subgroup of the National Quality Board (NQB) shows that in some parts of the country the different levels of neonatal care are commissioned by different bodies: with intensive care and high dependency care commissioned by Specialist Commissioning Groups (SCGs), and special care commissioned by Primary Care Trusts (PCTs).

3.3 This fragmentation in the commissioning of different levels of neonatal care negatively impacts on the ability of services to plan capacity and manage the flow of babies between intensive, high dependency and special care. From a clinical perspective, the distinction between the three levels of care is often fluid as a baby’s condition can improve or deteriorate in a very short space of time while in the same cot.

3.4 This fragmented approach has been widely criticised, including by the National Audit Office, the NHS and Department of Health in their Toolkit for High Quality Neonatal Services and a subgroup of the National Quality Board set up to advise the Board on the future of neonatal care. Bliss believes that the reorganisation of commissioning structures presents an opportunity to ensure that neonatal services in the future are commissioned in a coordinated way across all levels of care. We therefore urge the Government to ensure neonatal services are commissioned in their entirety by the NHS Commissioning Board.

3.5 Recommendation: Explanatory Notes published alongside the Bill outline that the NHS Commissioning Board will be directly responsible for commissioning specialised neonatal services. However the relevant provision in the Bill (Clause 11) does not clearly set out if the definition of specialised services used is that outlined by the Specialised Services National Definitions Set. Bliss recommends that Clause 11 subsection 1(d) clearly sets out that the NHS Commissioning Board will commission those services set out in the Specialised Services National Definitions Set.


2 http://www.specialisedservices.nhs.uk/info/specialised-services-national-definitions
4. CLINICAL AND LAY INVOLVEMENT IN COMMISSIONING

Clause 19—The NHS Commissioning Board: further provision

New Section 13L—Public involvement and consultation by the Board

4.1 Bliss believes that for the NHS Commissioning Board to be able to effectively commission neonatal services, mechanisms must be in place to facilitate close working with neonatal service providers. Bliss recommends that this close working can be achieved in neonatal care, through commissioner membership of neonatal network boards.

4.2 Bliss also believes it is vital that parents of premature and sick babies are involved in the commissioning of neonatal services. Parents currently make a very valuable contribution to strategic planning and commissioning of neonatal services through neonatal network boards, all of which include parent representation.

4.3 Recommendation: Clause 19, New Section 13L should be strengthened to place a duty on the NHS Commissioning Board to involve service users, or as is the care in neonatal care, their parents or guardians, and consult the public in the commissioning processes of the Board. This is in order to take into account the views of not only medical experts but also parents with direct experience of having a baby admitted to neonatal services when commissioning this area of care.

5. ROLE OF NHS COMMISSIONING BOARD IN RELATION TO MATERNITY SERVICES

Clause 9—Duties of consortia as to commissioning certain health services
Clause 10—Power of consortia as to commissioning certain health services
Clause 19—The NHS Commissioning Board: further provision

5.1 Clauses 9 and 10 place responsibility for commissioning of maternity services with GP consortia. This is in line with the Government’s position, outlined in the recent Command Paper. However the Command Paper outlined that the NHS Commissioning Board will have a special remit with regards to maternity services, at least in part as a means of ensuring integration of maternity and neonatal services:

While responsibility for commissioning responsibility should sit with GP consortia, we will expect the Board to give particular focus to promoting quality improvement and extending choice to pregnant women . . . The Department considers that this approach is most likely to deliver improvement and a joined-up approach to local services for women and newborn babies.

5.2 Bliss believes it is vitally important that there is improved integration between maternity and neonatal services to ensure a smooth pathway of care for women who experience complications in their pregnancy resulting in their babies being admitted to neonatal services. Better integration will also help ensure more effective planning of services and the best possible use of resources. We therefore welcome the remit given to the NHS Commissioning Board in regard to this issue. However this responsibility should be outlined in the Bill to ensure that the Board see it as the important duty it is and do not deem it inferior to other duties set out under Clause 19.

5.3 Recommendation: The NHS Commissioning Board’s responsibility to promote quality improvement in maternity should be outlined in the Bill, potentially through the addition of a new section under Clause 19, after New Section 13L, entitled General duties of the Board.

6. OTHER ISSUES SURROUNDING THE BILL—TRANSITION PERIOD

6.1 Neonatal services in England are organised into regional neonatal managed clinical networks. Neonatal networks, which first started being introduced across the country in 2003, have had a positive impact on babies’ care and the overall experience of whole families by:

— developing local strategies for service improvement;
— providing an important performance management role and effective forum for dialogue and cooperation between providers and commissioners;
— improving communication between units, coordination of care and the flow of babies into the right level of hospital unit at the right time; and
— reducing the need for babies and expectant mothers to be transferred long distances to find a unit with spare capacity. This reduces the risks faced by very fragile babies in undergoing these unnecessary transfers and vastly improving the experience of families.

6.2 The operational costs of neonatal networks are at present generally funded jointly either by a number of PCTs across a region, or directly through the regional specialised commissioning groups or strategic health authorities. Bliss is concerned that unless sufficiently robust transitional arrangements are put in place with immediate effect to ensure neonatal networks are maintained, the support structures that

underpin these networks could be undermined in the drive to cut management costs. We are extremely concerned about the impact such ill thought through cuts could have on the care of babies and families, through the loss of expertise that could result from this situation.

6.3 **Recommendation:** We are urging the Government to ensure arrangements are in place to maintain neonatal networks in the transitional period.

7. **Background Information on Neonatal Care**

7.1 Around 70,000 babies are admitted to neonatal care in England every year because they are born too soon, too small, or too sick. Neonatal care is a specialist branch of medicine, and includes three categories of care. These are:

   - **Special care**—the least intensive level of care and most common. This includes care such as monitoring of a baby’s breathing and/or heart rate, provision of ultra violet light for jaundice and so on.
   - **High dependency care**—this level of care is for babies weighing less than 1,000 g, or who are receiving help with breathing via continuous positive airway pressure or intravenous feeding but who do not require intensive care (see below).
   - **Intensive care**—highly specialised care for the most seriously ill babies who will often be on a ventilator or need constant care to keep them alive.

7.2 These three categories of care are delivered across three levels of neonatal units:

   - **Special care baby units**—provide special care for their own populations. May in some areas, subject to local agreement, provide some high dependency care to babies.
   - **Local neonatal units**—provide all categories of neonatal care, including short term intensive care, however would transfer babies requiring complex or longer term neonatal care to neonatal intensive care units.
   - **Neonatal intensive care units**—provide the most specialist care for the sickest babies across their network, also provide the whole range of neonatal care for their local population.

7.3 The 178 neonatal units in England are arranged into 23 neonatal networks, each network covering units of the various levels across a region.

7.4 Neonatal care is one of the few disciplines where the care of the patient (the baby) is inextricably linked to the wider family. When planning neonatal services, integration and coordination with a range of other complementary disciplines, in particular maternity services, is crucial.

7.5 Key standard frameworks and policy documents relating to neonatal services are:

   - **Quality Standard for Specialist Neonatal Care**, NICE (October 2010).
   - **Service Standards for Hospitals Providing Neonatal Care (3rd edition)**, British Association of Perinatal Medicine (August 2010).
   - **Toolkit for High Quality Services**, NHS & Department of Health (November 2009).

February 2011

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**Memorandum submitted by Ken Kirk, Claire Hughes, David Hughes and Mick Barry (HS 04)**

1. Over recent decades we have become one of the most unequal countries in Europe. Despite this, there doesn’t appear to a recognition that poorer regions, with a higher proportion of patients in lower socio-economic groups, need more healthcare than patients in more affluent areas. The GP Consortia in poorer areas will be overloaded with conditions such as smoking-related and obesity illnesses, resulting in an impoverished health service, adding further to local people’s disadvantage. We occasionally hear of a postcode lottery now for certain health services. But the effect of this Bill will add a huge disparity to the lives of the poor. A founding principle of the NHS, the provision of a comprehensive service for all regardless of social background, will be lost.

2. The insistence that all health services will be put out to tender, will in some circumstances, put the local hospital out of business. as private providers offer a “loss leader” low price that the local hospitals can’t possibly match. The Consortium, under competition rules, will be forced to accept. Once the hospital is gone (or perhaps reduced to offering a rump of the unprofitable services) the private provider can then look to make its profit. In effect, England’s public health service will be closed down by this Bill.

3. As “efficiency savings” bite, so GP Consortia will become rationing organisations, that will exclude more and more health procedures. Patients will then definitely have a “choice”—going private or going without.
4. The Bill provides for scant public involvement in the provision of local health services. GP consortia and the Commissioning Board will take their decisions in secret, and are not even obliged to go through the motions of consultation. Local people will only be provided with PR spin. There is no statutory right to know what is being discussed, to provide hard information or to explain the financial situation to local communities. Council “Health and Wellbeing” committees will only offer token public involvement, and the “Local Healthwatch” bodies set up by the Bill will be ineffective advice and information bodies only, with limited local independence.

5. All limits on the money Foundation Trusts can earn from private medicine are to be scrapped. But with NHS budgets frozen for four years, and £20 billion of “efficiency savings” forcing down the price hospitals are paid by the NHS for each item of treatment, this will more or less compel many hospital managers to prioritise attracting wealthy private patients from both home or abroad—rather than providing services for less profitable NHS-funded.

6. England’s primary care system is the best in the world. There is a real danger that the trusted nature of the primary care patient-doctor relationship will be undermined by this Bill, as GPs add a rationing function to their job specification. For example, on the one hand the GP might say “I think you need this procedure”, but on the other he/she may have to say “but we no longer provide it on the NHS, our consortium budget won’t allow it.”

7. In reality most GPs will not do any of the commissioning themselves. They are not trained and have no time for this role and many are being dragged reluctantly into consortia they don’t support. So the consortia will hand the reins over to managers from private management consultants. Equally, GPs are dedicated health professionals, and could be persuaded, brow-beaten or “hood-winked” by sophisticated commercial operators, to buy health services that are more in the interests of private profit and not solely in the interests of the health of their populations.

8. Price competition is to be introduced in clinical services despite warnings from all sides (including NHS chief executive Sir David Nicholson) that this will trigger a disastrous race to the bottom, undermining the quality of care in just the same way as competitive tendering of hospital cleaning services wrecked hygiene standards in the 1980s and unleashed a wave of MRSA-style infections.

9. The overwhelming opinion of all professionals in the health industry, be they doctors (BMA, RCGPs), nurses (RCN), the health unions (Unison and the GMB), or patients groups oppose this legislation; even Conservative members of the Commons Health Committee have been critical. Only private health corporations like America’s United Health and Care UK, who stand to gain considerably from the contracts when they bid for the most profitable services, are in favour.

February 2011

Memorandum submitted by RNID (HS 05)

ABOUT US

RNID is the UK’s largest membership charity supporting people who are deaf or hard of hearing. We provide information, services and support; we fund and undertake medical, social and technological research; we work to influence policy and practice and campaign for improved services; and we raise public and professional awareness on the impact of hearing loss.

INTRODUCTION

This briefing sets out some key points relating to hearing loss in the following areas of the Health and Social Care Bill. We would encourage the Committee to seek clarification on these points with Ministers.

1. Summary
2. Commissioning
3. Information
4. Hearing loss as a public health issue
5. Integrated health and social care services
6. Standards

1. SUMMARY

1.1 There are nine million people in the UK who are deaf or hard of hearing—one in seven of the population. Two million people in the UK use hearing aids, but a further four million people who could benefit from their use don’t currently have them. At present it takes people an average of 10 years to receive a diagnosis of hearing loss, in which time they can become isolated from the work place and from friends and family networks. This delay can also exacerbate other health conditions.

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1.2 The prevalence of hearing loss increases with age. Over half (55%) of people over 60 have a hearing loss and 90% of patients over 81.

The number of people with a hearing loss is increasing. The Medical Research Council estimates that the number of deaf and hard of hearing people is set to increase by about 14% every 10 years. This means that in 30 years time there will be more than 13 million people who are deaf or hard of hearing in the UK.

1.3 Hearing loss is a major public health issue which carries a serious impact on life quality, potentially leading to more complex mental health and social needs. It is vital that if audiology and hearing loss services are to be commissioned by local consortia that these groups have the necessary expertise, that information about audiology and hearing loss services and information on wider health and social care services is readily accessible to people with a hearing loss and that services are operated to a high standard.

2. COMMISSIONING

2.1 Under the proposals put forward in the Bill, audiology and hearing loss services will be commissioned locally by GP Consortia. RNID is concerned that GPs have low awareness of the needs of people who are deaf or hard of hearing. Recent research shows that GPs fail to refer up to 45% of people reporting hearing loss (for any intervention, such as referral for a hearing test or a hearing aid).

2.2 We therefore welcome the duty placed on the Commissioning Board in the Bill to obtain advice from persons with professional expertise relating to the physical or mental health of individuals (Clause 19, New Section 13G, page 17, line 17), and would like to clarify through committee stage what form this duty will take and confirm that they will take advice on all conditions, including hearing loss, and that this will then be passed on to all commissioning consortia.

2.3 We also welcome that this duty will also apply to each commissioning consortium (Clause 21, New Section 14O, page 30, line 32), particularly as audiology and hearing loss services will be commissioned at this local level. We would welcome clarification about whether receiving guidance from the Commissioning Board, in line with the point raised above, would constitute meeting this duty, or if consortia must take expert advice on the services they are commissioning on an individual basis.

2.4 Whilst we welcome these duties, we are unclear as to the impact of wording used earlier in the Bill (Clause 16(6), page 13, line 1 “The regulations may require the Board to consult prescribed persons before exercising any of its functions…” ) that regulations may, as opposed to must, require the Board to consult prescribed persons before exercising any of its functions. We would welcome clarification of the impact that this wording could have on the expertise that the Board seeks.

2.5 We would welcome clarification during committee stage of how detailed the guidance that will be published for commissioning consortia will be (Clause 22, New Section 14V(1), page 33, line 8), particularly in order to ascertain whether there will be published guidance on all conditions for which the consortia must commission services. Equally, we would welcome clarification of how meaningful the commissioning plan that each commissioning consortium must prepare before the start of each financial year will be. We would welcome clarification of how detailed these plans will have to be and whether they will go down to condition specific level (Clause 22, New Section 14Y(1), page 34, line 5).

3. INFORMATION

3.1 We welcome provisions in the Bill around the supply of information to people accessing health and social care services. We would urge the committee to explore the three issues of: ensuring that there is sufficient information available to people about audiology and hearing loss services; ensuring that information on wider NHS and social care services is accessible to people with a hearing loss; ensuring that health professionals are able to easily obtain and use information about a person’s hearing loss in order to help meet their needs.

3.2 Information about audiology and hearing loss services

Information is essential for people who are deaf or hard of hearing. When people are given more choice and information over the interventions they can receive such as being fitted with a hearing aid, attending lip reading classes or receiving hearing therapy, they are more likely to partake and benefit from these services.

3.3 High quality and accessible information is fundamental to addressing hearing loss needs and preventing a person’s hearing loss causing or exacerbating other health issues. Researchers have found that people who are deaf or hard of hearing can experience lower health-related quality of life, higher distress, anxiety, depression, social isolation and loneliness with negative implications on emotional, mental, and physical health.  

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5 Davis, A Hearing in Adults 1995.
6 Ibid.
3.4 The appetite of people with hearing loss for this information is clear—in 2008 alone, over 300,000 printed pieces of information were handed out or posted out via events or help lines by RNID, over 250,000 leaflets were distributed to audiology clinics and pharmacies and 3.4 million visits were made to the information and resources section of our website.8

3.5 We are therefore concerned that a recent RNID survey showed that four out of five people (79%),9 when fitted with a hearing aid, received no information about other services or assistive technology, which might help to maximise their independence and wellbeing. We welcome that the Bill includes the provision of information and advice in the duty on local authorities and the Secretary of State to improve public health (Clause 8 (3(a)), page 5, line 11). We would welcome the committee exploring how Ministers envisage this duty being met, particularly in light of Government citing the voluntary sector as a potential information provider.

3.6 As a provider of specialist information, RNID expects an increase in the volume of information requests we receive. This service comes at a cost and it is essential that, if the reforms place voluntary sector organisations at the heart of information provision to help meet this duty, they are adequately resourced. Already, the Department of Health has decided not to fund further reprints of its booklet “How to use your hearing aid”. This content was developed by RNID, and we know patients and audiologists find it invaluable—the DH printed 75,000 last year and stocks are now below 30,000.

3.7 Information on wider NHS and social care services

Improvements in information provision for people with a hearing loss accessing wider health and social care services are essential to help reduce the inequalities that this group faces, and we therefore welcome provisions in the Bill to place a duty on various bodies, including commissioning consortia, to reduce these inequalities (Clause 19, New Section 13F(1), page 17, line 5—the Board’s duty; Clause 22, New Section 14N(1), page 30, line 19—the duty on individual consortiums).

3.8 Research shows that more than a quarter of patients with hearing loss have difficulty getting an appointment with their GP, where surgeries won’t book appointments by email, web or text. Of those patients who see their GP, a third are left unclear about the diagnosis after the visit because of communication difficulties.10 Almost a third (30%) of British Sign Language (BSL) users avoid going to see their GP because of communication problems.11 Research shows that 70% of BSL users admitted to A&E units were not provided with a BSL interpreter to enable them to communicate.12

3.9 Information regarding options for people with communication support requirements available on admittance to hospital would ensure that patients and service users are more adequately supported when stressed or anxious and accessing NHS services. Deaf awareness amongst staff is particularly important in acute settings. Healthcare staff also need to ensure that hearing aid users have well maintained and working hearing aids fitted at all times, and check regularly that patients can hear. With this in mind we would welcome clarification at committee stage as to how stringent these duties will be.

3.10 Information about a patient’s hearing loss

It is essential that a person with hearing loss receives any communication support that is necessary, from ensuring that staff are aware that they lipread to the provision BSL interpreter. We would like to see healthcare records prominently displaying a person’s communication requirements and any support they require by having this information electronically flagged for healthcare staff, including receptionists. In this manner the right provisions can be made in a timely way. We would therefore welcome clarification of this during examination of Clause 234, page 196, line 10.

4. Hearing Loss as a Public Health Issue

4.1 We welcome the example provided in the explanatory notes accompanying Clause 19, New Section 13F, page 17, line 4 of the Bill that reducing late presentation of conditions is a means to help reduce health inequalities. At present it takes people an average of 10 years to receive a diagnosis of hearing loss,13 a delay which can exacerbate other health conditions and lead to isolation from the work place and from friends and family networks.

4.2 The isolation that results from a hearing loss being allowed to develop, the withdrawal from accessing services such as a GP or pharmacist and the adaptation that people make in terms of avoiding communication with others, all lead to a reduction in the ability to access healthcare services when needed. We would like to ensure that conditions such as unaddressed hearing loss are not ignored as public health issues and that Ministers clarify how public health can be broadened out from traditional areas such as

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8 RNID Information Review July 2010.
obesity and smoking cessation. This is particularly pressing with hearing loss as the Medical Research Council estimates that the number of deaf and hard of hearing people is set to increase by around 14% every 10 years.

5. **INTEGRATED HEALTH AND SOCIAL CARE SERVICES**

5.1 We welcome provisions in the Bill to seek a better link up between health and social care providers through the duty placed on the National Commissioning Board in Clause 19, New Section 13J(1), page 17, line 40 and on Health and Wellbeing Boards in Clause 179, page 152, line 25. There are many services that people can be signposted to once they have been diagnosed with a hearing loss and fitted with a hearing aid, such as community equipment to help them adapt their home to their hearing loss and to services such as RNID’s Hear to Help projects that help new hearing aid users learn basic maintenance and upkeep of the devices. However, we know that at present this signposting does not always take place, as a recent RNID survey showed that four out of five people (79%), when fitted with a hearing aid, received no information about other services or assistive technology, which might help to maximise their independence and wellbeing.

5.2 Whilst we welcome the provisions in the Bill that may facilitate this taking place, we would welcome Ministers clarifying how this will take place in practice, particularly in light of the prospect of non co-terminus boundaries between commissioning consortia and local authorities.

5.3 We welcome provisions in the Bill that Joint Strategic Needs Assessments will now have a wider scope to include future needs of the local population (Clause 176(3(c)), page 149, line 13). It is essential that these assessments take hearing loss into account—RNID looked at a small sample of these and found that at present they do not. We would like to see more robust national guidelines introduced so that they capture the needs of every person.

5.4 Two key factors—the current level of unaddressed hearing loss and demographic change leading to an ageing society—mean that the demand for audiology and hearing loss services will grow. There are four million people across the UK currently experiencing a hearing loss for which the use of hearing aids would be appropriate but who do not have them, and the Medical Research Council estimates that the number of deaf and hard of hearing people is set to increase by about 14% every 10 years.

5.6 We would welcome clarification during committee stage as to how future need will be assessed and the level of evidence that will be required to demonstrate a future need that must be taken into account.

6. **STANDARDS**

6.1 The provisions in the Bill for the National Institute of Health and Care Excellence (NICE) to develop quality standards present an opportunity for robust quality standards that encompasses public health, clinical and social care interventions of hearing loss services, to the benefit of patients (Clause 218, page 189, line 28). We would welcome clarification of how broad these standards will be and to what degree they would be condition specific, and would also welcome examination of the term ‘may’ in this clause, as we are concerned that this could indicate that quality standards will be viewed with differing importance between commissioning consortia.

6.2 We also see the database of quality indicators that the Bill sets out as being produced by the Information Centre (Clause 248, page 203, line 23) as an excellent opportunity to ensure that audiology and hearing loss services operate to a high standard to the benefit of patients, and would again welcome clarification of how broad these indicators will be and to what degree they would be condition specific.

February 2011

Memorandum submitted by the British Dental Association (HS 06)

1. **ABOUT US**

1.1 The British Dental Association (BDA) is the professional association and trade union for dentists in the UK. It represents 23,000 members working in general practice, in community and hospital settings, in academia and research, and in the armed forces. It also includes dental students.

2. **OVERVIEW**

2.1 The BDA welcomes the provision for dental services to be commissioned by the NHS Commissioning Board, although it must be clarified whether this means all types of services. Commissioning by primary care trusts has been of variable quality and we believe that national commissioning will lead to greater consistency of approach and will ensure that dentistry is not overlooked. Whilst there are significant advantages in central commissioning of dental services by the NHS Commissioning Board, we are nonetheless anxious to ensure that mechanisms are in place to strengthen the ability of commissioners and

providers to develop services that are responsive to local needs, and to ensure that they are fully integrated with other NHS services. There will be a delicate balance to be struck between central determination and local flexibility. Local input is a key element which needs to be secured within the Bill.

2.2 There are other areas in the Government’s proposals that need clarification. These include the services to be provided for children, the role of Monitor and education and training for the healthcare workforce.

3. Key Points

3.1 The scope of the Board’s responsibilities for dentistry

3.1.1 The BDA understands that it is the Coalition Government’s intention that all dental services will be commissioned by the NHS Commissioning Board. The BDA supports this as it is essential that all dental services are commissioned by the same commissioner because of the dynamic and complementary nature of the relationships between general dental services (family dentistry), salaried dental services (also known as community dentistry, for vulnerable groups) and hospital dental services. This approach would ensure consistency in commissioning and safeguard care for vulnerable groups. Despite this stated intention, the current wording in clauses 9 and 11 leaves open to question where commissioning for all dental services will sit.

3.1.2 The BDA asks that Committee members seek clarification of the term “primary dental services”. Primary dental services have generally been considered to be services provided by either general dental practitioners or salaried primary dental care services, but the explanatory notes to clause 11 (paragraph 128) refer to both salaried primary dental care services and hospital services as “secondary dental services”. It is this confusion that is causing the BDA concern, as noted in paragraph 3.1.1 above.

3.2 The need for dental advice centrally

3.2.1 For the successful commissioning of dentistry, it is essential that expert dental advice is available to the Board. The Bill states (in Schedule 1, paragraph 10) that “the Board can appoint such committees and sub-committees as it considers appropriate”. These appointments will be important because they will help to ensure that the right expertise informs commissioning decisions. In order for dental care to be commissioned so that it effectively meets patients’ needs, the BDA believes that a national dental advisory group should sit alongside the Board to support the commissioning of dentistry across the country. This could be added to the Bill in Schedule 1. The advisory group should include representation from all the different dental services (general dental services, salaried dental services and hospital dental services) and provide clinical input into the management of the national commissioning process.

3.3 The need for dental involvement locally

3.3.1 The BDA is concerned that there is no statutory duty on local authorities, through the Health and Wellbeing Boards, to consult local representative committees when devising a health and wellbeing strategy and joint strategic needs assessment. (Clauses 176 and 177.)

3.3.2 In order to ensure that dental services operate effectively, professional and local expertise must be utilised. The contribution of Dental Practice Advisers, Local Dental Committees and, in some areas, Oral Health Advisory Groups, is invaluable in supporting the quality of care and tailoring services to local needs. We suggest that the ability of Health and Wellbeing Boards to respond to dental needs, to inform the health and wellbeing strategy, joint strategic needs assessment and National Commissioning Board, and to encourage integrated working across local healthcare providers, will be significantly enhanced by a statutory responsibility to include representatives of relevant health professions in their constitutions and to consult them (Clause 178).

3.3.3 In order for local experts—in the form of Local Dental Committees (LDCs)—to input into local commissioning, they must be recognised and have the resources to function efficiently. With dental services in transition and other sources of expertise ebbing away, the BDA believes that LDCs will be more important than ever. Alongside a transfer of responsibility for commissioning the full breadth of dental services to the Board, provision should be made for all providers and performers of primary dental services, not just providers of general dental services, to be represented by LDCs.

3.4 The need for dental public health expertise

3.4.1 The Bill passes to local authorities duties in relation to public health and dental public health, and a duty to appoint a Director of Public Health. There is no reference in the Bill, however, to where Consultants in Dental Public Health will sit in the new structure and how their expertise will be utilised. The BDA believes that there must be a duty in the Bill to ensure that local authorities have the benefit of specialist dental public health advice which is essential if local public health measures are to lead to oral health improvement and reduce oral health inequalities. Consultants in Dental Public Health play a pivotal role in identifying need and balancing the provision of services to provide the maximum health benefits to diverse populations. We would welcome the inclusion in clause 25 of a duty on a local authority to appoint a dentist to have responsibility for dental health (a Consultant in Dental Public Health).
3.5 School dental inspections

3.5.1 The Bill extends local authorities’ duties to provide for the dental inspection and treatment of schoolchildren (Clause 13). Whilst the wording appears to provide for inspection and treatment of identified need, it is not clear if re-introducing routine, systematic school dental screening is envisaged. School dental screening has been shown to be ineffective in reducing oral health inequalities because it tends to prompt those who would arrange visits to the dentist for their children anyway to do so, rather than getting non-attenders to visit.15

3.5.2 Clause 13, as presently worded, puts a duty, as opposed to the ability in appropriate circumstances, to provide for dental inspection and treatment in schools. The BDA is seeking clarification of the Government’s intention and believes that a multi-faceted approach to oral health inequalities that targets pre-school children and their parents would be a more effective strategy for reducing oral health inequalities.

3.5.3 The Public Health Outcomes Framework includes one oral health indicator—the reduction in the caries (decay) rate in five-year-old children. We support this outcome and there are a number of effective measures that can be adopted to achieve it, but they must start well before the child begins school and so we do not see how they will be captured by this provision.

3.6 The role of Monitor

3.6.1 The role of Monitor in the regulation and pricing of dental services remains unclear in the Bill. We believe that it should be explicit that primary dental service providers are to be exempt.

3.6.2 Dental service providers (dentists, for the most part) are already heavily regulated by their professional regulator, by performers lists provisions, by the terms of NHS contracts and now by the Care Quality Commission. We believe that it is disproportionate to include dentists in economic regulation as there is no evidence of risk to patients or the health service from lack of competition, patient choice or lack of continuity of service.

3.6.3 We believe that licensing by Monitor would impose an unnecessary burden which, according to clause 56, is contrary to its duty to review regulatory burdens. The consequence would be increased costs for small businesses and resulting negative effects on the availability of services for patients. The explanatory notes (paragraph 607) suggest that general medical practitioners may not be covered by the licensing requirements and we seek confirmation that dentists will not be covered.

3.6.4 The BDA is also seeking clarification of whether Monitor will have a role in determining the fees and/or contract values for dental services or whether this will be determined through the National Commissioning Board. Currently, the Health Act 2006 (section 103) states that the Secretary of State may give directions as to payments under general dental services contractors. The BDA hopes that this will remain the case.

3.7 Education and training for the healthcare workforce

3.7.1 Concurrently with the Bill, the Department of Health is consulting until the end of March on proposals for transferring responsibility for the education and training of the healthcare workforce to providers (Liberating the NHS: developing the healthcare workforce). The dental workforce is educated and trained principally in university dental schools, and national responsibility, oversight and provision must be managed centrally. The BDA is concerned at the implications for dental service providers, most of whom are small family practices, if they are to take responsibility for assessing workforce need, arranging for training and paying for it by means of a levy. The consultation stresses that the changes are significant and that time must be taken “to develop the proposals to ensure that the appropriate legislation is in place, that the administrative arrangements are appropriate and proportionate . . .”. We seek assurance that nothing in the Bill pre-emptsts proper consultation and consideration of the implications of the proposals for the entire healthcare service provider sector.

February 2011

Memorandum submitted by Dr Naomi Elton (HS 07)

I have worked as a Consultant in Child & Adolescent Psychiatry for 15 years. I currently work for an NHS trust, and while my views about Equity and Excellence are shared by many colleagues I am not in a position to represent the views of my employing organisation.

My concerns are two-fold.

1. I am very concerned about the likely effects on patient care should the changes outlined in Equity and Excellence be enacted in the Health and Social Care Act. Firstly, it seems clear that the re-organization itself will be very costly. There is little hard evidence that a re-organisation along the lines proposed would render

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a system that would be more cost-effective than the status quo. The numbers of GP consortia will be far greater than the numbers of existing Primary Care Trusts so it is very hard to see how management costs within the envisaged system will be reduced. Most GPs will not have the skills or time to engage in commissioning, so will be forced to delegate commissioning to other organisations. In a competitive market, multinational companies may well be the most successful contenders. If such organizations take on the commissioning, I believe that commercial interests will inevitably constitute a very significant influence over the process and its outcomes. There is little good evidence to allow us to believe that patient choice or more accurate assessments of the local health needs will be outcomes of the envisaged changes as the bill intends, and the opposite is in fact more likely.

2. A further concern is that, as the recent Kennedy Report makes clear, children’s services are in desperate need of integration. In their day to day work, practitioners must work together, and when they fail to do so, this is to the very great detriment of the patient. Proper co-operation between practitioners is unlikely to be accomplished by putting the provider organizations into a position in which commercial interests foster high levels of competition.

I trust these comments will be useful.

February 2011

Memorandum submitted by the Chartered Institute of Environmental Health (HS 09)

SUMMARY

1. The CIEH limits its comments to the Bill’s provisions relating to public health. The CIEH welcomes the step-change in addressing public health challenges, including the adoption of the Marmot Review agenda towards tackling the wider determinants of poor health and reducing health inequalities.

2. It is right to give the lead responsibility for public health in England to local authorities. The CIEH believes that the Bill fails to address adequately the complexities of delivering public health services in parts of England where there is two-tier local government. The CIEH proposes a statutory duty to co-operate and agreements for shared services to enable local authorities to make arrangements for the delivery of public health services in these areas.

3. The CIEH welcomes the strengthened duties on the Secretary of State and local authorities to improve the health and wellbeing of the population. To strengthen the support for the carrying out of these duties, the CIEH proposes the creation of the post of Chief Environmental Health Officer for England and an advisory committee.

4. The CIEH foresees that the Chief Environmental Health Officer for England, working to the CMO, will advise the Secretary of State, Public Health England, Parliament and the public on all matters relating to environmental health that have a bearing on public health and wellbeing.

5. The CIEH foresees that the advisory committee will oversee the work of Public Health England and ensure that the experience and views of public health practitioners and members of the public inform the decisions and work of Public Health England.

6. Environmental Health Practitioners work in all communities and all sectors of the economy and their work already supports the public health agenda. The CIEH strongly believes that a greater focus on improving health and wellbeing and reducing health inequalities will be assisted by involving Environmental Health Practitioners in all aspects of such work.

THE CIEH’S EVIDENCE

7. The CIEH is a professional membership body representing over 10,000 members. It sets the standards for entry to the professional and maintains standards of competence and conduct through continuing professional development and through self-regulation. Its charitable and Royal Charter objective is to promote good environmental and public health.

8. Within the three domains of public health (health protection, health promotion and population healthcare) Environmental Health Practitioners (EHPs) are active in communities working holistically with partner organisations and community groups to support health protection and health improvement. Links with PCTs and GPs linked to healthcare services are less well developed but innovations like exercise on prescription often involve EHPs.

9. If the Committee wishes, the CIEH can provide a witness who can expand on the work of EHPs in collaboration with organisations like the Health Protection Authority (HPA) and PCTs and across the range of local authority services.

10. At the national level of the new public health service, the abolition of the HPA and the setting up of Public Health England in the Department of Health does reduce the opportunities for independent advice and views to get through to the decision-makers. This is why the CIEH believes that a Chief Environmental Health Officer for England and an advisory committee overseeing the work of Public Health England will be needed.
11. If members look to the public health arrangements in Northern Ireland, Scotland and Wales they will see that the post of Chief Environmental Health Officer is central elsewhere. The CIEH can arrange for evidence about these arrangements if required.

12. In parts of England where there is two-tier local government (a county council and a number of district—sometimes called borough-councils), the Department proposes that the statutory duties and responsibilities and the ring fenced funding will be directed to the county council. However, the environmental health workforce is usually entirely with the district councils. Clearly there is a need for there to be arrangements to ensure that the Director of Public Health (located in the county council) can have access to this resource.

13. The Department, in line with the spirit of localism, believes that the local authorities in these two-tier areas will make arrangements to resolve this difficulty in ways that suit their local area. This is over-optimistic. The CIEH says that there needs to be a statutory duty to co-operate (in line with similar duties in respect of civil contingencies and safeguarding children) so that the county and district councils have to find a suitable way of working together. It remains open to the councils to make arrangements that suit their local area and the CIEH would anticipate that there will be a variety of solutions including joint agreements, shared services and supra-local collaborations.

14. In two-tier local government areas of England, it seems reasonable to the CIEH that the district councils should have a seat on the county’s health and wellbeing board by right. In keeping with the spirit of localism it should be for the district councils to work agree how to determine the representation. The Secretary of State has said that the challenge of co-ordinating public health services in two-tier local government areas will be through the health and wellbeing boards. It will also be open to county and district councils to agree for there to be a number of subsidiary health and wellbeing boards in the county—but this should not be a reason for excluding the district councils from the county’s health and wellbeing board.

February 2011

Memorandum submitted by BASW—The College of Social Work (HIS 10)

SUMMARY

The Health and Social Care Bill is a vital opportunity to improve services and improve people’s lives. However without significant amendment it is an opportunity which will be missed.

In placing key responsibility for providing, developing and commissioning services with GP’s it is vital that we recognise the social roots of so many “health problems”. The experience of multi-disciplinary teams based for many years in GP Practices is that a social worker can often actually address problems more effectively than a doctor.

Social Work in England is in crisis but it is often the case that high profile cases in Children’s Services mean that the situation in services for Adults is overlooked.

At a time when unprecedented attention is being given to the need for people with disabilities, older people, people with mental health problems to be able to manage their own person centered support and to benefit from more localised, more integrated care it is a terrible irony that some 50% of Directors of Adult Services state that they do not see a role for social work.

BASW—The College of Social Work is lead by and accountable to some 13,500 social workers in the UK. We are international representatives of a profession whose significance is recognised across the world. BASW firmly believe that the skills and principles of Social Work are vital to safeguarding, supporting and empowering the most vulnerable people in our society and can be invaluable to all of us when we need to make important decisions sometimes at the most vulnerable times of our lives.

We are deeply concerned that the current move to reduce the numbers of social workers will undermine the well being of some of the neediest people in every constituency in the land. Moreover we are very worried that the current tactic to replace social work roles with people with different job titles will reduce the requirement for registration and thereby reduce the protection of the public.

— BASW—The College of Social Work believes that the following issues must be addressed in the Health and Social Care Bill:

1. THE DEFINITION OF SOCIAL WORK

It cannot be good enough to say that social work is what social workers do which is the current stance of clause 193(5) of the Bill. Social Work has an international definition approved by the United Nations.

BASW therefore recommend an amendment to S 193 (5).

After “England” insert “and meets the international definition of Social Work set out below”.

2. THE DEFINITION OF SOCIAL WORK SET OUT BELOW

BASW therefore propose a definition of Social Work.

Social Work is the profession of working to prevent or relieve suffering and to ameliorate disadvantage in all its forms by mobilising the capacity of the individual, the family, the community and the state to achieve these aims. It is an enabling work which is characterised by person-centered practice, collaboration, partnership and advocacy in the public, voluntary and private sectors.

Social Work is an enabling work which is characterised by person-centered practice, collaboration, partnership and advocacy in the public, voluntary and private sectors.
2. THE ROLE AND FUNCTION OF SOCIAL WORK

Having defined social work it is surely important for the Bill to set out the role and function of social work in England.

BASW recommend a further amendment to S 193 (5).

After subsection 27A insert—

(27AA) Social Work in England is that which through the exercise of its statutory functions and/or the employment of its range of skills works to:
(a) Promote social justice by helping people to achieve change in their lives.
(b) Meet the needs of people and enable their social inclusion and the cohesion of society.
(c) Protect those who may be at risk of abuse or harm from others.
(d) Reduce the risk of people abusing or harming others.
(e) Enhance self respect and respect for others within families groups and communities.
(f) Reduce conflict and distress in families, groups and communities.

(27AB) Social Work operates within a wide range of legislative frameworks and with Government guidance and regulations.

(27AC) Social Work puts individuals, families, groups and communities at the forefront of its concern and works with all others to promote their health, socio-economic well being and empowerment.

(27AD) Social Work provides the necessary challenge to governments and institutions through advocacy which is rooted in internationally recognized ethical principles and undertaken alongside individuals, families, groups and communities.

3. PROTECTION OF SOCIAL WORK FUNCTION AS WELL AS SOCIAL WORK TITLE

Protection of the title of social worker as established by the Care Standards Act 2000 was an important measure to ensure that those who have job titles which include “social worker” are registered and regulated. However there are currently a myriad of job titles under development and already in place which re-label work with the most needy people at the most vulnerable time of their lives. The argument of far too many employers is that if you aren’t described as a “social worker” you don’t need to register thus denying the public the protection which Parliament has decided that they require.

To fail to protect social work functions as well as title is to drive a coach and horses through the Bill’s amendment of current procedures for the registration and regulation of people who have such close contact with the public.

— Proposed New Clause.
— New Clause 1.

Insert after clause 61 (1) Care Standards Act 2000

(a) The title of Social Worker is a protected title.

(b) A person may use the title of Social Worker only if they have the qualification of social worker and are registered as a social worker.

(c) If a person who is not registered as a social worker in any relevant register with intent to deceive another:
   (i) takes or uses the title of Social Worker; and
   (ii) takes or uses any title or description implying that he is so registered.
   He is guilty of an offence.

61 (2)

(a) Any organisation which employs individuals to undertake the functions and roles of a social worker must ensure that any individuals occupying such posts are appropriately qualified and registered as a social worker.

(b) All qualified and registered social workers should operate at all times within the International Ethical Principles for Social Work.

BASW—The College of Social Work would propose a further amendment to recognise that the values, principles and skills of Social Work are actually vital rather than superfluous to those undertaking the fundamentally important role of an Approved Mental Health Professional where the liberty of a human being and the safety of the public are at stake.
BASW therefore recommend an amendment to S 193(8).
Remove the word “not” in line 2

(2ZE) The exercise of functions of an approved mental health professional by a member of a profession to which subsection (2) applies is to be regarded as social work of the kind engaged in by the Social Work profession in England.

4. SOCIAL WORK AND HEALTH PROFESSIONS COUNCIL

The proposal in S 198 of the Bill to acknowledge the new role of the Health Professions Council in registering and regulating social workers by changing its title to the Health and Care Professions Council is absurd because it will have no “care professions” under its control and disgraceful because it doesn’t even mention the profession whose numbers will far outweigh all of the other professions it regulates. To call the body anything other than the Social Work and Health Professions Council will be regarded as an insult to social workers.

BASW—The College of Social Work therefore recommend the following amendments to S 198.

S 198
1(b) is to change its name to the Social Work and Health Professions Council
198(3) replace “Health and Care Professions Council” with “Social Work and Health Professions Council”.
198(4) replace “Health and Care Professions Council” with “Social Work and Health Professions Council.”

5. ESTABLISHMENT OF THE OFFICE OF CHIEF SOCIAL WORKER

In order to maintain the presence and visibility of Social Work at the heart of Government it is now vital to establish the role of a Chief Social Worker.

— New Clause 2
There will be a Chief Social Worker.
(a) To report to and advise Ministers.
(b) To make an annual report to Parliament on the state of Social Work in England.
(c) To work in close co-operation with the College of Social Work, the Social Work and Health Professions Council, the Professional Standards Authority for Health and Social Care, the National Institute for Health and Care Excellence, Inspectors and Employers,

6. STATUTORY DUTIES IN RESPECT OF A COLLEGE OF SOCIAL WORK

The Social Work Taskforce recommended the establishment of a College of Social Work to raise the standing and the status of the profession. BASW originally promoted the idea of a College of Social Work with the Taskforce and a referendum of our members in April 2010 confirmed that Social Workers require a powerful body to advance our profession.

BASW—The College of Social Work is an independent body financed by and accountable to members of the social work profession which operates within the International Ethical Principles for Social Work and which benefits from our work as a professional association over 41 years.

We are very clear that if there is no statutory duty on Government, Local Government, regulators and others to consult with the College then it has no power.

At the same time we recognise that it is vital for the College of Social Work to demonstrate its own credibility through obtaining and retaining 51% of all social workers in membership.

— New Clause 3
(a) There will be statutory guidance and regulation to ensure that Government, and Local Government, the Chief Social Worker, Social Work and Health Professions Council, inspectors and employers consult with and respond to the advice offered by the College of Social Work.
(b) The statutory entitlements of the College of Social Work will be dependent on its ability to demonstrate every four years that it has 51% of registered social workers in membership. If it fails to do so its statutory role will be suspended for 12 months and thereafter indefinitely until this can be rectified.

7. SOCIAL WORK, HEALTH SERVICES AND SOCIAL CARE

The Bill which passed through Second Reading talks about Social Work and Social Care without being able to distinguish between them. The amendments prepared by BASW—The College of Social Work draw the distinction between a profession which has international recognition and definition and a vitally important activity which has not.
BASW believe that Social Work and Social Care are inextricably linked and that it is vital that the two are increasingly integrated with a very wide range of Health professions in order to serve people well. However, in order to deliver integrated services well it is important to respect the identity and the coherence of the various parts.

People will be served well by giving Social Work much greater recognition in this Bill. As we can’t now change the Bill title to reflect the significance of our profession BASW—The College of Social Work would make a final recommendation to add “Social Work” wherever in Part 8 it is proposed that the National Institute for Health and Care Excellence attends to “health services” and “social care”.

February 2011

Memorandum submitted by the London Scrutiny Officer Network (HS 14)

INTRODUCTION

The London Scrutiny Officer Network is an informal network of officers supporting scrutiny members. By our calculation there are approximately 1,861 councillors in London. Of this number approximately 1,500 are non-executive councillors and many of this group will have experienced taking part in overview and scrutiny and in scrutiny of health and social care. It is in our wealth of collective support to this large number of elected councillors on the ground that we draw upon in raising comments on the Health and Social Care Bill.

The Officer Network has been meeting for the past 10 years and its role is in brief to:

— Share best practice and exchange ideas;
— Help build capacity of scrutiny officers and members through learning and development activity;
— Provide practitioner-to-practitioner, peer support;
— Work with and support members in promoting and championing scrutiny across London and nationally.

As practitioners, officers of the Network represent the variety of scrutiny support arrangements across local government. The officer support ranges from dedicated scrutiny officers (and health scrutiny officers), to officers who support both policy and scrutiny or democratic services and scrutiny, across a range of salary grades (assistant chief officer to more junior positions). The experience of supporting scrutiny members ranges from 11 years to recent appointments as well as those who have helped to build the architecture and culture of health scrutiny and contributed to the development of successful scrutiny in their boroughs.

We would like the Committee to note that the views expressed in this submission are those of individual scrutiny officers working in London, based on their experience and not of their councils or their members.

In supporting cross party councillors to carry out their formal health scrutiny roles, many scrutiny officers have witnessed first hand the powerful influencing role that independent and objective critical friend challenge can bring to the discussions on complex health and social care changes within the borough and beyond the council’s geographical boundaries:

— By enabling plans on services and spend to be changed by health decision makers.
— Ensuring a focus on addressing inequalities and outcomes.
— Creating space for patients and public voice to be heard and using experiences to build evidence to inform commissioning decisions.
— Placing emphasis on equal access to health services.
— Creating a neutral political space for a range of interested people (professionals, residents, community organisations, providers and decision makers for example) to discuss complex service configuration within and beyond borough boundaries.
— Bringing a whole systems approach to discussion and debate.

The key points we wish to make in our submission are as follows:

1. SCRUTINY ROLE AND GP COMMISSIONING CONSORTIA

It is unclear in the Bill whether overview and scrutiny can hold GP Commissioning Consortia to account. To simplify and make clear the accountability framework, and drawing upon the current arrangements which work well, we would argue that overview and scrutiny should have the power to hold GP Commissioning Consortia to account.

This clarity on the role of overview and scrutiny should be extended to make the wording clear in the Bill that all commissioners and providers of health and social care services are subject to scrutiny by local authorities overview and scrutiny function. We assume that the Centre for Public Scrutiny will be providing comment on the specific areas of the Bill.
2. Foundation Trusts
We had hoped to see the Bill address the current accountability gap that exists with Foundation Trusts (FTs). To empower patients and public alike and to enable scrutiny of spend and key decisions we would suggest that there should be a formal holding to account of FTs by scrutiny members. We also believe that FTs should hold regular meetings in public and publish minutes of their meetings.

3. Health Overview and Scrutiny Committee Power of Referral to the Secretary of State
We consider that the proposal to shift the current referral powers from the health overview and scrutiny committee to full council is a significant weakening of accountability and may well make referrals highly party political.

The current arrangements ensure that due to the cross party nature of scrutiny that where referrals have occurred they are objective and evidence based. Our experience has shown that scrutiny member use their powers responsibly. We would argue that the referral power is retained by the health and overview scrutiny committee.

4. Health and Wellbeing Boards
We are not sure that public accountability gap on health and well being boards will be addressed by the membership suggested in the Bill. Due to the focus and attention of the Boards we would suggest that they should be required to meet in public.

5. HealthWatch
Based on our collective experience of working with and supporting LINKs (and PPIFs prior to LINKS), we believe that HealthWatch will not be able to carry out the aims and ambitions set out in the Bill without proper and realistic resources.

Conclusion
In conclusion we hope that you are able to consider our comments and suggestions as part of your deliberations on the Health and Social Care Bill.

February 2011

Memorandum submitted by Mencap (HS 18)

About Mencap
Mencap supports the 1.5 million people with a learning disability in the UK and their families and carers. Mencap fights to change laws and improve services and access to education, employment and leisure facilities, supporting thousands of people with a learning disability to live their lives the way they want. We are also one of the largest providers of services, information and advice for people with a learning disability across England, Northern Ireland and Wales. See www.mencap.org.uk for more information.

About Learning Disability
A learning disability is caused by the way the brain develops before, during or shortly after birth. It is always lifelong and affects someone's intellectual and social development. It used to be called mental handicap but this term is outdated and offensive. Learning disability is NOT a mental illness. The term learning difficulty is often incorrectly used interchangeably with learning disability.

Mencap’s Interest in Health
— Mencap have a long standing interest in the health of people with a learning disability
— Research has shown that people with a learning disability still experience worse health outcomes and health inequalities than the general population.
— Mencap’s Death By Indifference report (2007) highlighted the six premature, avoidable deaths of people with a learning disability in the NHS.
— These shocking deaths led to a government ordered independent inquiry (Sir Jonathan Michael/Healthcare for all) as well as an investigation by the Health Service Ombudsman (Six Lives report).
— Since these reports, progress has been made within the NHS, but performance is patchy.
— A recent progress update to the Ombudsman (the Six Lives Progress Report, DH, 2010) showed that concerns remain around poor use of mental capacity legislation and lack of health services being reasonably adjusted.
— With the changes proposed in the bill, the challenge is to make sure that progress in driving better health outcomes for people with a learning disability is not lost.
— Mencap leads the *Getting it Right* campaign, which is a coalition of charities and Royal Colleges working together to realise better health outcomes for all disabled people (including those with learning disability), collaborating on this bill.

**What do health professionals know about learning disability?**

A poll conducted by ICM on behalf of Mencap asked over 1,000 health professionals about their experiences and views of the way people with a learning disability are treated within the NHS. The main findings are as follows (regional figures are available):

(i) Almost half of doctors and a third of nurses said that people with a learning disability receive a poorer standard of healthcare than the rest of the population.

(ii) Nearly half of doctors and a third of nurses revealed that they had personally witnessed a patient with a learning disability being treated with neglect or a lack of dignity or receiving poor quality care.

(iii) Four out of 10 doctors and a third of nurses said people with a learning disability are discriminated against in the NHS.

(iv) A third of healthcare professionals have not been trained in how to make reasonable adjustments for a patient with a learning disability.

(v) Over half of doctors and more than two thirds of nurses said they needed specific guidelines on how care and treatment should be adjusted to meet the needs of those with a learning disability.

**General Points on the Health and Social Care Bill 2011**

Mencap accepts the general direction of travel as laid out on the face of the Bill and is keen to ensure that the new NHS structures are constructed in the fashion that best delivers improved health outcomes for people with a disability (including those with a learning disability), without prejudice to other groups. This bill present a number of opportunities to improve the healthcare offered to people with a disability, including the focus that comes from the NHS outcomes Framework, the arrival of Healthwatch, NICE quality standards and the roles and duties of the NHS Commissioning Board and the GP Consortia.

**Challenges in ensuring better health for all people, including those with disabilities**

— Only three mentions of disability are made throughout the Bill.

— In the bill there is very little mention of need to tackle existing health inequalities or discrimination for all groups, not just those that are easiest to reach.

— Most of the detail on how the new structures will work in practice is left for regulations and secondary legislation.

— Although this is not unexpected, it will be crucial for those with an interest in driving health outcomes for people with a disability to consistently engage on this issue.

**Key Issues Mencap Would Like the Bill to Address**

(a) The need for all new bodies to tackle discrimination and improve health outcomes for all people

People with a learning disability still experience worse healthcare and get worse outcomes than the general population. People with a learning disability are at disproportionate risk of premature death, epilepsy and mental health problems.

Mencap will be proposing amendments to ask that there be explicit duties on all bodies within the new NHS structure to tackle discrimination and improve health outcomes for all patients, not just those that are easiest to reach.

(b) GPs as commissioners—particularly for those with the most complex needs

Commissioning of services for people with a learning disability by Primary Care Trusts (PCTs) has been patchy and it is questionable whether commissioning led by GP consortia will lead to improvements. It is possible however that the transition will pose issues in ensuring that progress made at regional level, by some very dedicated individual NHS staff, is not lost.

Mencap fully supports personal budgets and would like to see them extended to all who need them, with no upper limit on the amount that can be spent on the package offered. Mencap believes that the piloting of personal health budgets has brought a new era of choice and control for people with profound and multiple learning disabilities and their families.

However, given the relative expense of these packages, and budget cuts, Mencap believes that commissioning for this group should fall within the ambit of the NHS Commissioning Board, as otherwise the temptation may be too strong for local authorities to cut care packages and so deny the right to a dignified and meaningful life for this group.
The *Raising our Sights* report (Department of Health, 2010) showed that for patients with the most complex needs joined up planning is essential if people are to live longer and healthier lives. This joined up planning needs to span both health and social care.

Given the changes planned to commissioning, Mencap believes that there is a real risk of fragmentation and the possibility of a triple discrimination. A triple discrimination could occur if GPs fail to make reasonable adjustments in their work (recent Mencap polling showed that GPs did not feel they had enough training to reasonably adjust their services for patients with a learning disability). This could then be compounded as patients with a learning disability go into hospital—where there lives have often not been properly valued. If commissioning is then done by consortia of GP, without the right training, people with a learning disability may not be fully considered when designing services.

(c) Health professionals and reasonable adjustments

Making reasonable adjustments makes good clinical sense for healthcare professionals, particularly given the increasing tendency towards payment by results, which should incentivise professionals to deliver the right healthcare first time. Reasonable adjustments have a clear basis in law (Disability Discrimination Act, Equality Act) and are implicitly supported by the Human Rights Act.

In the primary care setting, a key reasonable adjustment is the annual health check. This is offered by some GPs and is currently funded under the Direct Enhanced Scheme payment. Evidence from Australia has shown that the use of a health check with people with a learning disability led to a 6.6-fold increase in detection of vision impairment, *inter alia*. The use of annual health checks has also been reported to deliver positive gains in health outcomes over a 12-month period.

In England, during 2008–09, 41% of those eligible had a health check—this has meant that nearly 6/10 people are not getting a service that could be extremely helpful in realising the preventative health agenda.

Mencap believes that within the proposed changes to NHS, a key reasonable adjustment should be continuation of the Annual Health Check.

Mencap believes that GP Commissioners and the NHS Commissioning Board need to be given explicit guidance from the outset as to the importance, in all clinical specialties, of making reasonable adjustments to include people with a learning disability.

(d) Accessibility (in the context of the NHS Commissioning Boards and Foundation Trusts, Health Watch England etc)

People with a learning disability, people with communication difficulties, older people, people with visual impairments and those with hearing difficulties are often heavier users of the NHS than others. Given the Equalities Act stricture to ensure that there is no “substantial discrimination” in the public sector, it is vital that the NHS Commissioning Board (along with all the other parts of the new NHS structure) is fully accessible to all these.

(e) The importance of collecting data by impairment group

People with a learning disability continue to die prematurely and avoidably, as the cluster of deaths at Royal Berkshire, and Basildon and Thurrock NHS Trusts have attested. It is vital that data on the safety of services is made available to the widest constituency, in order to drive patient choice and patient safety. Without the breakdown of this data (by impairment type) it is not obvious to see how the system will prevent a repeat of these clusters of deaths.

(f) The importance of advocacy services

With the proposal in the bill for local Healthwatch to support people with complaints, through the provision of advocacy, Mencap’s experience may be informative.

Mencap has supported a large number of families through the NHS complaints system, through both the local and ombudsman stage. In our experience, going through these stages can take many years. Mencap is aware of many cases where the complaints process has taken more than two years. Advocacy support should be extended for as long as is needed. Starting and then stopping advocacy support to families could be deeply upsetting to these families.

Mencap therefore believe it is vital that advocacy support be extended for as long as needed. Without a commitment for “as long as it takes support”, families will have a harder time getting justice and the NHS will have less opportunities to learn from their mistakes.

**What Mencap wants from the Bill (and associated guidance)**

— For there to be explicit duties on all bodies within the new structure to tackle discrimination and reduce health inequalities for all.

— Ensuring GPs (and all healthcare professionals) know how to make reasonable adjustments when delivering care to patients with a learning disability.
Support for provision of personal budgets, particularly where the high costs may be seen as prohibitive by commissioners.

For the NHS commissioning board to commission services for people with Profound and Multiple Learning Disabilities (PMLD).

For the NHS Commissioning Board to ask NICE to produce quality standards on learning disability and to inform standards.

Need for collection of data on all health outcomes, across the NHS, disaggregated by disability/impairment type.

Ensuring all new NHS structures (Commissioning Board, Consortia, Healthwatch England and local as well as Health and Wellbeing Boards) have a duty to fully engage with disabled people.

How the Bill Committee might be able to help to drive up outcomes for all people

Members of the Bill Committee can play a key role in clarifying the government’s commitment to disabled people. Mencap would like members to consider the following points:

1. How will the Secretary of State ensure that the NHS tackles discrimination and improves the health of people with a disability?

2. What role can the NHS Commissioning Board play in developing commissioning expertise around those with the most complex disabilities—including Profound and Multiple Learning Disabilities?

3. A survey of 1,000 healthcare professionals commissioned by Mencap (June 2010) found that GPs did not understand how to make reasonable adjustments to their work when dealing with patients with a learning disability. How can this be addressed?

4. What reassurances can we have that the workings of the NHS Commissioning Board will be genuinely open and accessible to those with disabilities?

5. How can data on the health needs of people with disabilities be collected, made available and used to drive and inform patient choice?

6. How can we ensure that Commissioning Consortia have a duty to commission for all in their area, including the often specialist (and expensive) health needs of people with disabilities, without reference to cost (particularly around personal budgets)?

7. How can we ensure that Foundation Trust meetings and communications are fully accessible to disabled people?

8. How can we ensure that Healthwatch England and the Local Healthwatch proceedings are fully open for and accessible to people with disabilities?

9. What reassurances can the Secretary of State give us that advocacy, provided via the Local Healthwatch (possibly via a third party) will be offered for as long as needed, particularly given the years it may take for a complaint to go through the NHS?

10. What reassurance can the Secretary of State offer on Health and Wellbeing Boards and ensuring that each of the new bodies have a duty to consult disabled people, given their specific needs and the proven health inequalities that exist?

Suggested Amendments for Committee Consideration

Page 2: Clause 2 (1A) Duty as to improvement in quality of services

(1) The Secretary of State must exercise the functions of the Secretary of State in relation to the health service with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with:

(a) the prevention, diagnosis or treatment of illness, or

(b) the protection or improvement of public health, or

(c) the promotion and improvement of the health of all disabled people, including those with co-morbidities, and

(d) tackling discrimination/promoting greater health equality.

This amendment aims to ensure the Secretary of State has a clear duty with regards to tackling health inequalities and discrimination faced by all people, including those with a disability.

Page 7: Clause 11—line 3—Secretary of State’s power to require Board to commission certain health services

(1) Regulations may require the Board to arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of—

(a) dental services of a prescribed description;

(b) services or facilities for members of the armed forces or their families;
(c) services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description;

(d) services or facilities for those with profound and multiple learning disabilities; and

(e) such other services or facilities as may be prescribed, including for those with profound and multiple learning disabilities and people with complex needs whose behaviour challenges services.

Mencap believes that the piloting of personal health budgets has brought a new era of choice and control for people with profound and multiple learning disabilities and their families. Mencap fully supports personal budgets and would like to see them extended to all who need them, with no upper limit on the amount that can be spent.

However, given the relative expense of these packages, Mencap believes that commissioning for this group should fall within the ambit of the NHS Commissioning Board, as otherwise the temptation may be too strong for local authorities to cut care packages and so deny the right to a dignified and meaningful life for this group.

Page 18: Clause 13L (2)—Line 33—Public involvement and consultation by the Board

After (c) ADD

(d) ensuring that reasonable adjustments are made so that the views of people with any impairments or disabilities can also be sought in relation to subsections (a–c)

People with a learning disability, people with communication difficulties, older people, people with visual impairments and those with hearing difficulties are often heavier users of the NHS than others. Given the Equalities Act stricture to ensure that there is no “substantial discrimination” in the public sector, it is vital that the NHS Commissioning Board (along with all the other parts of the new NHS structure) is fully accessible to all these.

Page 18: Clause 13M (1) Information on safety of services provided by the health service

The Board must establish and operate systems for collecting and analysing information relating to the safety of the services provided by the health service, and provide a break down of the data by disability impairment type.

People with a learning disability continue to die prematurely and avoidably, as the cluster of deaths at Royal Berkshire, and Basildon and Thurrock NHS Trusts have attested. It is vital that data on the safety of services is made available to the widest constituency, in order to drive patient choice and patient safety. Without the breakdown of this data (by impairment type) it is not obvious to see how the system will prevent a repeat of these clusters of deaths.

Page 29: Clause 14L (1) Duty as to improvement in quality of services

Each commissioning consortium must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, including for people with a disability.

Despite a central NHS tariff it is possible that the move commissioning consortia will see an ever higher focus on the cost of provision for an individual patient rather than on the improved health outcomes that may accrue. We remain particularly concerned about the issues pertaining to those loved and valued family members who have PMLD and seek reassurance that this duty will apply to all.

Page 30: Clause 14N Duties as to reducing inequalities, promoting patient involvement etc.

(1) Each commissioning consortium must, in the exercise of its functions, have regard to the need to—

(a) reduce inequalities between all patients with respect to their ability to access health services;

(b) reduce inequalities between all patients with respect to the outcomes achieved for them by the provision of health services and tackle discrimination;

(c) promote the involvement of all patients and their carers in decisions about the provision of health services to them;

(d) enable all patients to make choices with respect to aspects of services provided to them as part of the health service;

(e) collect data on the experience and outcomes experienced by all patients and where the person has a disability, break data down by impairment type.

Mencap want it made explicit that consortia must have regard to these issues for all patients, rather than just those that are easiest to reach. Choice and control are often not as widespread for people with a disability as they are for the general population and therefore this is an important statement of intent.

It is vital that data on the safety of services is made available to the widest constituency, in order to drive patient choice and patient safety. Without the breakdown of this data (by impairment type) it is not obvious to see how the system will prevent a repeat of these clusters of deaths.
Page 30: Clause 14P (2) Public involvement and consultation by commissioning consortia

After subclause (c) ADD

(2a) Regulations may also be introduced to ensure that consortium should engage proactively and seek the views of all disabled people and marginalised groups.

People with a disability often make much greater use of the NHS than the general public. Given the Equalities Act stricture to ensure that there is no “substantial discrimination” in the public sector, and as Consortia will be a Public Body under this act, it is vital that the Commissioning Consortia are fully accessible to all people, including those with a disability.

Page 60: Clause 44 Secretary of State’s annual report

In Part 13 of the National Health Service Act 2006 before section 248 insert—

20 “247B Secretary of State’s annual report

(1) The Secretary of State must publish an annual report on the performance of the health service in England.

(2) The Secretary of State must lay any report prepared under this section before Parliament.”

After subclause (2) ADD

(1a) The Secretary of State must include progress on tackling health inequalities for hard to reach groups and those with a disability.

This statutory duty to report on progress in tackling health inequalities would keep up the momentum to ensure that progress in outcomes was made for all.

Page 119: Clause 138 (2)—line 43—Members

“(2) In deciding which areas are to be areas for public constituencies, or in deciding whether there is to be a patients’ constituency, an NHS foundation trust must have regard to the need for those eligible for such membership to be representative of those to whom the trust provides services and ensure that such proceedings are made fully accessible to any disabled persons”

Rationale for this point has been previously made above.

Page 138: Clause 45A (3)—Line 37 Advice given by Healthwatch England

After (3)(b) ADD:

(C) Advice on how to ensure that all meetings, communications and reports are fully accessible to those with a disability or any form of impairment.

See rationale above.

Page 143: Clause 170 (4) Independent Advocacy Services

“Each local authority must make such other arrangements as it considers appropriate for the provision of assistance to individuals in connection with complaints relating to the provision of services as part of the health service, ensuring that there is no upper limit on the length and type of advocacy support that may be provided.

NHS complaints, through either the local or ombudsman stage may take many years. Starting and then stopping advocacy support to families could be deeply upsetting to these families. Mencap is aware of many cases where the complaints process has taken more than two years. Advocacy support should be extended for as long as it is needed.”

Page 150: Clause 177 (2) Line 10—Joint strategic needs assessments

“(2) The responsible local authority and each of its partner commissioning consortia must include in the strategy a statement of their views on how arrangements for the provision of health-related services in the area of the local authority could be more closely integrated with arrangements for the provision of health services and social care services in that area and the steps they will take to tackle discrimination and ensuring equality of access and outcomes for people with a disability”

If the government is to live up to its ambition of “no decision about me, without me”, it is vital that disabled people are involved in the formulation of Joint strategic needs assessments.

Page 152: Clause 178 (2) Establishment of Health and Wellbeing Boards

“The Health and Wellbeing Board is to consist of—

(a) subject to subsection (4), at least one councillor of the local authority, nominated in accordance with subsection (3),

(b) the director of adult social services for the local authority,
(c) the director of children’s services for the local authority,
(d) the director of public health for the local authority,
(e) a representative of the Local Healthwatch Organisation for the area of the local authority,
(f) a representative of each relevant commissioning consortium, and
(f1) representatives from relevant user groups, such as disabled people’s organisations, learning
disability partnership boards and a representative from local voluntary sector organisations who
represent marginalised groups”

See rationale above.

Page 152: Clause 179 (1) Duty to encourage integrated working
“A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of
the people in its area, encourage persons who arrange for the provision of any health or social care
services in that area to work in an integrated manner and must engage with disabled people,
marginalised groups, hard to reach groups, carer groups and voluntary groups.

See rationale above.

Page 189: Clause 217 (1) National Institute for Health and Care Excellence
In exercising its functions NICE must have regard to—
(a) the broad balance between the benefits and costs of the provision of health services or of social
care in England,
(b) the degree of need of persons for health services or social care in England and the importance of
tackling known health inequalities and discrimination.”
(c) the desirability of promoting innovation in the provision of health services or of social care in
England.

Page 201: Clause 243 (5) Publication of information
In considering the appropriate form, manner and intervals for publication of information under this
section, the Information Centre must have regard to—
(a) the need for the information to be easily accessible to all people including those with specific
access needs,
(b) the persons who the Centre considers likely to use the information, and
(c) the uses to which the Centre considers the information is likely to be put,
(d) the ability to break down the data by disability impairment type.

Mencap welcome Patient Reported Outcomes Measures for recording patient experience. That said they
have often been poor at capturing the experiences of people with a learning disability, their families and
carers. Any efforts to gather patient experience must be fully accessible to all groups.

The points on data are as per the points made previously in this document.

Page 223: Schedule 1—NHS Commissioning Board— (8) Staff
AFTER
(1) The Board may appoint such committees and sub-committees as it considers appropriate.

ADD
(1a) The Board must consider the most appropriate way of ensuring the views of disabled people,
marginalised groups, hard to reach groups, carer groups and voluntary groups are sought.

Page 229: Schedule 2—Commissioning Consortia—(6) Accountable Officer
AFTER
The accountable officer is responsible for ensuring that the consortium or, in the case of a joint
appointment, each of the consortia in question—
(a) complies with its obligations under—
(i) sections 14K and 14L,
(ii) sections 223I to 223K,
(iii) paragraphs 12 and 13 of this Schedule, and
(iv) any other provision of this Act specified in a document published by the Board for the
purposes of this sub-paragraph,
Aiming to ensure that Commissioning Consortia should have regard to tackling health inequalities, reducing discrimination and ensuring the proceedings of the Commissioning Consortia are open to all.

February 2011

Memorandum submitted by the National Children’s Bureau (NCB) (HS 19)

1. SUMMARY
1.1 NCB believes that the Health and Social Care Bill provides a real opportunity to improve integration across the broad range of services that promote children’s health and well-being. However, if this opportunity is missed, the result could be even greater fragmentation in the way that services are planned, commissioned and delivered, resulting in children, young people and families—and especially the most in need—facing greater barriers to accessing the services and support they need. During the passage of the Health and Social Care Bill, NCB will therefore be seeking to ensure that the government’s reforms deliver for children and young people, and especially the most vulnerable to poor outcomes and social exclusion.

1.2 NCB urges Committee members to:

(a) ensure that Health and Well-being Board arrangements deliver for children and young people by:
  — amending the Bill so that Health and Well-being Boards “must” (rather than “may”) encourage integrated planning and delivery across health, social care and health-related services;
  — amending the Bill to require Health and Well-being Boards, when developing their joint strategic needs assessment and joint health and well-being strategy, to have specific regard to children, and in particular, vulnerable groups of children; and
  — scrutinising government’s plans for enabling Health and Well-being Boards to implement effective ways of planning services in an integrated manner for all children in their area.

(b) ensure that the Bill supports the engagement of children and young people in decisions about local health services and their own health care, through explicit duties on HealthWatch England, Local Healthwatch, the NHS Commissioning Board and GP commissioning consortia;

(c) scrutinise government’s plans for ensuring that GP consortia base their commissioning decisions on a thorough understanding of the diverse needs of children and young people and on evidence of what works to promote their health and well-being;

(d) seek clarity as to how government will ensure there is clear accountability for promoting the health and well-being of looked after children and care leavers within the new planning and commissioning regime; and

(e) investigate how government plans to enable the voluntary and community sector to contribute to the new health system.

2. INTEGRATED LOCAL PLANNING FOR CHILDREN AND YOUNG PEOPLE’S HEALTH AND WELL-BEING
2.1 NCB is pleased to see recognition in the Bill that services that are not part of the health service still have an important role to play in improving the health and well-being of individuals. This is particularly important for children and young people, for whom the most effective interventions are often those delivered through non-health settings and services. For example:

— schools: school health initiatives can have a positive impact on pupils’ health and behaviour, and can be particularly effective in improving young people’s knowledge of health issues;¹⁶ and

— children’s centres: young children with access to a local children’s centre are more likely to receive the appropriate immunisations and to have fewer accidents than those living in areas not served by a centre.¹⁷

Other non-health services which are key to children and young people’s health and well-being include: further education colleges, youth justice services, housing and local planning.


2.2 Many of these services are particularly important for delivering health interventions to children with complex needs, such as disabled children and looked after children and care leavers, and to those who may be less likely to engage with universal health services, such as children and families living in poverty and young people involved in the youth justice system.

2.3 The Bill establishes local Health and Well-being Boards to promote co-ordinated planning and delivery across the NHS, social care and public health services (clause 179(1)). In addition, it states that these boards may encourage integrated working between the commissioners and providers of health and social care services and of “health-related” services (those that are not part of the health service but impact upon the health of individuals) (clause 179(3) and (4)).

2.4 While we welcome this broader focus on “health-related” services, we are concerned that the Bill is too weak to ensure that every child in every area benefits from education, health, social care, safeguarding and recreation services that are developed and commissioned in an integrated way.

2.5 NCB also welcomes the proposal to require councillors, local authorities, GP commissioners and local Healthwatch to work in partnership to develop a plan to improve the health and well-being of local people (the new joint health and well-being strategy), based on an assessment of local needs (the joint strategic needs assessment) (clause 180(1)). However, with such a broad remit, we are concerned that children and young people’s needs may get lost in the process, especially as they are less likely to be receiving services primarily through the health system. This is particularly significant in the context of government’s decision to remove the requirement on local authorities and their Children’s Trust partners to develop a specific plan for improving the well-being of children (the children and young people’s plan).

2.6 NCB urges the Committee to ensure that Health and Well-being Board arrangements deliver for children and young people by:

(a) amending the Bill so that Health and Well-being Boards “must” (rather than “may”) encourage integrated planning and delivery across health, social care and health-related services;

(b) amending the Bill to require Health and Well-being Boards, when developing their joint strategic needs assessment and joint health and well-being strategy, to have specific regard to children, and in particular, vulnerable groups of children; and

(c) scrutinising government’s plans for enabling Health and Well-being Boards to implement effective ways of planning services in an integrated manner for all children in their area.

3. GIVING CHILDREN AND YOUNG PEOPLE A VOICE WITHIN THE HEALTH SERVICE

3.1 As a member of Participation Works, NCB welcomes government’s ambition to ensure that, through Healthwatch England and Local Healthwatch, patients and the wider public have greater influence over decisions about their own healthcare and the development of health and social care services (clauses 166 to 169). However, any measures to achieve this ambition must include children and young people from the start. A move to truly shared decision-making between the public, patients, practitioners and commissioners will require long-term cultural change, on the part of both the public and professionals. Supporting the younger generation to make a contribution, and understand the value of engaging in decisions about health care and services, will be a key step in this process.

3.2 Through the work of NCB and its Participation Works partners, we know that children and young people want a say in decisions about their own healthcare and the development of local services. However, the level and quality of their engagement in the health sector varies considerably across the country.

— The percentage of children and youth organisations as a proportion of the membership of local involvement networks (LINks)—which government proposes to transform into Local Healthwatch—ranges from one to 90%;22

— In 2007, 75% of patient advice and liaison services (PALS) (providing support to patients to make complaints and make choices about their care) were not actively involving children and young people in their service;23

— Many LINks are not always clear that children and young people are part of their remit;22 and

— Many LINks and PALS have struggled to develop the skills and access the tools needed to work with confidence with younger members of the public.25, 26

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22 Clauses 176 and 177 of the Bill place duties on local authorities and each partners commissioning consortia to prepare a joint strategic needs assessment and joint health and well-being strategy. However, clause 180(1) states that these duties will be exercised by the health and well-being board.

23 Participation Works is a partnership of six national children and young people’s agencies that enables organisations to effectively involve children and young people in the development, delivery and evaluation of services that affect their lives.

24 BYC (2010). Young people’s views on the Big Society: The Big Listen—we said.


3.3 Government must make clear from the start that children and young people are central to the remit of Healthwatch England and Local Healthwatch, and enable these organisations to work with younger age groups in a meaningful way.

3.4 Certain groups of children and young people—including disabled children and young people, children in care and care leavers, those involved in the youth justice system and refugees and asylum seekers—have specific physical and mental health needs and face specific challenges in accessing services. However, too often their voices are not heard. Local Healthwatch will need additional capacity and skills to reach out to and engage these children and their families.

3.5 NCB endorses the evidence submitted to the Committee by Participation Works. We urge Committee to ensure that the Bill supports the engagement of children and young people in decisions about local health services and their own health care, through explicit duties on Healthwatch England, Local Healthwatch, the NHS Commissioning Board and GP commissioning consortia. We also urge Committee to seek clarity from government as to how it will enable Healthwatch and NHS commissioners to work effectively with younger members of the community.

4. ENSURING THE NEW COMMISSIONERS HAVE A THOROUGH UNDERSTANDING OF THE NEEDS OF CHILDREN AND YOUNG PEOPLE

4.1 The Bill provides for new commissioning consortia (led by GPs) to commission the majority of NHS services (clause 6). NCB wants to ensure that those taking over NHS commissioning are able to do so on the basis of a sound understanding of children and young people’s needs. We are concerned that not all GPs have the depth of knowledge required to commission effectively for all children and young people. For example, they are unlikely to have a detailed understanding of the role and importance of wider children’s services in promoting health and the particular needs of disabled or looked after children. Our concerns reflect Sir Ian Kennedy’s review of children’s NHS services, which highlighted gaps in GPs’ paediatric training and experience.

4.2 In order to commission effectively for children and young people, the work of GP commissioning consortia (including the pathfinders), and their Health and Well-being Board partners, must be informed by:

— a thorough understanding of child development and how to promote children’s health and well-being holistically;
— knowledge of the specific needs of vulnerable groups (including disabled children, looked after children and care leavers, those involved in the youth justice system and refugees and asylum seekers); and
— the best available evidence of what works to improve children’s physical, mental and emotional health and well-being.

4.3 NCB urges the Committee to scrutinise government’s plans for ensuring that GP commissioning consortia base their commissioning decisions on a thorough understanding of the diverse needs of children and young people and on evidence of what works to promote their health and well-being.

5. MEETING THE HEALTH NEEDS OF LOOKED AFTER CHILDREN AND CARE LEAVERS

5.1 Looked after children are particularly vulnerable to health risks and problems, often due to their experiences prior to entering care and the subsequent challenges they face in the care system itself. While some of their health outcomes have improved in recent years, there have been persistent difficulties—particularly in relation to partnership working across health bodies and local authorities and arrangements for securing provision for children placed out of authority.

— 45% of looked after children aged five to 17 were assessed as having at least one mental health disorder, compared to 10% of the general child population.
— Looked after children exhibit high rates of self-harm and high-risk behaviour, particularly when living in secure accommodation;
— Two-thirds of all looked after children were reported as having at least one physical health complaint—most commonly eye and/or sight problems, speech and language difficulties, coordination issues and asthma; and
— Some studies have shown higher levels of substance misuse among looked after children, when compared to the non-care population.

24 Sir Ian Kennedy (2010). Getting it right for children and young people: overcoming cultural barriers in the NHS so as to meet their needs.
5.2 It is vital that these vulnerable children and young people are not further disadvantaged by the reforms contained in the Bill. The proliferation of health commissioning boundaries that may result from the replacement of Primary Care Trusts by GP consortia, and the need for local authorities to work with multiple consortia, is a particular concern for those in or leaving care.

5.3 NCB urges the Committee to seek clarity as to how government will ensure there is clear accountability for promoting the health and well-being of looked after children and care leavers within the new planning and commissioning regime.

6. **Ensuring the Voluntary Sector Promoting Children's Health can Flourish**

6.1 As providers of health services to children, young people and families—and often to the most vulnerable—voluntary and community organisations (VCOs) are central to the successful implementation of government’s ambitions for population health and well-being outcomes to be delivered by the NHS, public health and their partners. They are particularly well-placed to support children and their carers to influence local service provision and decisions about their care, and to empower vulnerable and marginalised children and families to take-up universal and specialist services.

6.2 However, the VCOs NCB works with (through our membership and specialist networks) tell us that they will need help to thrive in the new health system, in particular to engage with the new commissioning arrangements and to compete to secure service contracts. There are already reports of VCOs losing public sector contracts or having their funding cut, as local authorities and Primary Care Trusts seek to reduce their spending. At the same time, these organisations are likely to face increasing demand for their services as statutory services are squeezed.

6.3 NCB urges the Committee to investigate how government plans to enable the voluntary and community sector to contribute to the new health system, and to maintain and build upon the huge contribution these organisations already make to promoting the health and well-being of vulnerable children, young people and families.

7. **About NCB**

7.1 NCB’s mission is to advance the well-being of all children and young people across every aspect of their lives. As the leading national charity which supports children, young people and families, and those who work with them, across England and Northern Ireland, we focus on identifying and communicating high impact, community and family-centred solutions. We work with organisations from across the voluntary, statutory and private sectors through our membership scheme, and through the sector-led specialist networks and partnership programmes that operate under our charitable status.

7.2 NCB has a history of working to promote health improvement among children and young people and enable them to influence the quality and choice of the health services they receive. As a Department of Health strategic partner, NCB runs the Voluntary Sector Support (VSS) Programme for voluntary organisations providing health services to children and young people.

February 2011

Memorandum submitted by the Children's Sector (HS 20)

**The Health and Social Care Bill Must Deliver for Children and Young People**

1. Organisations that work to promote the health and well-being of children and young people have come together to ensure that the Health and Social Care Bill leads to improved and integrated services for all children across the country, particularly for vulnerable groups and those with complex needs who often struggle to receive adequate care.

2. **We want the reforms to secure effective integrated planning across the full range of services that promote children’s health and well-being**

Children and young people’s health and well-being is enhanced through a wide range of services, beyond health and social care. Schools and colleges, children’s centres, youth services and youth offending teams all have a vital role to play. The Bill must give a much stronger direction to health and well-being boards about their role in promoting integrated commissioning and provision across all these services to improve outcomes for children and young people. Government must ensure that the health and well-being board early implementers trial effective ways of planning services for children in an integrated manner.

3. **We want children and young people to have a voice in the new health system**

Healthwatch England and Local Healthwatch organisations must put in place strategies for engaging children and young people, and their parents and carers, to ensure they have a say in the development of local services and decisions about their care. This cannot be an afterthought, but must be central to the remit of Healthwatch from the start. In doing so, government and Healthwatch England should work with
partners across the children’s sector to build the capacity of Local Healthwatch organisations to work effectively with children. There must be a clear strategy for engaging those children and young people who often struggle to have a say, including: disabled children and young people and those with long-term health conditions, looked after children and care leavers, unaccompanied asylum seeking and refugee children, those involved in the youth justice system, those with mental health needs, and babies and young children.

4. We want to ensure that health commissioners have a thorough understanding of children and young people’s needs

GPs do not always have the depth of experience and understanding of children’s healthcare needs to commission directly and effectively for children and young people, and in particular for those with complex needs. For example, they are unlikely to have a detailed understanding of: the role and importance of wider children’s services in promoting health; safeguarding and child protection; the particular needs of disabled or looked after children; and children’s mental and emotional needs. If GPs are to lead health commissioning, it is crucial that potential gaps in children’s healthcare commissioning are addressed, perhaps through partnerships with paediatricians and relevant children’s sector organisations, to ensure pathways of care are not fragmented. Commissioning consortia pathfinders should examine children’s care pathways in detail, so that no child or family receives poorer quality care as a consequence of the new arrangements.

We look forward to working Committee members, during the passage of the Bill, to identify positive solutions to address our concerns.

This statement is supported by: 4Children; BAAF; Barnardo’s; British Academy of Childhood Disability; British Association for Community Child Health; Children’s Hospices UK; CLIC Sargent; Council for Disabled Children; Early Childhood Forum; Every Disabled Child Matters; Family Action; Fostering Network; NCB; NCVYS; Netmums; Royal College of Paediatrics and Child Health; The Children’s Society; The Children’s Trust, Tadworth; Unite/Community Practitioners and Health Visitors Association; Voice; and YoungMinds

February 2011

Memorandum submitted by Roger Rymer (HS 21)

I am writing as a member of the Central Lancashire PCT Patient Focus Group, a member of the Lancashire Over 50s Assembly and Chairman of a Patient Representative Group at a large GP practice.

I would refer you to clauses 21 and 22 and the proposed insertions in the NHS Act 2006 contained therein and specifically to insertion 14P (2) which states:

“The consortium must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—”

I would ask that this rather loose and vague requirement be strengthened by requiring every consortium to establish a patient representative group with whom they will consult on a regular basis and in a meaningful way. This should be a mandatory requirement in order to ensure public involvement at this critical decision-making level.

February 2011

Memorandum submitted by the General Social Care Council (HS 22)

SUMMARY

The Health and Social Care Bill contains the powers to transfer the functions of the General Social Care Council (GSiCC) to the Health Professions Council (HPC), which will become the Health and Care Professions Council (HCPC) to reflect this. The Bill provides an opportunity to bring together best regulatory practice from two organisations.

The GSCC has identified key areas where there are either potential risks to the regulatory system or opportunities for public protection to be deepened and improved:

— UK-wide regulation—The registration of social workers in the UK is devolved and each of the four countries has its own registration council. The Bill places a duty on the HCPC—which regulates across the UK—to co-operate with the other Care Councils and permits social workers registered with Care Councils outside of England to practice there on a “temporary” basis. Greater clarity is needed on how these arrangements will work in practice.
— Fitness to practise—The GSCC supports the fitness to practise approach used by the HPC, but recognises that this will lead to social workers in different parts of the UK being held to account in different ways. The HPC should be required HCPC to work with the other Care Councils to align approaches to regulation as far as possible.

— Professional Standards—The GSCC believes that the Reform Board’s Professional Capabilities Framework and the HCPC’s proficiency standards should be aligned to ensure that social work is underpinned by a single set of standards. We welcome early discussions that indicate alignment is an aim of the HCPC. We are pleased to be involved alongside colleagues from the SWRB in the development of HCPC’s standards of proficiency which will be consulted on later in the year.

— Student registration—The GSCC registers student social workers. Though HPC does not currently register students, clause 212 of the Health and Social Care Bill will allow the HCPC to open a voluntary register for students. The GSCC believes that, as a minimum, voluntary registration should continue. In due course, registration should become a requirement for all students before they begin practice placements with service users.

— Assessed and Supported Year in Employment (ASYE) – The GSCC awards full registration once a recognised degree is completed successfully. The Social Work Task Force recommended that social workers ought to have completed an “Assessed and Supported Year in Employment” (ASYE) after their initial qualification. The HCPC is being provided with powers to allow it to develop a structure to support the ASYE. The GSCC believes that the Reform Board’s recommendations for ASYE should be accepted and addressed.

— Regulation of social care workers—The Bill contain powers for the HCPC to register social care workers. Even though social care workers are not currently regulated in England, the GSCC code of practice is an important part of the standards framework for social care. The future ownership and role of the code of after the abolition of the GSCC needs to be clarified. In particular, what will happen to the code should the HCPC introduce a voluntary register for these workers in future.

ABOUT THE GENERAL SOCIAL CARE COUNCIL

1. The GSCC is the regulator of the social work profession and education in England. We protect the public by requiring high standards of education, conduct and practice of all social workers.

2. We ensure that only those who are properly trained, competent and committed to high standards practise social work. We do this by maintaining a compulsory register of social workers and issuing and enforcing a code of practice for the profession. The GSCC has the power to impose sanctions on social workers who do not meet the required standards of conduct. Where public protection warrants it, an independent panel of the GSCC can remove them from the register or impose other sanctions following a full investigation and hearing. Social workers who have been removed from the register are no longer able to practice because they are not legally entitled to use the title “social worker”.

3. We also regulate and promote high standards in social work education by approving the quality of social work courses offered by universities.

4. We aim to be a high performing regulator protecting the public through the regulation of social workers and their training. We strive to provide users of social work services and the public with confidence in our work and in the social work profession.

BACKGROUND

5. In July 2010, the Government published the Report of the Arm’s-Length Bodies Review. This announced the Government’s intention to abolish the GSCC and transfer its functions to the HPC. The Health and Social Care Bill contains the necessary legislation to effect this change.

6. The HPC currently regulates around 200,000 individuals from 15 health professions, from hearing aid dispensers to practitioner psychologists. The transition of the GSCC’s functions may add around 100,000 more to the HPC’s register. HPC is to be renamed the Health and Care Professions Council (HCPC) to reflect its wider remit.

7. The decision to transfer the GSCC’s functions was reached in the context of the unprecedented economic challenges facing Government and was based solely on the grounds of the costs of registration: the Government estimated that it would be cheaper for social workers to register with a larger, generic, regulator than a smaller, specialist, one. Ministers specifically acknowledged that it was not a reflection on the performance of the GSCC.

8. The GSCC is now working to see that the change is carried through in a way that does not undermine public protection. The transfer of regulatory functions does provide an opportunity to bring together the knowledge and skills of the GSCC with the regulatory experience of the HPC.

9. This transfer is happening while the Social Work Reform Board, led by Moira Gibb, is finalising its proposals and publishing concrete recommendations for reform in the social work sector. This work has wide support and the GSCC has been involved in much of this work. It important that the impact of these reforms is not lost in the transfer.
KEY ISSUES

10. There are a number of aspects of the transfer that require further clarification. Some may need coverage in the Bill itself; some can be dealt with by Ministers making a clear statement of government policy in the course of debate.

Impact of the transfer on UK-wide regulation processes

11. The registration of social workers in the UK is devolved to Scotland, Northern Ireland and Wales, with registration of social workers in England, being reserved to Westminster. Consequently, each of the four countries has its own registration council. However, it has been the policy of the four administrations that the councils should, so far as possible, align their policies and practices so that there are no barriers to social workers moving within the UK and that no public protection risks arise from cross border working. To this end, the registers of the four Care Councils are currently stored on a single database. Data are shared as appropriate and necessary. As a result social workers are easily able to move, register and work between the four nations.

12. The GSCC welcomes Clause 199 of the Bill, which places a duty on the HCPC to co-operate with the other Care Councils. The Bill also permits social workers to register with other Care Councils outside of England in order to practice there. Social workers registered outside England will be permitted to work here, without registering with the HCPC on a “temporary” basis. Greater clarity is needed on how these arrangements will work in practice—including the definition of “temporary”—and the costs to social workers of any additional registration or transfer of registration.

13. In consideration of these clauses, it should be noted that the regulatory models of the Care Councils in Scotland, Wales and Northern Ireland differ significantly from that currently operated by the HPC and the proposed model for the HCPC. Under the HPC/HCPC model, social workers can be held to account based on an assessment of their “fitness to practise” (including their professional competence) whereas in the rest of the UK they can only be held to account according to their conduct. As a result there is a possibility that social workers operating in different parts of the UK would be held to account in different ways. The GSCC very firmly supports the fitness to practise approach, but recognises that consistency across the UK is also an important consideration for people who use social care services. In the future the HCPC should be expected to work with the other Care Councils to align approaches to regulation as far as possible.

Ensure that social work is underpinned by a single set of standards

14. The Social Work Reform Board and the former Children Schools and Families Select Committee have both noted that the current standards for the social work profession, including for the education and training of social workers, are confusing.29 The Social Work Reform Board is currently developing—with the government’s support—an overarching Capabilities Framework that is intended to inform a range of standards used in social work. This will bring coherence to all the standards underpinning social work. It is intended that the Framework will be used to define what is expected of “new” social workers at the point of registration as well as to set standards for education and training.

15. Before starting to register social workers the HCPC model will need to develop its own standards for registration. This will involve the development of a set of proficiency standards using a generic set of “headline” standards, which is common to all 15 professions that they currently regulate. The HCPC will have the sole responsibility of determining the registration requirements for social work; Government does not require the HPC to consider the work of the Reform Board or the Capabilities Framework in setting these standards.

16. It is important that the Reform Board’s Framework and the HCPC’s proficiency standards for social workers are aligned. We welcome the early discussions that indicate alignment is an aim of the HPC. It is essential that the Capabilities Framework is kept at the forefront of these discussions. GSCC is pleased to be involved alongside colleagues from the SWRB in the development of HPC/HCPC’s standards of proficiency which will be consulted on later in the year.

The need for student social workers to be continued to be registered

17. A key element of the reform programme is to ensure that the calibre of students is raised. The GSCC current registers students on a voluntary basis. However, by linking registration to the funding that is available for practice placements, and developing strong links with HEIs, we have managed to ensure that student registration is at very high levels—around 95%. The GSCC argues that students should continue to be registered as they are at present: to move away from registration at this time would give the wrong messages to those aspiring to become social workers and to the public whose trust and confidence in social work requires development.

18. The GSCC believes that student registration is important for the following reasons. First, student social workers on placement have direct and unsupervised contact with vulnerable service users. Registration brings to their attention their responsibility to ensure that their conduct and practice are of the

required standard and this enhances public protection. Second, the systems that universities have in place to exclude unsuitable students are not considered to be universally effective and consistent. We understand from employers and external examiners that there is some concern that university social work courses are reluctant to exclude unsuitable candidates because of the financial penalties they incur for “shedding” students. Since registration opened for students in 2005 the GSCC has refused registration to nine social worker students on the basis that they did not meet the GSCC’s standards of good character and registered another seven with conditions. Ten students have been through the Conduct process in the last year.

19. Finally, registration means that the GSCC’s code of practice (or the HCPC’s standards of ethics and conduct) becomes binding on student social workers when they are engaging with service users.

20. The universities that train social workers are keen to support registration. They report that it helps them to instil the sense of professional identity that the role requires. Some employers refuse to accept students onto practice placements unless they are registered. Many universities use the GSCC code to initiate debate about the ethical basis of social work practice and some use it as the basis of a contract between the student and the institution. This promotes the professionalisation of social work.

21. Though HPC does not currently register students, clause 212 will allow the HCPC to open a voluntary registers for students. The GSCC believes that, as a minimum, voluntary registration should continue, moving to a requirement for all students before they begin practice placements with service users. This is particularly important as the HCPC will not have grants to encourage registration as the GSCC has (see below).

Assessed and Supported Year in Employment (ASYE)

22. At present the GSCC awards full registration once the degree is successfully completed. The Social Work Task Force recommended that social workers ought not to be judged fit to be awarded full professional registration until they have completed an assessment after their first year in practice. To implement this idea the Reform Board is developing a set of arrangements under the label of the Assessed and Supported Year in Employment (ASYE). This is based on learning from the NQSW (newly qualified social worker) pilots that have been running for the last two years and is similar to the arrangement for newly qualified teachers. It is likely to involve a formal assessment which the social worker would have to complete successfully before being confirmed in post.

23. The HCPC is being provided with powers to allow it to develop requirements for registration, which could include a structure to support the ASYE arrangements, once agreed. The GSCC believes that the Reform Board’s recommendations for ASYE should be accepted and addressed. We are confident the HPC/HCPC will work with colleagues on the Reform Board to develop feasible proposals that build on evidence of best practice.

Distribution of Education Support Grant following the abolition of the GSCC

24. The GSCC currently distributes over £27 million each year in Education Support Grants to Higher Education Institutions to support practice placements for students. It has been suggested that a new College of Social Work—which has been given seed funding from the Department of Health—could be asked to take on the role of distributing these grants. However, the College is unlikely to become a full legal entity until the middle of 2011 and may not be in a position to make “business” decisions, including decisions about whether it is capable of administering this grant until late in 2011. Funding contracts to HEIs are for one year based on their predicted number of students in practice placements for the new academic year.

25. If the funding arrangements are not transferred in time, HEIs may not be able to provide practice placements. It is important that government provides clarity on the administration of the Education Support Grant as soon as possible to allow for a smooth transfer of this function to another organisation and the continued availability of suitable practice placements.

The regulation of social care workers and the GSCC codes of practice for social care workers and employers

26. The GSCC welcomes the powers for the HCPC to register social care workers and other health care workers. It is important to stress that care workers are currently registered in Scotland, Wales and Northern Ireland and so this will help to produce a common approach to regulation of the more than one million social care workers in the UK.

27. Even though social care workers are not currently regulated in England, the GSCC code of practice for social care workers is an important part of the standards framework for social care, and applies to all social care workers, not just those on the register. It provides service users with an understanding of what can be expected from the workers who provide services to them. The code is built into the sector’s induction standards for social care workers (issued by Skills for Care) and the GSCC has issued over one million copies of these codes over the past decade.

28. The future ownership and role of the code of practice for social care workers after the abolition of the GSCC should be clarified. In particular, what will happen to the code should the HCPC introduce a voluntary register for these workers in future.
29. The Care Councils also issue a code of practice for the employers of social workers. The Social Work Reform Board has proposed a voluntary standard for employers that will provide guidance on the support and supervision that employers should provide to social workers. The GSCC welcomes this work by the Reform Board and the current consultation on it. The link with regulatory procedures in Wales, Scotland and Northern Ireland will also need clarification.

February 2011

Memorandum submitted by the British Heart Foundation (HS 23)

The British Heart Foundation (BHF) welcomes the Government’s intention to create an NHS which focuses on improving health outcomes and tackling health inequalities and that is responsive to patients’ needs and wishes. We also support the emphasis on public health and the allocation of a ring-fenced budget.

However, the Government must ensure that the significant changes to the NHS being considered by Parliament do not impede the delivery of high quality care for patients. We also believe that there are several areas where the Bill needs to be amended to ensure that patients are truly at the heart of the NHS. For more detail on this, please see the submission we have jointly made with seven other national health charities.

This briefing summarises the BHF’s overall messages around the proposals for NHS reform. Some of these messages do not relate to specific provisions in the Bill, but instead identify key issues and risks that must be considered as the proposals and legislation are developed.

**KEY MESSAGES FROM THE BHF**

1. *The significant changes to the NHS must not impede the delivery of high quality evidence-based care*
   - In developing and implementing the ambitious plans for the NHS, the Government’s primary priority must be the provision of high quality care, in accordance with national guidelines.
   - In December 2010, a national audit of heart failure showed that guidelines on the treatment of heart failure patients were not being followed and that patients were dying needlessly because of lack of access to specialist care.
   - Systems must be in place, including through commissioning and national regulation, to ensure that all heart patients have access to high-quality, specialist cardiac care.

2. *Ensuring a strong patient voice and effective scrutiny*
   - The NHS Commissioning Board and GP consortia must be required to involve and genuinely engage with patients and carers in commissioning decision-making. This should be reflected in the publicly available annual reports of the Commissioning Board, and in consortia commissioning plans and the assessment of consortia performance.
   - Local HealthWatch should build on the work of LINks, should work closely with local services and clinical networks, and must have sufficient authority, independence, and resources to carry out their functions. Local HealthWatch should have a key role in contributing to Joint Strategic Needs Assessment, commissioning plans, and local scrutiny processes.
   - Advocacy work by local HealthWatch must not detract from patient and public involvement in shaping services.
   - The scrutiny function in local authorities must be led by independent elected representatives.

3. *Supporting patient choice*
   - Genuine patient choice is dependent on access to accurate, understandable and meaningful information at a time and place that suits patients, as well as patients having the confidence, skills and personalised support to make choices. Some vulnerable groups and some people from black and minority ethnic groups will need particular support in being empowered to make and communicate choices.
   - Voluntary sector organisations like the BHF, and specialist health professionals, including BHF cardiac nurses, will provide valuable support to patients in exercising choice and control.
   - Some people may prefer to trust in healthcare professionals to make decisions on their behalf—these preferences must be fully respected.

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— Some people will find it difficult to act on choices or may have a more limited range of options available due to lower incomes, lack of personal transport, or limited mobility. All patients must receive high-quality evidence-based care, where ever they go for treatment.

— Shifts in demand must not destabilise essential local services or result in popular services becoming overburdened.

4. The new freedoms for providers must not impede the delivery of comprehensive and integrated care

— Providers’ increased autonomy and accountability for planning and developing their own workforce must not impede national workforce planning or access to consistently high quality and comprehensive training and development.

— Providers must not be deterred from delivering specialised services for small and dispersed patient groups or from taking on complex cases that may be more costly.

— Increased competition between providers must not impede networking and integrated care—cardiac and stroke networks and coordinator roles like BHF specialist cardiac nurses are key to promoting integrated, innovative, and cost effective care, and their vital work must continue and develop.

5. Directors of Public Health with independence, authority and resources

— We strongly welcome the focus on public health and the development of a Public Health Service with a ring-fenced budget.

— Directors of Public Health must have the independence, authority and resources to advise on policy areas that have a bearing on physical activity, healthy eating, and all aspects of population health and health inequalities.

— We welcome the commitment to empowering local communities, but state regulation is required to create environments that enable people to exercise genuine freedom and to make choices that protect their health. National oversight and monitoring will also be essential.

6. Partnership working with the voluntary sector

— Charities like the BHF should be involved in commissioning decision-making so we can share experience of integrated care and commissioning and of innovative service models.

— Charities can also share intelligence on patients’ needs and experiences, and facilitate discussions with the patients, carers, and health professionals with whom we already engage.

7. Multi-disciplinary commissioning

— Specialist healthcare professionals, including BHF specialist cardiac nurses, are well-placed to advise on optimal patient pathways and the commissioning of high-quality, patient-centred, and cost-effective care.

— To improve the quality and continuity of care and promote integration, the NHS Commissioning Board and GP consortia must involve health and social care expert professionals in commissioning decision-making.

8. Promoting clinical research

— Research must be regarded as a priority by commissioners and providers, and given appropriate status in the new market-orientated system; the tariff system, the NHS Outcomes Framework, and the quality regulation by the Care Quality Commission should provide strong incentives for conducting research. The Bill should ensure a duty to promote research.

— As the principal budget-holders and commissioners, GPs will need considerable support to recognise the importance of commissioning research activity and to ensure patients are aware of clinical trials and similar opportunities.

— We welcome the commitment to make available for research aggregate datasets from data held securely in people’s records—we look forward to further information about the research data service that is to be developed.

9. Data collection to promote continuous improvement

— While we welcome the shift from targets to health outcomes, process measurement must continue where clinically relevant—continuous improvement is dependent on the collection of data not only on the overall outcomes of the NHS and Public Health Service, but also on the effectiveness of individual interventions that lead to these outcomes.
— The Government should ensure that support is made available so the valuable work of national, independent, clinically-led audits can continue.

February 2011

Memorandum submitted by the Royal College of Psychiatrists (HS 24)

1. The Royal College of Psychiatrists (RCPsych) welcomes the opportunity to submit evidence on the Health and Social Care Bill. RCPsych is the leading medical authority on mental health in the United Kingdom. We are the professional and educational organisation for doctors specialising in psychiatry, representing over 12,000 psychiatrists in the UK. We collaborate with key players in the mental health field and are champions for improvements in the quality of mental healthcare throughout all sectors of society.

2. Our approach to health reform is fundamentally based on how it will affect the care, welfare and treatment of the one in four people with mental health problems. We welcome the following aspects of the Health and Social Care Bill: putting the patient at the centre of care, the focus on clinical outcomes, increased involvement of clinicians in commissioning (with a corresponding reduction in management costs), ring-fenced money for Public Health and the aspiration for joined up social care and public mental health outcomes.

3. However, we remain concerned about how the scale and the pace of change may impact on the care and, in particular, the continuity of care that can be given to patients with mental health problems. We are particularly concerned that in some areas the new GP consortia will not yet have developed the skills or expertise to support mental health commissioning and believe that there needs to be engagement of specialist clinicians from the outset. We are pleased that in the recently published Mental Health Strategy (para 5.73) the Government state that they will work with the Royal College of General Practitioners, the Royal College of Psychiatrists, the Association of Directors of Adult Social Services and the NHS Confederation to develop guidance and support for GP consortia in commissioning effective mental health advice.\footnote{No Health Without Mental Health: A Cross Government Mental Health Outcome Strategy for people of all ages; Department of Health (2011). http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf}

4. We urge the Committee to seek clarification on how certain areas of the reforms will work in practice and agree amendments to strengthen the legislation.

5. In this submission we would like to emphasise the following key points:

— The Government has already stated that all clinicians will need to work collaboratively to share expertise in the commissioning of services. They have not, however, stated on record how this will work in practice and we welcome the fact that the Health Committee has identified this as an area of concern.

— The meaning of the duties in the Bill for GP consortia and the NHS Commissioning Board to “obtain appropriate advice” when carrying out their functions need to be explained fully at Committee Stage. Both consortia and the Board should also be required to outline how they carried out this duty in their annual reports.

— Reassurances are needed at Committee that clinicians working together across primary, secondary and tertiary care will not be accused of breaking Competition Law by working closely on service delivery.

— The College is concerned that GP consortia—who have little or no prior experience of local population needs assessment—will struggle to commission services for hard-to-reach groups, such as people with severe mental illness, unless they carry out high quality local needs assessments. Amendments are needed at Committee to ensure that this takes place.

6. At Second Reading of the Bill, the Secretary of State, Rt Hon Andrew Lansley MP, stated clearly that clinical leadership in the management and design of care is an essential part of the Government’s reforms: “It is only by virtue of our ability to engage front-line clinicians more strongly in the management and design of care that we will deliver those quality, innovation, productivity and prevention ambitions.\footnote{Col 600: HOC Hansard: 31.1.11.} He went on to say that: “at every step, clinical leadership—that of doctors, nurses and other health professionals—will be right at the forefront.”\footnote{Ibid}

7. The Royal College of Psychiatrists support this view. However, we believe that the mechanics of how this collaboration will work in practice still need to be set out at Committee Stage.

SPECIALIST EXPERTISE IN COMMISSIONING (PART 1)

6. At Second Reading of the Bill, the Secretary of State, Rt Hon Andrew Lansley MP, stated clearly that clinical leadership in the management and design of care is an essential part of the Government’s reforms: “It is only by virtue of our ability to engage front-line clinicians more strongly in the management and design of care that we will deliver those quality, innovation, productivity and prevention ambitions.\footnote{Col 600: HOC Hansard: 31.1.11.} He went on to say that: “at every step, clinical leadership—that of doctors, nurses and other health professionals—will be right at the forefront.”\footnote{Ibid}
8. We are concerned to ensure that the newly-established bodies are able to commission mental health services effectively so that high-quality services are provided to all that need them. In order to achieve this we believe, along with all the other Medical Royal Colleges including the Royal College of General Practitioners, that clinical commissioning must involve a close working relationship between GPs and specialists. Furthermore, in order to meet the needs of those mental health patients with particularly complex difficulties—a group of patients for whom care is costly and about whom GPs will have relatively little knowledge—the role of psychiatrists in advising commissioners will be vital.

9. The Nuffield Trust has documented international research which shows the importance of specialist involvement: “The US experience shows that holding risk-bearing budgets can motivate doctors to deliver efficient, coordinated care that reduces avoidable and repeated admissions to hospital. However, to achieve this, the groups had to ensure that primary and specialist doctors cooperated closely and were able to invest in a range of high quality and innovative services that offer alternatives to hospital care, particularly for older patients with chronic conditions.”

10. People with mental illness range widely from those with common mental disorders, such as anxiety, depression and addiction problems, to those with severe and complex disorders, such as schizophrenia and bipolar disorder. Among them are groups with very specific diagnoses and specific needs who are not always well understood or for whom adequate services have been lacking, for example those with borderline personality disorders, dual diagnosis (both serious mental health problems and addiction problems) and learning difficulties. We believe that without specialist clinical expertise in commissioning, there is a danger that services for patients with severe and complex services will be adversely affected. Although this group of patients is smaller in number than people with common mental disorders, the cost of treatment is significantly higher. We are concerned that this could make them a lower priority for GP consortia.

**Duty to Obtain Appropriate Advice (Part 1, Clauses 19 and 21)**

11. The Bill sets out duties for both the Commissioning Board (Clause 19 (13G)) and GP consortia (Clause 21 (14O)) to “obtain appropriate advice” in carrying out their functions. These duties are further outlined in the explanatory notes to the Bill.

12. For GP consortia, the explanatory notes describe it as a duty to “obtain appropriate advice from people with professional expertise in relation to physical and mental health. This could involve, for example, a consortium employing or otherwise retaining healthcare professionals to advise the consortium on commissioning decisions for certain services, or appointing professionals to any committee that the consortium may set up to support commissioning decisions.” For the NHS Commissioning Board, the duty is to: “take the view of other healthcare professionals, so it can effectively discharge its functions.”

13. Neither the wording in the legislation or the description in the explanatory notes adequately explains what will constitute having obtained appropriate advice, in order that the NHS Commissioning Board and GP consortia will be able to demonstrate how they met these duties (as we feel they should be required to in their annual report—see below).

**Annual Report (Part 1, Clauses 19 and 21)**

14. The Bill places a duty on the NHS Commissioning Board ( Clause 19 (13P)) and GP Consortia (Clause 21 (14Z)) to publish annual reports. We believe that these will be important documents to assessing the performance of these bodies and indicating areas for improvement. We believe that there should be a duty on the NHS Commissioning Board and GP Consortia to outline how they “obtained appropriate advice” in their annual reports. This will ensure that there is meaningful involvement from secondary care specialists—who, after all, are the health professionals with the most experience of, and knowledge about, particular groups of patients—in the commissioning of services.

**Concerns about Close Working between Clinicians Being Seen as a Conflict of Interest (Part 3, Chapters 1 and 2)**

15. Section 51(1a) places a duty on Monitor to promote competition in health and adult social care services, while Section 62 ensures that healthcare services come under the aegis of the Office of Fair Trading (under part 4 of the Enterprise Act 2002). The College is seeking clarification on a potentially contentious issue whereby clinicians may feel that they will be accused of breaking Competition Law by working collaboratively over service issues. This would have direct implications for integrated care and good patient outcomes.

16. It will be critical in the new system that clinicians (both GPs and psychiatrists) feel able to work closely to improve local services. We are concerned about a situation where providers who have been unsuccessful in bidding for services may cite the close working between clinicians as a conflict of interest, and we feel that

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35 The Nuffield Trust is one of the leading independent health policy charitable trusts in the UK. http://www.nuffieldtrust.org.uk/aboutus/index.aspx?id=37

clarification on what is acceptable and unacceptable behaviour in terms of contact between GPs and other clinicians should be given by the NHS Commissioning Board at the outset in order that all clinicians know where they stand.

**Any Willing Provider: (Part 3, Chapter 2, Clause 61–63.)**

17. Chapter 2 of the Bill, in particular Clause 61 will further roll out the Government’s service provision model “Any Willing Provider”. The Government’s aim in introducing “Any Willing Provider” is to promote choice and competition in the NHS. The Royal College of Psychiatrists support choice and competition where they can stimulate innovation and, importantly, drive up the quality of mental health care.

18. However, we are very concerned about the crude potential use of the concept of “any willing provider” and we have evidence from addictions services to suggest that the current model has involved frequent tendering, with decisions often made on price over quality and which has led to service fragmentation, disruption to continuity of care, and loss of integration of care pathways.  

19. We would like clarification as to whether Any Willing Provider will apply fully to mental health. If this is the case, we have grave concerns that patient continuity of care will suffer under such a system. and would urge that the Government stipulates that mental health will instead be subject to competitive tendering, with one main provider being granted a contract for services rather than myriad providers under the Any Willing Provider model.

20. We would also urge the Government to ensure that competitive tendering for mental health services should be done on the basis of a minimum period contracts (whether that service be run by a statutory, private or voluntary sector provider) in order that the lack of stability which arises when services are re-tendered after only two or three years, and which are already apparent in some sections of the mental health service work, are not replicated across the sector.

**Joint Strategic Needs Assessment: Meeting the Needs of Hard-to-Reach Patients, including those with Severe Mental Illness and Other Complex Needs (Part 5, Chapter 2, Clause 176)**

21. In Part 5, Clause 176, the Bill sets out the framework for “Joint Strategic Needs Assessments”. This is the process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness. JSNAs are currently carried out by the local authority, but Clause 176 sets out a joint responsibility between local authorities and GP consortia.

22. There are already concerns (which a number of local authorities acknowledge) about the ability of local authorities to ensure the JSNAs reflect the true prevalence of mental health problems and the needs of their populations.  

23. Amendments are needed at Committee to ensure that the NHS Commissioning Board is required to produce guidance for consortia on how to conduct a Joint Strategic Needs Assessment such that it best captures the current and future needs of their population in its entirety; and to ensure that GP consortia are required to demonstrate that they have taken this guidance into account when conducting their JSNA.

**Changes to the Mental Health Act (Part 11, Clause 273)**

24. The College welcomes clause 273 of the Bill which will permit patients with mental capacity subject to a community treatment order to consent to the treatment recommended by their doctor, should they wish, without the need for a statutory second opinion doctor to agree. This will both strengthen safeguards and reduce costs. Furthermore, it will mean that if patients with mental capacity, who have been consenting to treatment, change their minds, they will have the right to a second opinion doctor before being forced to have the treatment (other than in an emergency).

25. The College however, as a member of the Mental Health Alliance has concerns for those patients who lack capacity to consent and their access to a second opinion doctor should they be recalled to hospital. We also believe that the criteria for community treatment orders are too widely drawn and need to be narrowed so that they are used for that group of people for whom they were originally intended and for whom they are beneficial. We will be seeking amendments to address these problems.

*February 2011*

37 http://www.scan.uk.net/docstore/scanBites20.pdf  
39, 40, 41 http://www.cambridgeshire.nhs.uk/downloads/Your%20Health/JSNAs/Mental%20Health%20JSNA.pdf (for example, p 11).  
40 http://www.ic.nhs.uk/webfiles/Services/in%20development/jsna/Calderdale2.ppt  
Memorandum submitted by Age UK (HS 25)

1. AGE UK

Age UK is the new force combining Age Concern and Help the Aged. We are a national charity and social enterprise working to transform later life in the UK and overseas. Our vision is of a world in which older people flourish. We aim to improve later life for everyone through our information and advice, services, products, training, research and campaigning.

SUMMARY

2.1 The overall vision for healthcare set out by Government is one Age UK supports. Developing a much clearer focus on the outcomes the NHS achieves in terms of treatment and patient experience is a positive step. Increased emphasis on public health and prevention is equally welcome.

2.2 We are less convinced that the strategy articulated by Government and the provisions set out in the Bill will deliver improvements in health outcomes or succeed in eradicating the serious barriers older people face in accessing high-quality care.

2.3 The NHS does not deliver optimum treatment outcomes for older people, lagging behind other EU countries in successful treatment of cancer, stroke and heart disease for example. Nor does it deliver on experience of care for older patients. There are clear indications that ageist attitudes remain entrenched amongst health professionals and that substandard levels of care are tolerated in too many care settings. We need to see a real step-change in the way that the NHS views and treats older people.

2.4 Older people often struggle to access the basic care they need as the NHS continues to undercommission essential community and preventative services such as falls prevention, continence care and audiology. In addition, there are simply service gaps for many older people. Evidence also shows that nearly 400,000 older people living in a care homes face real difficulty accessing GP and primary care services.

2.5 The NHS also has a poor track record of providing joined-up care, personalised to meet patients’ needs or respect their preferences. Services and professionals operate in silos and fail to provide a coherent package of support across organisational boundaries, the most obvious example being between health and social care.

2.6 We urge caution in proceeding to undertake wholesale change on such a tight timetable. We are concerned that current plans are moving quickly without demonstrating sufficient strategic planning or the support and engagement of NHS staff. For older people with complex health needs any disruption to care or loss of services could have very serious consequences. We want to see a robust process put in place for monitoring the impact of these changes on older patients and ensure that risks are well managed.

2.7 While the NHS reforms will impact on everyone to a greater or lesser extent, they are likely to be most keenly felt by older people as frequent service users. Getting it right for older people is fundamentally about getting it right for everyone.

3. IMPROVING OUTCOMES

3.1 The Bill establishes provisions for the Secretary of State to set out a mandate for the NHS Commissioning Board and commissioning consortia. In turn the NHS Commissioning Board and commissioning consortia must demonstrate how they have sought to meet the mandate in their plans and strategies, and report annually on their progress.

3.2 The draft NHS Outcomes Framework, which we presume forms the basis of the Secretary of State’s mandate with regard to health improvement, adopts a population wide approach to setting health improvement areas which we fully support. However, we know that older people’s needs are currently underprioritised and under-recognised within the NHS. We also know that ageism in clinical practice persists, with older people lagging behind in terms of health outcomes. We are concerned that, unless there is a clear obligation to demonstrate improvement is being achieved across the whole population, the needs of older people will continue to be obscured.

3.3 In setting the mandate and outcomes for the NHS Commissioning Board the Secretary of State should have a duty to clearly demonstrate that she or he has taken into account the needs of the whole population, including those aged over 65. In order to demonstrate this, the Secretary of State should be able to justify how and why the improvement areas they have selected will contribute to improving the health of the whole population and should report annually on progress towards improvement. They should also be able to demonstrate that the improvement areas are balanced and fair in their focus.

3.4 The NHS Commissioning Board and commissioning consortia in turn should be under a duty to demonstrate how they plan to deliver continuous improvement in outcomes and the provisions set out in the Secretary of State’s mandate in relation to each section of the population; this should form part of their annual reports. For example, in cancer improvement they must disaggregate and demonstrate how plans


P 20, Ageism and Age Discrimination in Primary and Community Healthcare in the UK: A Clark, Centre for Policy on Ageing (2009).
and strategies will drive improvement across all age groups. They should also be able to demonstrate that activity across the population is balanced and fair in its focus. The risk otherwise is that the mandate incentivises commissioners to invest their efforts in driving improvement for those groups where they believe they can make the easiest and quickest gains.

3.5 GP commissioning consortia and local health and wellbeing boards should also be able to demonstrate how they have considered the needs of their whole population in setting their commissioning priorities. The NHS Commissioning Board should have the power to conduct thematic reviews of commissioning performance and outcomes in relation to different areas of patient care (such as footcare services or falls prevention). The NHS Commissioning Board should be under an obligation to do this if there is a persistent failure to deliver improvement in relation to an area of health care provision or a particular subsection of the population.

4. HEALTH AND SOCIAL CARE INTEGRATION

4.1 Services frequently fail to offer a coordinated package of support across health and social care. It is this lack of integrated delivery that causes difficulties for so many older people living with long term conditions and co-morbidities, and impedes better management of their care. Under the provisions laid out in the Bill, local health and wellbeing boards will take responsibility for producing the Joint Strategic Needs Assessment (JSNA) and a local health and wellbeing strategy. Consortia and local authorities are under an obligation to demonstrate that they have taken both the strategy and JSNA into account in developing their commissioning plans. However, we are concerned that this does not give the local health and wellbeing board sufficient power to ensure that actual service delivery matches up nor to challenge gaps in services.

4.2 We believe that local health and wellbeing boards need to be given the power to undertake an inquiry into local service provision and publish independent public reports. Local authorities and commissioning consortia should be under an obligation to cooperate with any inquiry and have a duty to respond to any recommendations set out in a report.

5. CLEAR LINES OF ACCOUNTABILITY FOR DELIVERY AND POWERS TO DEAL WITH FAILURE IN THE SYSTEM

5.1 Age UK believes that accountability for how well the NHS serves the needs of its users should lie with the Secretary of State for Health. Ultimately, it is the Secretary of State who should be responsible for transparent reporting of the activities of the health service. Parliament should have an opportunity to comment on how well the health service is meeting the needs of the population. So, Age UK believes that it is the Secretary of State who should lay before Parliament an annual report on the performance of the NHS not the NHS Commissioning Board. In light of the current financial challenges facing the NHS, the Secretary of State’s report should also include information on the financial and productivity performance of the NHS.

5.2 Under these proposals the NHS Commissioning Board will take responsibility for primary care contractors through direct commissioning of general practice, dentistry, pharmacy and optical services. This responsibility is currently held by PCTs. Where contract management currently works well, PCTs—working with professional representatives and expert advisors—take an active role in performance managing contractors. PCTs develop a direct relationship with providers and have regular communication to make sure they are appropriately supported, and that any emerging problems are identified and managed before they impact adversely on patient care. This function is distinct from the role of CQC and Monitor as regulators who gather information about quality after the fact and are not as well supported by professional or specialist expertise. Equally some PCTs have played an important role in developing and managing clinical networks, for example, and sharing best practice. We are very concerned that this day-to-day provider management will be lost if overseen remotely by a single national board. Although the Bill creates provisions for the NHS Commissioning Board to establish a regional presence, we believe that this will be essential if it is to adequately fulfil its obligations to properly performance manage primary care contractors.

6. REAL POWER FOR PATIENTS AND PUBLIC TO DRIVE SERVICE USER-LED CHANGE

6.1 Patient advocacy in health care will be vital if all patients are to benefit from the opportunities to exercise greater choice and control. Whether choosing a health care provider or making decisions about the management of their care, patients will require information and support. We know that information provision and patient involvement in decision making works best where patients are supported to interpret information and apply it to their specific circumstances. Many patients will be easily able to access online information and may feel confident to participate in decision-making with limited support. However, other patients with complex cross-cutting needs, or who may experience cognitive or sensory impairment, will need access to advocacy and advisory services able to provide them with additional support they need.

6.2 The Bill currently limits mandatory advocacy services to complaints, we believe that this is a very narrow interpretation. Local authorities should have the responsibility to commission or provide a suitable advocacy service that delivers appropriate advice and support across health and social care to any person who needs it.
6.3 Currently provisions for patient and public engagement in the Health and Social Care Bill are weak. We want to see mandatory patient representation on all commissioning consortia and on the NHS’ Commissioning Board as part of their governance framework. If there is truly “no decision about me, without me” this principle should extend to every level of the NHS.

6.4 In addition, we believe that there should be a public right to petition the NHS Commissioning Board to undertake a review into a particular health service at a national level or a thematic issue, such as health inequalities.

6.5 The NHS Commissioning Board and commissioning consortia should be under an obligation to publish all information relating to their commissioning strategy and planning, results and outcomes including their rationale and justification for decisions. The minutes of meetings must be open to public scrutiny (with the same ability to restrict certain categories of business as would apply to a local authority). Meeting details should be published in an accessible format and made available in hard format on request, not just online.

7. Supporting Vital Social Care Services

7.1 The Bill offers support should a foundation trust collapse financially and we believe this support should be extended to cover some social care services. The Bill should be amended to broaden the scope of “special administration” to include all regulated health and social care services where continuity of service is desirable in order to safeguard service users in the event of a provider experiencing business failure.

7.2 Amending the Bill in this way would enable the protection offered by special administration to be extended to other regulated health and social care services where continuity of service is essential to the safety and wellbeing of service users. This protection stems from the role of the special administrator which includes “securing the continued provision of the designated service” and ensuring that any regulated activity carried on in providing the designated services is carried on in accordance with any requirements or conditions imposed by virtue of Chapter 2 of Part 1 of the Health and Social Care Act 2008 (which refers to minimum standards).

7.3 Continuity of service provision is particularly important for long term care services such as residential care homes where service failure, particularly if it results in a sudden or forced move, can be extremely harmful to service users.

February 2011

Memorandum submitted by the Children’s Rights Alliance for England (HS 26)

About the Participation Works Partnership

1. This submission has been prepared by the Children’s Rights Alliance for England on behalf of Participation Works, a partnership of six national children and young people’s agencies that are working together to ensure that all children and young people are given information, opportunities and appropriate assistance to participate in decision-making that affects them, as individuals and collectively. Our membership includes the British Youth Council, the Children’s Rights Alliance for England, the National Children’s Bureau, the National Council for Voluntary Youth Services, the National Youth Agency and Save the Children. Participation Works has a comprehensive programme of activity and resources on participation which include workshops, training sessions and practitioner networks, designed to support organisations and practitioners who work with children and young people under 25 years old.

Introduction

2. This submission focuses on ways in which the Health and Social Care Bill could be strengthened to ensure children and young people’s involvement in health decision-making.

3. The Bill proposes several new (and replacement) mechanisms by which the public will be informed about, and engaged in, health decision-making. However, as it currently stands, there is no particular provision for children and young people.

4. The Participation Works Partnership strongly welcomed the coalition Government’s promise in December 2010 that it would give due consideration to the Convention on the Rights of the Child (CRC) when making new law and policy. Further, this is the first legislative opportunity Parliamentarians have had to respond to the findings of the Kennedy Review, Getting it right for children and young people: Overcoming cultural barriers in the NHS, published in September 2010.
CONVENTION ON THE RIGHTS OF THE CHILD

5. As a signatory to the CRC, the UK must take all possible steps to fully realise the rights and freedoms in the Convention, including Article 12 which requires that:

States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

6. The international monitoring body for the CRC, the UN Committee on the Rights of the Child, has been clear that Article 12 applies to collective decision-making processes, as well as matters affecting the individual child. In its General Comment on Article 12, the Committee notes:

... wide interpretation of matters affecting the child and children helps to include children in the social processes of their community and society. Thus, States parties should carefully listen to children’s views wherever their perspective can enhance the quality of solutions.44

7. In October 2008, the UN Committee issued its concluding observations on the UK and, in relation to Article 12, urged the Government to widely “promote, facilitate and implement, in legislation as well as in practice, ... the principle of respect for the views of the child (and) support forums for children’s participation”.45

KENNEDY REVIEW

8. In 2009–10, Professor Sir Ian Kennedy carried out a review of how the NHS delivers to children and young people and recommended a Local Partnership in each local authority that would co-ordinate public services in the best interests of children and young people. His ambition was that: “the welfare and well-being of children and young people, seen as so important by so many, will be the prevailing cultural approach. Then, once the needs of the children and young people for whom it is responsible are identified, the Local Partnership must ensure that they are provided for in an efficient and effective manner”. Children and young people’s views and experiences were to be at the heart of these Local Partnerships:

... By being wholly focused on the concerns of children and young people, the Partnership can ensure that their voices are heard as priorities are determined. Indeed, it would be an advantage to take a further step by seeking to ensure that there is some mechanism to enable the Local Partnership, in its structure, to be broadly representative of the community served ... In particular, the Local Partnership should be required to devise and operate mechanisms through which children and young people’s voices can be heard and appropriately acted upon.46

9. The coalition Government did not support Local Partnerships dedicated to the best interests of children and young people, though it did accept Professor Sir Ian Kennedy’s powerful arguments about engaging children and young people in the NHS. The Government’s response explained:

In the past, the NHS was not always set up to put the needs of patients and the public first. Too often patients were expected to fit around services rather than services around patients. Nowhere was this more the case than for children, young people and their families ... If we are to meet the needs of children, young people, families and carers, it is vital that we listen to them in designing services, gather information on their experiences and priorities, provide them with the accessible information that they need to make choices about their care, and involve them in decision making.47

OTHER EVIDENCE

10. A recent review of law, policy and practice in relation to children and young people’s participation in the NHS and other public services and settings found that:

— In their efforts to support user involvement, health authorities and NHS Trusts have not specifically identified children and young people as service users.

— There is no evidence of children and young people being systematically served by Local Involvement Networks (LINks).

— Although 41% of GP practices are reported to have a Patient Participation Group, there is no evidence of children and young people’s active engagement in these forums.48

46 Professor Sir Ian Kennedy (September 2010). Getting it right for children and young people. Overcoming cultural barriers in the NHS so as to meet their needs. Page 57.
47 Department of Health (September 2010). Achieving equity and excellence for children. How liberating the NHS will help us meet the needs of children and young people. Pages 4 and 6.
11. Amendments to the following Clauses would make a significant difference to children and young people’s status and profile within the NHS. They would help ensure the views and experiences of children and young people are firmly in mind from the very beginning:

— General duties of the NHS Commissioning Board (Clause 19);
— General duties of commissioning consortia (Clause 22);
— Provision of independent mental health advocates (Clause 35);
— Secretary of State’s annual report (Clause 44);
— General duties of Monitor (Clause 52);
— Designation of services (Clause 69);
— NHS Foundation Trust membership (Clause 138);
— Panel for advising governors (Clause 147);
— Healthwatch England (Clause 166);
— Local Healthwatch organisations (Clause 167);
— Activities relating to local care services (Clause 168);
— Independent advocacy services (Clause 170);
— Local Healthwatch organisations annual reports (Clause 173);
— Health and Wellbeing Boards (Clause 178); and
— General duties of Health and Social Care Information Centre (Clause 237).

12. We hope that Parliamentarians will consider amendments to these Clauses to ensure that the Bill genuinely delivers for children and young people.

February 2010

Memorandum submitted by Every Disabled Child Matters (HS 28)

1. SUMMARY

1.1 Every Disabled Child Matters (EDCM) is the campaign to get rights and justice for every disabled child. We have been working to raise the political profile of disabled children and their families, and campaigning to get the services and support they need to lead ordinary lives.

1.2 EDCM is a consortium campaign with four members operating as equal partners:

— Contact a Family;
— Council for Disabled Children;
— Mencap; and
— Special Education Consortium.

1.3 Between them, the campaign partners work with and represent all of the 770,000 disabled children and young people in the UK, and their families.

1.4 This submission highlights evidence relating to four key issues that are relevant to the health and wellbeing of disabled children. It is informed by the views and experience of disabled young people and their families throughout and also draws on some of the findings of the Kennedy Review into NHS services for children.49

1.5 Firstly, there is evidence that commissioning services for disabled children is a particular area where GP Consortia are likely to find fulfilling their duties challenging. This is in part due to GP’s limited experience of supporting disabled children as their health needs are usually met through a paediatrician.

1.6 We would also like to highlight evidence of the importance of health and social care services being coordinated with education so that disabled children can have their needs met with minimal disruption to their schooling. The Bill as published does not directly address this issue.

1.7 In the proposed new structure the commissioning of services for disabled children is likely to be spread across the newly autonomous agencies. We have therefore provided evidence on the challenges that fragmented services can present.

1.8 To inform the Bills aims of delivering more patient involvement, the last section of our submission highlights evidence of the attitudinal barriers that disabled children are often faced with in getting their voices heard in relation to their healthcare.

49 Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs, a Review by Professor Sir Ian Kennedy, Crown Copyright 2010.
2. GP’s AWARENESS OF DISABLED CHILDREN’S NEEDS

2.1 Disabled children will mostly be in contact with a paediatrician to assess their needs and coordinate their health services, rather than their GP. GPs themselves therefore have little experience of the needs of disabled children and, as Sir Ian Kennedy found in his report\(^\text{50}\) commissioned by Government last year, GPs have little training in paediatrics generally.

“Despite the high number of children coming into their surgeries, many GPs have little or no experience of paediatrics as part of their professional training. This means that, technical competence notwithstanding, many GPs lack the confidence to assess and treat children effectively, something that comes from specialist training and experience.”

2.2 Some disabled children and their families face barriers accessing primary care itself. A report\(^\text{51}\) by the Disability Rights Commission highlights the following example:

“One woman who had three sons with autism spoke of how long waits in the waiting room could lead to her children becoming hyperactive and difficult to control. This resulted in her children becoming very distracted and challenging to communicate with once in the consultation room with the doctor. This same mother spoke of how the doctor at this surgery used to call her sons ‘the little bastards’ due to their behaviour at the surgery. Whilst this woman felt hugely insulted by this comment she never felt able to confront the doctor about it.”

2.3 The same report found that many practitioners did not realise or acknowledge that significant barriers existed or that they may have a duty to make reasonable adjustments to mitigate them. For instance, one practice said:

“As a practice we do not discriminate, any patient is welcome to use the practice services in the normal way.”

2.4 This evidence regarding access to primary care suggests that it may be a challenge for GPs to take on yet more responsibilities for meeting the needs of disabled children.

2.5 It will be important that when seeking expert advice to help them carry out their commissioning functions (Section 22 of the Bill/proposed section 14O of NHS Act 2006) that GP consortia have regard to the needs of the whole local population. This must include the needs those, such as disabled children, who GPs may have less experience of, or little training in. EDCM would like the committee to explore how this could be ensured.

3. WORKING IN PARTNERSHIP WITH EDUCATION PROVIDERS

3.1 Many disabled children require health related services at school including physiotherapy, occupational therapy and speech and language therapy as well as specific medical interventions. There are often problems with providing such services on the school site or it is not properly coordinated with other activities at school.

“I went to a mainstream secondary school. I did not get to see a physio or OT regularly. This is because I didn’t go to a special school for disabled people. I think health, education and social services need to work more closely together.”

Adam (disabled young person)

3.2 This lack of coordination of support presents disabled children and young people with barriers to the participation in education that their peers would take for granted. As Sir Ian Kennedy recognised:\(^\text{52}\)

If children do not receive appropriate support from the school, at worst those with severe health problems receive a “double whammy” as their ill-health damages their education by disrupting their schooling, either through being forced to stay at home or by long stays in hospital. Children with severe or long-term conditions receive enormous benefit from continuing their education during their treatment. And there are social as well as educational benefits. Continuing in education is a signal, to the child themself, the parents/carers and the peer group, that a child with a severe or complex health condition continues to belong to the “community of children” and does not become defined by their condition.

3.3 These issues are likely to contribute to the relatively poor attainment and outcomes that disabled children and young people experience. In 2009–10 the proportion of pupils with SEN without a statement achieving achieved five or more A*-C grades at GCSE or equivalent including English and mathematics GCSEs is 22.6%, compared to 7.3% of pupils with SEN with a statement, and 66.2% of pupils with no identified SEN. 17% of disabled young people are not in education, employment or training, compared to only 7% of non-disabled people.\(^\text{53}\) Latest figures\(^\text{54}\) from 2009 show that 12.4% of 16–18 year olds with learning difficulties and/or disabilities (LDD) are not in education, employment or training compared to 6% of young people with no learning difficulties and/or disabilities.

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\(^{50}\) Sir Ian Kennedy 2010, *Getting it right for children and young people*, pp 45–46.


\(^{52}\) Sir Ian Kennedy 2010, *Getting it right for children and young people*, p 40.

\(^{53}\) Department for Education: *GCSE and Equivalent Attainment by Pupil Characteristics in England, 2009–10*.

\(^{54}\) Connexions Services August 2010 (Disability Equality Indicator A13).
3.4 When schools and health services do not collaborate to meet the needs of children and young people it also has a significant impact on their families. A study\textsuperscript{55} by Diabetes UK found, for example, that half (46\%) of primary school pupils with Type 1 diabetes, and a third (29\%) of their secondary school counterparts, report their parents have had to reduce hours or give up work to help them administer life-saving insulin injections. It is clear that when children need such support during school hours, local services should work together to ensure that it is available and that disabled children’s health needs do represent a barrier to inclusion.

3.5 EDCM is concerned that the Bill in its current form does not require schools or Academies to participate in Health and Wellbeing Boards. Meanwhile, the Education Bill, currently on its passage through parliament, will remove the requirement for schools to cooperate in Children’s Trusts arrangements and the requirement for local authorities to produce Children and Young People’s plans has recently been removed through regulations.

3.6 The coordination of education with health and social care is vital for the welfare and development of disabled children so it will be important that this round of reform of public services strengthens the infrastructure for joint working with education providers rather than weakening it.

3.7 EDCM would like the committee to explore how the legislation could ensure that education providers work closely with health and social care commissioners. This could be through membership of Health and Wellbeing Boards (Section 178, subsection 2) or provisions regarding working closely with those that arrange for the provision of health related services (Section 179, subsections 3–6):

4. ACCESSING SPECIALIST AND UNIVERSAL SERVICES

4.1 Most disabled young people have a range of needs that will be met by professionals from different specialisms, paediatricians, therapists and GPs. This contributes to challenges in coordinating care.

“My 10 year old son has a rare and life-limiting disability and requires ongoing specialist healthcare. In six years I have never met anyone from the PCT, even at review meetings to discuss his care.”

Belinda (parent of a disabled child)

4.2 The proposed reforms will give the NHS Commissioning Board responsibility for commissioning some specialist services with other services nominally being commissioned by GP consortia. The White Paper Liberating the NHS defines specialist health services are 52 services listed in regulations\textsuperscript{56} and relating to specific conditions for example the “severe intestinal failure service” or the “Vein of Galen malformation service”. None of these services are intended to deliver holistic care but will provide a national system of commissioning particular low volume procedures and services. All disabled children would therefore require services commissioned by local GP consortia and many will also rely on nationally commissioned specialist services.

4.3 It will be important to be clear who will be ultimately responsible for ensuring that disabled children get the full range health services they need to meet their needs. For example for a child requiring ventilation support, it will need to be clear who within the new system will have responsibility for ensuring a holistic care package is delivered for them. EDCM would like the committee to explore this.

5. PARTICIPATION OF DISABLED CHILDREN AND THEIR FAMILIES

5.1 Disabled children and young people often find it difficult to make their voice heard when it comes to decisions about their healthcare.

“Doctors don’t listen the first time we say something is wrong, then they listen when it’s too late. They use really long technical words and they don’t always explain what those words mean which is confusing. They get really impatient with us—that’s not nice!”

Lavinia (disabled young person)

“One time I said to the doctor, ‘Excuse me, it’s not about my mum, it’s about me!’”

Kirsty (disabled young person)

5.2 The Bill proposes changes to the way in which service users are involved in the planning and commission of local services. Existing local involvement networks would be replaced with Local HealthWatch organisations (Sections 167–170 of the Bill), which would be represented on Health and Social Care Boards.


\textsuperscript{56} Secretary of State’s functions under Section 3(1) of the National Health service Act 2006 exercisable by Strategic Health Authorities for the purpose of securing the provision of services: specified services http://legislation.data.gov.uk/uksi/2010/405/regulation/made/data.htm?wrap=true
Wellbeing Boards and forward major concerns to the Care Quality Commission for investigation, as well as being involved in the provision of independent advocacy services. This may be an opportunity for disabled children, young people and their families to make themselves better heard.

5.3 Parent Carer Forums have been established in nearly all local authority areas in England. These Forums work strategically with local authorities and PCTs to design local services for disabled children. Forums are co-ordinated nationally by the National Parent Carer Forum Network. These Forums are well placed to work with local HealthWatch and HealthWatch England.

5.4 As the HealthWatch organisations are being set up to represent the views of service users it will be important that they have regard to the needs of those that are most impacted by the quality of services and those that have historically struggled to get their voices heard, of which such as disabled children, young people and their families.

5.5 EDCM would like the committee to explore how it can be ensured that local HealthWatch organisations have regard to the needs of disabled children, young people and their families. This could be with reference to targeting advocacy services or providing them in a particular way (section 170) or general priorities for HealthWatch organisations (Schedule 13).

February 2011

Annex 1

Key Facts and Prevalence Data

— There are around 770,000 disabled children in the UK, with 570,000 of those children in England.\(^{57}\)
— It is estimated there are around 100,000 children in England with complex care needs, who need support from a wide range of services.\(^{58}\)
— Over the last 30 years there has been an increase in the number of people reporting an impairment. Since 1975, the fastest growth in numbers has been for children—from 476,000 disabled children under the age of 16 in 1975, to 772,000 in 2002.\(^{59}\)
— Reviews by both the Healthcare Commission (2008) and Sir Ian Kennedy (2010) found major problems in the provision of services for disabled children.

“children with disabilities or those in situations that make them vulnerable, do not always get the attention and care from healthcare services that they need”

Healthcare Commission 2008\(^{60}\)

“Finding that their child is entitled to services does not mean that such services are available in their local area. Parents/carers report that services are overloaded, or that they have to travel long distances to receive them.”

Sir Ian Kennedy 2010\(^{61}\)

Memorandum submitted by Optical Confederation

1. About Us

1.1 The Optical Confederation represents the 12,000 optometrists, 6,000 dispensing opticians and 7,000 optical businesses in the UK who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of five optical bodies; the Association of British Dispensing Opticians, the Association of Contact Lens Manufacturers, the Association of Optometrists, the Federation of Manufacturing Opticians and the Federation of Ophthalmic and Dispensing Opticians.

2. Overview

2.1 The Confederation welcomes the principles of the Bill to abolish PCTs and SHAs and to reinvest the savings in frontline care. Bureaucracy has escalated significantly in our areas of the health service over recent years, with no demonstrable benefits to patients. We therefore welcome the measures to reduce the administrative and unnecessary regulatory burdens on frontline care.


\(^{58}\) Ibid.

\(^{59}\) ONS (2004) Living in Britain: Results from the 2002 General Household Survey (cited from Improving the lives of disabled people, PMSU, 2004).


\(^{61}\) Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs, a Review by Professor Sir Ian Kennedy, Crown Copyright 2010. p 32.
2.2 We also support the measures to give greater choice and control to patients. This is an area where we excel, where patients are able to choose where they go for a sight test (close to where they live or work) at a time and location that is convenient to them. The highly competitive, open market in which community optical practices already operate delivers high levels of quality, access and choice to all patients, including those that are confined to their homes. Being a national service, set out in regulations, regulated by the General Optical Council and market-led, the funding genuinely follows the patient and the system delivers accessible care without waiting, wherever patients want it, the length and breadth of the country. Almost uniquely in the NHS, in eye care money directly follows the patient and practices compete for each and every patient. If not, they go out of business and others move in to take their place.

2.3 We very much welcome the proposal to keep this efficient and high quality service as a national service commissioned by the NHS Commissioning Board. We also welcome the measures to improve health outcomes and the new public health role for Local Authorities.

2.4 We do however have some concerns regarding the detail of certain clauses in the Bill and we ask Committee Members to consider these points in more detail.

3. PERFORMERS’ LISTS HELD BY THE BOARD

3.1 Schedule 4, part 6, paragraph 58 makes provision for the power to establish Ophthalmic Performer Lists to be transferred from Primary Care Trusts to the NHS Commissioning Board, and we understand that the intention is for the NHS Commissioning Board to establish a national list of those “persons performing primary ophthalmic services”.

3.2 However our regulator, the General Optical Council, already keeps a Register which provides the same information, is publicly available online, and in our view is fit for purpose. If it is deemed not fit for the NHS Commissioning Board’s purposes, then the solution is to make it so, not to establish a duplicate system.

3.3 One argument often raised in support of a separate list is that the old listing arrangements include an additional parallel set of disciplinary functions which PCTs felt they needed in the old world. However if the NHS Commissioning Board has a problem with a contractor’s staff, it should raise the issue under “contractual terms” and, if there is an issue with a professional as now the options would be:

- to send in a professional optometric adviser to review and support them; or
- if serious enough, to refer them to the General Optical Council (GOC) or the General Medical Council (GMC), according to the individual case.

3.4 We strongly believe it is the Regulator who should control and discipline practitioners and the GOC is modernising and streamlining its functions to be able to separate out more easily important issues from those that can be dealt with by administrative means.

3.5 In our view therefore, this is duplication of the regulatory bodies’ functions through an additional professional list which adds an additional tier of unnecessary bureaucracy, which is a throwback to the old days of PCT bureaucracy. Moreover, this adds costs both for the NHS Commissioning Board and the primary care professions. We would therefore ask the Government to seriously reconsider if these duplicatory arrangements are necessary in the Liberated NHS and to clarify the cost effectiveness of this move.

3.6 The explanatory notes to the Bill also refer to Clause 41 which inserts new section 125A in the NHS Act 2006, which allows the Board to consider matters such as those relating “to a contractor’s performance under its contract.” This would suggest that there are adequate measures within the Primary Ophthalmic Services contracts to address any concerns regarding a contractor’s performance. In addition, as noted above, if there are concerns about practitioners locally, the NHS Commissioning Board can deal with this under its contractual powers possibly through a visit and recommendations by an optometric advisor or by referral to the GOC.

3.7 In our view, the solution to any problems under the Primary Ophthalmic Services contracts should be through the contracts themselves not through a separate and costly set of administrative and duplicatory arrangements.

4. OPTOMETRIC ADVICE TO GP COMMISSIONING CONSORTIA

4.1 Under Clause 22, “Commissioning consortia: general duties,” new section 140 requires consortia to obtain appropriate advice from healthcare professionals which could include obtaining advice on commissioning decisions in relation to particular services or allow for healthcare professionals to be appointed to any committees the consortia wishes to set up to provide support on commissioning decisions.

4.2 At national level the four contractor professions—medical, dental, pharmacy and optometry—have made clear their united view that local representative committees embrace the whole range of professions and modalities of care locally and are ideally placed to advise GP Commissioning Consortia on the commissioning of wider services in their professional areas.

62 ie Local Medical, Dental, Pharmaceutical and Optical Committees.
4.3 It follows therefore that it would be sensible for GP Commissioning Consortia to consult for example Local Optical Committees, when considering the commissioning of optical and ophthalmology services (as well of course as the local hospital service and social care).

4.4 We would ask that Ministers ensure that a reminder about consulting the appropriate local representative committee is included in commissioning guidance to GP consortia.

5. **NHS Commissioning Board**

5.1 The Optical Confederation fully supports the Government’s decision to retain a national sight testing service commissioned by the NHS Commissioning Board. This will minimise transaction costs for the NHS and on front line care. It is not only very cost-effective but, as we have outlined above, already offers an efficient and high quality service to all patients.

5.2 However subsection (3) of clause 41, “Primary care services: directions as to exercise of functions”, inserts new section 125A into the NHS Act and provides a power of direction in relation to Primary Ophthalmic Services. This section allows for the Board to direct to a commissioning consortium to exercise any of the Board’s functions relating to the provision of Primary Ophthalmic Services. We understand that will allow for commissioning consortium to commission enhanced eye care services—essentially those services outside the sight testing service.

5.3 We fully understand why enhanced eye care services, for example, shared care with hospitals and GPs, such as pre- and post-operation cataracts and stable glaucoma management need to be commissioned locally.

5.4 However, there are also identified single defined services—such as glaucoma referral refinement as recommended by NICE, and minor optical emergencies—which, on the same basis as the NHS sight test, should ideally be commissioned nationally against a national tariff in order to save transaction costs for GP Commissioning Consortia and front line providers.

5.5 If such standard national services were nationally commissioned, any optical practice which carried out such an item of service and would then simply submit a claim to the NHS Commissioning Board. If they did not, of course, no payment would be made. This would again save money and transaction costs throughout the system for standard nationally necessary services.

5.6 We ask Committee Members to ask the Minister what steps he is taking to ensure the NHS Commissioning Board give early consideration to this possibility. If, for whatever reason, it were not deemed possible, a nationally commended pathway to GP Commissioning Consortia could possibly go at least some way to achieving similar ends of efficiency and high quality without added bureaucracy.

6. **Working with the Professions Nationally**

6.1 As the Bill itself recognises some services are best commissioned locally and some nationally and, in the case of nationally commissioned primary care services, we believe that the Bill should be strengthened to ensure that the NHS Commissioning Board has a duty to consult the relevant national representative and professional bodies within primary care. There are currently no requirements on the Board to consult these bodies such as the BMA, the PSNC, the Optical Confederation and the BDA and we believe the Bill should be amended to rectify this oversight.

7. **Monitor**

7.1 The Optical Confederation has welcomed the commitments given by the Department of Health that Primary Ophthalmic Services (in common with other primary care providers) do not need to be brought within the Monitor licensing regime. This is sensible and proportionate.

7.2 However we would urge the Government to ensure that commissioning guidance and model contracts produced by the NHS Commissioning Board, are explicit in recognising that, although not “Monitor licensed”:

   — all appropriate tendering exercises should be open to primary care providers—in our case optical practices or consortia of optical practices; and

   — “any willing provider” or “preferred willing provider” regimes should similarly be open to non-Monitor licensed primary care providers.

7.3 Otherwise, there is a risk that the paperwork will simply require all NHS providers bidding for work to be “Monitor-licensed” as a matter of course which would rule out the optical and pharmacy sectors bidding for work, stifle innovation, and potentially seriously impair the development of local services for patients. (Clauses 76 and 77)
8. **DUTY ON LOCAL AUTHORITIES TO CONSULT LOCAL REPRESENTATIVE COMMITTEES**

8.1 We are concerned that there is currently no duty on Local Authorities nor Health and Wellbeing Boards to consult their local representative committees when preparing strategic plans and strategies. Clause 176 (6) makes provision for the Local Authority to consult any “person it thinks appropriate” when preparing the local Joint Strategic Needs Assessment. We are seeking an assurance that the Local Authority will have a duty to consult with the local representative committees.

8.2 Ensuring that Local Optical Committees are able to provide their expertise and advice in relation to eye health services, will be vital to improve the eye health of the local population. With rising levels of avoidable sight loss, placing a huge burden not only on the individual but on NHS and social care services, this major public health challenge must be part of the Joint Strategic Needs Assessment. Utilising the expertise of the Local Optical Committee in a collaborative nature, will ensure the local eye health needs are met.

8.3 Clause 177 makes provision for the Local Authority and GP Commissioning Consortia to produce a joint health and wellbeing strategy. Given the reasons outlined above the local representative committees must be consulted when devising these strategies.

8.4 Clause 179 places a duty on Health and Wellbeing Boards to encourage integrated working and to work closely with commissioners of health and social care services. As the local voice of expertise in primary care, the local representative committees, who represent providers of primary dental, pharmacy, optical and medical services, should be consulted. We believe that the Bill should be strengthened to ensure that Health and Wellbeing Boards consult these committees in respect of relevant services.

**February 2011**

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**Memorandum submitted by TreeHouse (HS 30)**

**HEALTH AND SOCIAL CARE BILL AND AUTISM EDUCATION**

TreeHouse is the national charity for autism education. We have an interest in the Heath and Social Care Bill, as it is vital that all health providers are equipped to ensure good outcomes for children and young people with autism.

In the committee stage of the Bill’s legislative journey, TreeHouse continues to have concerns relating to:

- the expertise of commissioners of working with children with autism;
- how Healthwatch will engage parents and carers of children with autism;
- the co-ordinated commissioning of specialist services for children with complex and low-prevalence needs; and
- the role of schools in local Health and Wellbeing boards.

**THE EXPERTISE OF COMMISSIONERS**

Studies have shown that GPs often lack experience or training in working with children and young people with autism. Four out of five GPs (80%) indicate that they require additional guidance and training to identify and manage patients with autism more effectively. We therefore have serious concerns about whether GP consortia will have the necessary expertise in autism to effectively commission services for children and young people with autism.

**Recommendation:** TreeHouse suggests that steps are taken to ensure expertise on autism is reflected in the commissioning process. One way of doing this may be to ensure the participation of the local authority autism lead and the autism partnership boards in the Health and Wellbeing boards or in GP consortia; this should be listed in part 5 chapter 2.

**HEALTHWATCH AND PARTICIPATION**

Healthwatch groups must ensure that there is provision for the participation of children with autism and their families. TreeHouse knows that children and young people with autism and their families find it difficult to engage positively with the services on which they rely.

TreeHouse endorsed the Health White Paper’s dictum that there should be no decision about me without me and believe that this is particularly relevant for young people with autism and other disabilities, who all too often have been seen as “passive” rather than “active” service users.

**Recommendation:** We suggest that HealthWatch be given a specific remit to advocate on behalf of children with disabilities and their families, as they are likely to be core users of these services.

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Co-ordinated Services

Children with autism often require input from a large number of health professionals, for example GPs, speech and language therapists, occupational therapists, and educational psychologists. TreeHouse is concerned that whilst at present there is a single body responsible for the provision of each of these services (PCTs), consortia could fail to commission and co-ordinate all of these services effectively.

Recommendation: TreeHouse ask that Part 1 Section 9, “Duties to Consortia as to Commissioning Certain Services”, include a clause that requires boards to commission specialist support services for disabled children and ensure that provision is co-ordinated.

The Role of Schools

The co-ordination and partnership of education and health services is essential for children and young people with autism, who may see a range of professionals from across education and health on a weekly basis. In order to ensure the effective sharing of information, use of resources, and minimal disruption for children and families, it is essential that all providers who support children work closely together.

At present schools are represented on Children’s Trusts. TreeHouse understands that the new Health and Wellbeing boards will take on many of the responsibilities of Children’s Trusts but there is no mention of how schools might be represented. With the opening of academies and free schools it is essential that there is a co-ordinated approach as these schools may need help in accessing specialist services such as speech and language therapists.

Recommendation: TreeHouse ask that Part Five of the Bill includes a requirement for an education representative to sit on Health and Wellbeing Boards, or that the boards are required to ensure regular liaison with local schools.

February 2011

Memorandum submitted by the following: Malcolm Alexander, Ruth Barnes, Jos Bell, Paul Bywaters, Alex Chambers, Frances Chilemana, Judith Cook, Jane Corbett, Dr Sarah Corlett, Dr June Crown, Dr Jack Czauderna, Susie Daniel, Surindar Dhesi, Debbie Fox, Jean Fraser, Louise Hurst, Dr Mike Joffe, David King, Sue Laughlin, Michael Leonard, Dr Robert MacGibbon, Daniel MacIntyre, Ruth du Plessis, Rita O’Brien, Thara Raj, Isobel Rosenstein, Professor Wendy Savage, Dr Alex Scott-Samuel, Professor Aubrey Sheiham, Dr Katherine Smith, Victoria Smith, Ruth Stern, Dr Jonathon Tomlinson, Alex Trouton, Marie-Noelle Vieu, Lynsey Warwick-Giles, Professor Jane Wills, Robert Williams (HS 32)

At a meeting held in London on 5 February, it was agreed by the above members of health professions and the public that the following be forwarded to the Health and Social Care Bill Committee. We wish to draw to your attention and to request your action regarding the following important aspects of the Health and Social Care Bill.

1. The contradiction between unrestricted patient choice of provider and centralised GP consortium commissioning makes effective commissioning impossible.

2. The absence of a minimum price tariff inevitably causes reductions in standards due to the sacrificing of clinical quality in an attempt to achieve the cheapest tender.

3. The knowledge that, when making referrals or treatment decisions doctors may be guided by vested interests in consortium policies rather than by the best interests of patients, undermines the doctor-patient relationship.

4. The inverse care law whereby poorer people receive poorer services will be reinforced by the ability of wealthier, more knowledgeable, or healthier people to shop around for GPs or GP consortia whose commissioning policies meet their perceived needs.

5. The transaction costs of implementing the Bill will be a drain on scarce health service resources.

6. Because the notion of unrestricted patient choice of provider imposes unpredictable variation in demand for any given provider or service, any kind of forward planning of services or economies of scale will become impossible.

February 2011
Memorandum submitted by the National Association of LINk Members (HS 33)

Proposed amendments to the Health and Social Care Bill
Public Involvement, Local Government and Commissioning

1. Members of the board of Healthwatch England should be elected from the membership of local Healthwatch
   166 (2) (1A) Page 138
   Line three: delete “appointed” and substitute: “elected from local Healthwatch”.

2. Healthwatch England should be able to make recommendations to the CQC in addition to giving the CQC advice and assistance
   166 (2) (1B) Page 138
   Line six: between “advice” and “or” insert: “, recommendations”.
   45 A Functions to be exercised by Healthwatch England.
   (3) Line 29: after “information” add: “, recommendations”.
   Line 29: after “advice” delete “on” and substitute “in relation to”.

3. Healthwatch England must deal with both health and social care issues
   (3)(a) Page 138
   Line 30: after “health” add: “and—”

4. The CQC should be included together with the Secretary of State, the NHS Commissioning Board, Monitor and English local authorities as key bodies to receive information, advice and recommendations from Healthwatch England about the views of people and Healthwatch on health and social care services
   (4) Page 138
   After Line 38: add:
   (b) the Care Quality Commission;

5. The CQC, Secretary of State, the NHS Commissioning Board, Monitor and English local authorities should not only respond to matters raised by Healthwatch England but should say what action they intend to take
   Line 44: add: after “advice” Page 138
   “and any action it intends to take”.

6. Healthwatch England must provide the CQC with information, advice and recommendations about the views of people and local Healthwatch on health and social care services. May is too weak
   45A (6) Page 139
   Line 1: Delete “may” and substitute “must”.

7. Reports produced by Healthwatch England must be distributed to local Healthwatch in addition to Parliament and the Secretary of State
   Page 139
   45B Reports
   (2)
   Line 22
   Add: (c) “send a copy of each such report to each local Healthwatch”.

8. If the Secretary of State intends to take action against Healthwatch England for failing in its statutory duties, local Healthwatch should be consulted before any directions are issued
   Page 139
   (5)
   Line 41
   Add: “and shall consult local Healthwatch before issuing such directions.”
9. As local Healthwatch will be a “body corporate” it should be clearly stated that the activities of local Healthwatch unambiguously derive from their duties and not secondarily from the duties of the local authority.

168 Activities relating to local care services
After line 37: Page 140–141
New (2)
(2) In subsection (2), omit the heading: “The activities for a local authority are—”
Substitute:
“The activities of the local Healthwatch in the area of the local authority are—”
Line 38
Renumber (2) to (3)

10. The role of local Healthwatch in making recommendations to Healthwatch England or the CQC needs to be strengthened

(3)(g) Page 141
Line 9
After “about” Add: “the need to conduct”

11. Members of local Healthwatch must have indemnity so that they can speak out freely and take part in all activities required to fulfil their duties
After Line 17: Page 141
Insert: (6) The Secretary of State may by regulations make provision requiring Healthwatch England to make arrangement under this section, for members of local Healthwatch to have indemnity cover against the risk of a claim in negligence arising out of the activities of local Healthwatch.

12. Local Healthwatch must not be the same organisation as a Host, local authority, an NHS Trust, Foundation Trust, Primary Care Trust, Strategic Health Authority or Commissioning Consortium
Line 27 Page 141
Delete “Omit subsection (4).”
Substitute:
(4) In subsection (4) Add (h) Commissioning Consortia

13. The Independent Advocacy Service should be provided at a level that meets local need
Page 142
170 Independent advocacy services
(1), (1)
Line 24
After “appropriate” add “in relation to the needs of people”

14. The Independent Advocacy Service should provide a service for people with complaints about social care and complaints about health care
After Line 30 Page 142
(b) after (2) add: and section 114 (1) and (2)

15. Commissioning Consortia must be added to the local bodies that are required to provide information to local Healthwatch and respond to their reports and recommendations
Page 144
171 Requests, rights of entry and referrals
After Line 6 insert
In subsection (2) (of para 224) after (d) add
(e) Commissioning Consortia
and change the current (e) to (f).
16. Commissioning Consortia must be added to the local bodies that are required to enable local Healthwatch to again access to services for the purpose of enter, view and observe the carrying on of health and social care activities
   Page 144
   After Line 20 add:
   In subsection (7) (of para 225) after (d) add:
   (e) Commissioning Consortia
   and change the current (e) to (f)

17. The NHS Commissioning Board will promote a duty of candour when an adverse event, incident or error has occurred in the care or treatment of patients
   Chapter A1 The NHS Commissioning Board
   13D, (3) Page 16
   Insert: (d) patients have been informed when an adverse event, incident or error has occurred in their care or treatment.

18. The NHS Commissioning Board shall secure the involvement of individuals and local Healthwatch in commissioning decisions, and strengthen involvement
   Chapter A1 The NHS Commissioning Board
   13L, (2), Page 18
   Line 20: after “that” insert: “local Healthwatch and”
   Line 21: delete: “whether”
   Line 22: delete the first and second “or” and replace both by “and”.

19. Commissioning Consortia shall secure the involvement of individuals and local Healthwatch in commissioning decisions, and strengthen involvement
   Chapter A2 Commissioning Consortia
   Public involvement 14P, Page 30–31
   Line 42: after “that” insert: “local Healthwatch and”
   Line 43: delete: “whether”
   Line 44: delete the first and second “or” and replace both by “and”.

February 2011

Memorandum submitted by Asthma UK (HS 34)

SUMMARY
1. The Health and Social Care Bill has the potential to make improvements to health outcomes but it will not deliver those improvements without aspects of the Bill being strengthened. The key areas which need to be strengthened are reporting on improvements in primary care by commissioning consortia, patient and public involvement in commissioning and multidisciplinary involvement in commissioning.

2. As the majority of both routine and acute management is provided by primary care, Asthma UK is advocating for clearer duties on reporting from commissioning consortia on improvements in the quality of primary care services. Secondly, regarding the commissioning of services to ensure that they are appropriate for people with asthma, Asthma UK is concerned about the downgrading of patient and public involvement in the Bill. Thirdly, Asthma UK recommends strengthening the duty on the commissioning bodies to obtain appropriate advice to ensure the appropriate involvement of multidisciplinary teams in the planning of services and care pathways, to ensure efficient and effective services.

ABOUT ASTHMA UK
3. Asthma UK is the charity dedicated to improving the health and well-being of the 5.4 million people in the UK, including the 4.5 million people in England, whose lives are affected by asthma. We work together with people with asthma, healthcare professionals and researchers to develop and share expertise to help people increase their understanding and reduce the effect of asthma on their lives.

Asthma

4. The prevalence of asthma in England is 8.9%. Asthma is a long-term condition that requires regular monitoring and therapeutic adjustment. However, survey research has consistently shown unacceptable morbidity associated with low expectations on the part of asthma patients. These low expectations include seeing asthma as an intermittent acute disorder rather than as a chronic condition. A key strategy for improving outcomes and quality of life is therefore to shift the emphasis from the acute management of asthma (with its associated exacerbations and high-cost emergency admissions, of which there were 67,766 in England in 2009–10) to supported self-care with asthma managed as a long-term condition.

5. In this submission Asthma UK is advocating for clearer lines of accountability in the Health and Social Care Bill to improve quality in primary care so that outcomes for people with asthma can be improved. Secondly, regarding the commissioning of services to ensure that they are appropriate for people with asthma, Asthma UK is concerned about the downgrading of patient and public involvement in the Bill, where GP Consortia and The NHS Commissioning Board have a weaker duty to involve patients and the public than Primary Care Trusts and Strategic Health Authorities currently have.

6. Finally, Asthma UK recommends strengthening the duty on the commissioning bodies “to obtain appropriate advice” to ensure the involvement of multidisciplinary teams in the planning of services and care pathways, to ensure efficient, effective and well-integrated services. This is particularly relevant for the 5% of people with asthma who have severe asthma—people who are living with severe asthma symptoms despite taking high doses of medicine correctly—and who need to use many different NHS services for their healthcare needs. We also hope that the promotion of multidisciplinary working will help to ensure that the work of the newly-established respiratory networks will continue to promote service improvement for people with asthma.

Quality Improvement in Primary Care

7. The majority of both routine and acute management is provided by primary care. Asthma UK is advocating for clearer duties of public reporting between the NHS Commissioning Board and Commissioning Consortia to demonstrate continuous improvement in the quality of primary medical services so that outcomes for people with asthma can be improved.

8. The White Paper proposed that the NHS Commissioning Board commission primary care services and consortia should have a key role in improving the quality of general practice services. The explicit duty for commissioning consortia “to assist and support the Board [to secure] continuous improvement in the quality of primary medical services” (Section 22, page 30, line 15) is a welcome addition, as Professor Chris Ham of the Kings Fund elucidates:

“Experience shows that quality improvement in primary care is best undertaken at a local level based on a thorough understanding of the work of practices and the use of performance data to bring about improvements. The NHS Commissioning Board will not be able to take this task on alone because it will lack the expertise and be too remote from the provision of care on the ground.”

9. However, as Asthma UK is interested in the continuous improvement of primary medical services and bearing in mind that there are potential conflicts of interest between commissioning consortia reporting on quality in primary medical services, we would like to see an explicit duty to publish standardised reports relating to quality in primary care. Asthma UK recommends amending section 22, page 34, line 42:

“An annual report must, in particular, explain how the commissioning consortium has discharged its duty under sections 14L and 14P.”

10. Asthma UK recommends that section 22, page 34, line 42 is amended to include section 14M (section 22, page 30, line 15), the “duty in relation to quality of primary medical services”:

“Each commissioning consortium must assist and support the Board in discharging its duty under section 13D so far as relating to securing continuous improvement in the quality of primary medical services.”

11. The relevant section “reports by commissioning consortia”, section 22, page 34, line 42 would then read:

“All annual report must, in particular, explain how the commissioning consortium has discharged its duty under sections 14L, 14M and 14P.”

References


66 For example, Pinnock et al (2010). Setting the standard for routine asthma consultations, Primary Care Respiratory Journal, 19(1), p.76.


69 Asthma UK (2010). Fighting for Breath: the hidden lives of people with severe asthma.


71 Professor Chris Ham (2011). Ten questions to ask about the Health and Social Care Bill. Available at: http://www.kingsfund.org.uk/blog/health_bill_question.html
12. As well as making information about quality improvement in primary care part of their published reports, Asthma UK also recommend that commissioning consortia make information available to patients and the public about quality in primary care. Asthma UK recommends strengthening section 22, page 30, line 28:

“(d) enable patients to make choices with respect to aspects of services provided to them as part of the health service.”

This section should be strengthened to reflect the White Paper consultations An Information Revolution and Greater Choice and Control to read:

“(d) enable patients to make informed choices with respect to aspects of services provided to them as part of the health service.”

This will help to ensure that quality is recognised and rewarded in primary care services.

13. Effective patient and public involvement leads to improvements in health services and more efficient and effective care pathways. The Health and Social Care Bill downgrades the current duty to involve patients and the public in commissioning. This is contrary to the White Paper’s statement that “patients will be at the heart of everything we do”.

14. The current duty on commissioning bodies (PCTs and SHAs) to involve patients and the public is described in Section 242 of the NHS Act 2006. This duty to involve is being retained for Foundation Trusts in the new NHS architecture. However, for the new commissioning bodies (the NHS Commissioning Board and commissioning consortia), the Bill places a weaker duty to public involvement and consultation in separate sections of the Bill.

15. Section 242 of the NHS Act 2006 places a duty to ensure that persons to whom services are being or may be provided are, directly or through representatives, “involved in and consulted on:

(a) the planning of the provision of those services;

(b) the development and consideration of proposals for changes in the way those services are provided; and

(c) decisions to be made by that body affecting the operation of those services.”

16. In the Health and Social Care Bill parts (a), (b) and (c) above are repeated (with minor changes in wording) in section 19, page 18, lines 23–33 and section 22, page 31 lines 4–11, but the duty to involve is downgraded. In healthcare the definition of involvement encompasses a range of activities, on a “continuum” of involvement. The stages, in order of increasing levels of involvement are: providing information, consulting, partnership and delegated power. Looking at the relevant sections of the Health and Social Care Bill (reproduced below) it can be demonstrated that there is a downgrading of patient and public involvement by the new commissioning bodies, away from people being involved and consulted and towards a situation where commissioners will be able to solely provide information.

17. Section 19, page 18, line 20:

“The Board must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—

(a) in the planning of the commissioning arrangements by the Board;

(b) in the development and consideration of proposals by the Board for changes in the commissioning arrangements where the implementation of the proposals would have a significant impact on the manner in which the services are delivered to the individuals or the range of health services available to them; and

(c) in decisions of the Board affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.”

18. Section 22, page 30, line 42 repeats the above duty for commissioning consortia.

19. Asthma UK believes that the key to commissioning effective and efficient services is understanding and capturing the needs of the patients and public who use those services. The Health and Social Care Bill, in its current form, does not encourage this. Asthma UK has been working with eight other national charities to develop a consensus view on this issue and we support the amendments put forward by this group.

75 Alzheimer’s Society, Asthma UK, Breakthrough Breast Cancer, British Heart Foundation, Diabetes UK, Rethink mental illness, the Stroke Association and National Voices.
MULTIDISCIPLINARY INVOLVEMENT IN COMMISSIONING

20. The bill places a duty to obtain appropriate advice on the NHS Commissioning Board (section 19, page 17, line 17) and Commissioning Consortia (section 22, page 30, line 32). It states that the Board and consortia must:

“make arrangements with a view to securing that it obtains advice appropriate for enabling it effectively to discharge its functions from persons with professional expertise relating to the physical or mental health of individuals.”

21. Asthma UK, in concert with eight other national health charities, is concerned about the lack of emphasis on input into local service design and commissioning by expert health and social care professionals and patient groups. This is particularly relevant for the 5% of people with asthma who have severe asthma—people who are living with severe asthma symptoms despite taking high doses of medicine correctly—and who need to use many different NHS services for their healthcare needs. Furthermore where the commissioning of whole pathways of care for some conditions will fall under the remits of public health, the NHS Commissioning Board and GP consortia, this risks the fragmentation of service provision.

22. Integrated and effective care depends on collaboration between professionals, but the current duty on the National Commissioning Board and GP Consortia to “obtain advice” from health professionals is not a strong enough requirement for integrated working. Multi-disciplinary involvement of specialists, Allied Health Professionals, education, social care and patients is required to enhance continuity of care and improve quality standards for patients. We recommend that the duty to “obtain advice” is strengthened to a duty to “consult” expert health and social care professionals, expert patient groups and organisations.

February 2011

Memorandum submitted by Dr A Talbot-Smith (HS 35)

SUMMARY OF SUBMISSION

— The Health and Social Care Bill removes Public Health Expertise from the NHS, reducing the ability of GP consortia to develop and commission cost-effective solutions to local issues.

— The Department of Health’s own impact assessment on the Public Health white paper recognises that moving Public Health into Local Authorities will reduce the cost-effectiveness of NHS commissioning (by removing HealthCare Public Health from NHS Commissioning).

— Where does the specialty of “Healthcare Public Health” figure in these reforms, particularly at a local level.

SUBMISSION

1. HealthCare Public Health is a recognised sub-specialty of Public Health Medicine, and forms one of the three core elements of Public Health Practice as defined by the Faculty of Public Health and outlined in the Public Health White Paper Healthy Lives, Healthy People.1

2. The specialty of HealthCare Public Health constitutes an essential component of NHS commissioning, providing the evidence base on clinical effectiveness and cost-effectiveness for local commissioning decisions, and enabling the development of local solutions to service development and re-configuration.

3. Healthcare Public Health provide the local “grass-roots” advice/input on the clinical effectiveness and cost-effectiveness of interventions and models of care. This advice enables clinicians to develop effective and cost-effective care pathways and commissioning decisions that meet local needs. In my own and many other area’s we work in partnership with GP practice based commissioners, with clear benefits obtained from integrating the evidence base (Public Health) with clinical knowledge (GPs).

4. This is a “bottom-up” relationship, that occurs at the inception of commissioning decisions, and at a very local level in order to be effective.

5. The role of Healthcare Public Health has not been mentioned in any of the recent policies/reform, despite being an integral part of NHS commissioning.

6. The Department of Health’s own impact assessment of the Public Health White Paper recognised that moving Public Health into Local Authorities will reduce the cost-effectiveness of NHS commissioning. This will reduce the ability of the NHS to improve health outcomes, and/or increase the resources required to maintain current population health outcomes.

7. The solutions offered in terms of mitigation are at a very strategic level—“perhaps” through NHS Commissioning Boards or through Health and Well Being Boards.2
8. There is no identification of how the operational “day to day” work undertaken by Consultants in Healthcare Public Health (as opposed to Directors of Public Health) will be formally, and more importantly consistently, provided to GP commissioning consortia at a local level. This activity is vital to ensuring that that evidence base relating to clinical and cost-effective solutions is embedded into NHS commissioning at the inception of decision making.

9. It seems as though national policy, and the DH impact assessment of the Public Health white paper, has been undertaken without a true understanding of the grass-roots, local level, input made by Consultants in Healthcare Public Health to NHS commissioning—and in my own PCT this includes the commissioning undertaken by practice based commissioners.

REFERENCES

Memorandum submitted by Devon Health and Social Care Forum (HS 36)

1. The Devon Health and Social Care Forum comprises entirely volunteers, who give their time to their community voluntarily and without payment. It is, therefore concerned that any social policy should aim to encourage and support volunteering and not deter, let alone alienate, volunteers from coming forward and serving their local and the wider community.

2. In its response to the Government Health White Paper, the Forum drew attention to the fact that neither the existing LINks nor the support organisations, the Hosts, were subject to the Freedom of Information Act. This exclusion of accountability has led to a situation where a Host and LINk together may collect data about Public attitudes and deep concern, say to the reform of maternity services for a community, and transmit that data set to an NHS provider, in this case a Primary Care Trust, which then uses that data set to make certain claims about Public attitudes to proposed service changes, say to an OSC. Neither the Host nor the LINk are willing to release information about the methodology of the data collection, including the instrument or instruments used to collect the data and its scientific rigour, nor the views attributed to the public, on the basis of the data. In a modern democracy this is clearly not acceptable.

2.1 It is thus important that this loophole in accountability and transparency is not continued under Health Watch. It should be a fundamental principle that where responsibility for the disbursement of public money is delegated to another body, be it a charity, a social enterprise, a private business or some other body, it is the logic of a democracy that the organisation concerned should be openly and publicly accountable for the way, in which that money has been spent. Any recalcitrance to be so open and public would need to be subject to a request under the provisions of the Freedom of Information Act.

3. The government is quite rightly proposing that provision of some services under the provisions of the Health Act should be opened up to “any willing provider”. The Forum strongly supports the introduction of greater competition in the provision of health and social care services. The reason is obvious, namely that competition should bring greater value for money and, therefore, lead to the provision of more services for the same quantum of funding. For the reasons given above, however, it is important that those services and the disbursement of public money associated with them are fully open to public scrutiny. This can only happen in the experience of the Forum, if those organisations, be they charities, voluntary bodies, social enterprises or private businesses are also subject to Freedom of Information.

3.1 The Forum is aware of the difficulty associated with the amendment of the Freedom of Information Act, which might be necessary to achieve this goal. In this context it may be of interest to the Committee to examine copy of a letter, which the Forum has received in response to its query of the Minister of Health.

4. In any case by whatever mechanism, the basic principle should be that with the transmission of public funds to any other body should be transmitted a commitment to full openness and accountability for the utilisation of public funds.

February 2011

Memorandum submitted by the London Health Forum (HS 37)

1. The London Health Forum is a coalition between the voluntary and private sectors seeking to promote partnership with the statutory sector to improve the health of Londoners.

2. Summary: The London Health Forum makes the case for the importance of retaining strategic oversight in London.
3. Section 19 confers power on the NHS Commissioning Board to exercise its functions but is silent on how the Board will operate at sub-national level.

4. The Forum wishes to highlight the importance of retaining strategic oversight in London. This may be exercised by the Mayor in relation to public health. The Forum suggests that it is also important for the NHS to maintain pan-London capability where appropriate.

5. London is affected by particular challenges posed by its demography and geography. The provision of high quality care for London’s mobile and hard-to-reach populations such as asylum seekers, homeless people and ex-offenders is vital to reducing health inequalities with knock-on effects in areas like hospital admissions, all requiring strategic leadership across the capital. The most recent data shows 44% of HIV and 38% of TB cases are in London. HIV and TB, along with other infectious diseases, are not contained within borough boundaries given London’s highly mobile population.

6. The importance of strategic oversight is also essential in delivering high quality acute care, illustrated by the reconfiguration of stroke services in London over the last two years. The introduction of a “hub and spokes” model has pooled funding and expertise where it is most needed and brought about large improvements in performance and outcomes.

7. The London trauma system was launched in April 2010 using a similar hub and spokes model. There are four networks in London and each network has one major trauma unit to treat the most critically ill and local trauma units for those in a less critical condition. The mid-year report published in September 2010 reported that since rationalising trauma care there have been an additional 37 survivors within London compared to the expected number of survivors using national data. It is predicted that the new system will save over 100 lives each year.

8. The Forum would welcome clarification about how the Board will maintain strategic capacity across London as part of its duties under Section 19.

February 2011

Memorandum submitted by Network Europe Group (HS 38)

Network Europe Group is delighted to submit this written evidence to the Public Bill Committee as it considers the Health and Social Care Bill. In the submission we set out evidence and arguments to support our contention that:

— the Secretary of State’s proposed duty as to improvement in quality of NHS services should include a recognition of the need to secure an improvement in the quality of NHS Primary Care Telephony;
— the Secretary of State’s Mandate to the NHS Commissioning Board should include a requirement to secure such an improvement; and
— the NHS Outcomes Framework should encourage GPs and other Primary Care professionals to increase the proportion of patients getting through to their local surgery by telephone and thereby continuously improve the quality of telephony services and patient experience patients receive.

WE UNDERSTAND THE IMPORTANCE OF PRIMARY CARE

NEG is the market leader in the provision of enhanced telephony services to NHS Primary Care, and is the preferred choice of the vast majority of GPs and other primary care professionals that use such services. Every month, around five million calls are made by patients to over 1,500 GP and dental surgeries in the UK using our Surgery Line solution.

For most people, most of the time in their lives, NHS Primary Care is their first port of call for healthcare. Vaccinations, check-ups, travel inoculations and advice, parent and baby clinics, prescriptions, dentistry, ante-natal and post-natal care, health visiting—all of these and more are provided every day to millions of patients and their families by NHS Primary Care.

Primary Care is also for most people the “human face” of the NHS. The local GPs, nurses, midwives, dentists and other primary care professionals are embedded in the fabric of their local communities and provide a familiar reassuring face over the years to families and individuals.

It comes as no surprise to us, therefore, that NHS Primary Care plays a central role in the Government’s strategy for the future of the NHS. The Secretary of State has made clear his desire to see a radical shift in power and decision-making away from Whitehall and downwards to GPs and other Primary Care professionals. The Health and Social Care Bill is the legislative vehicle by which this reform is proposed to be enacted.

76 http://www.tht.org.uk/informationresources/factsandstatistics/uk/
Patients are our Number One Concern

We do not believe it is our role to provide a view on the central contention of whether GP Commissioning Groups, Primary Care Trusts or any other arrangement is the most effective or desirable way to commission Primary Care. We are happy to work within whatever commissioning framework Parliament eventually decides should prevail in the NHS. Our sole concern is to ensure that patients are able to access a whole range of Primary Care settings in as modern, efficient and convenient way as possible, no matter what their particular organisational form.

Patients Choose to use the Telephone to Access Primary Care

It is the telephone that most people turn to in the first instance when they wish to use Primary Care. Whether it is ringing up to make an appointment, access basic healthcare, seek reassurance, check what they need to do if their baby or partner falls ill, obtain test results or organise repeat prescriptions, most people use their telephone to do so. More people choose to make a call to their local GP rather than use any other method. They don’t just use the telephone because they have to, but because they want to.

This is borne out by the most recent results of the Department of Health’s GP Patients’ Survey—published shortly after the Coalition Government took office. This showed that when it comes to booking appointments—possibly the most common reason a patient contacts the GP’s surgery:

- the majority prefer to book appointments by telephone (85%);
- 34% prefer to book in person;
- two in five (21%) prefer to book online;
- 1% or fewer would like to book by digital TV or fax machine; and
- 2% say they have no preference or it doesn’t apply to them.

NB The DH Report containing these findings explains that “where results do not sum to 100, this is due to multiple responses or computer rounding.”

Millions of Patients every Month get an Engaged Tone when they try to Contact their GP Practice

The NHS and the Department of Health like to talk of people’s interaction with the NHS in terms of it being a “patient journey”. We would argue that the initial departure point at the start of most patient journeys is picking up the telephone to make a call to the local GP surgery, dentist or other primary care setting.

That is why we feel the need to submit to the Committee evidence derived from our company data suggesting that every month over 20 million patients encounter an engaged tone when they try to contact their GP practice. They are thereby being denied the easy access to local health services which the Government recognises is the top priority for patients.

The facts are:

- every month, over 20 million patients attempting to contact their GP are confronted by the brick wall of an engaged tone—denying them access to local healthcare services and advice; and
- over six million patients encountering an engaged tone are denied access by telephone to Primary Care when they need it most—between 8 am and 10 am.

One of the main reasons GPs and other Primary Care professionals turn to us on behalf of their patients is to resolve the problem of those attempting to get through to the surgery being confronted with an engaged tone. This will be a painfully familiar problem to any patient or Primary Care manager whose local surgery uses a normal landline.

To get an idea of the problem, we often suggest to surgeries considering an enhanced telephony solution that they use a service provided by BT called the Network Call Performance Report. This report, according to BT’s website “reveals the true pattern of your call traffic throughout the day.” The Report includes data on how many callers to a number receive an engaged tone.

Data provided to NEG from our customer base, using this BT service, reveals that a staggering 93% of calls to a typical GP surgery encounter an engaged tone if they use a normal landline without a queuing facility. This means that fewer than one in 10 patients in surgeries using normal landlines get through first time to their doctor when they call.

The pattern analysis provided to GP surgeries by BT suggests that, for patients whose surgeries use normal landlines, whilst 1.6 million calls get through successfully to the local GP first time, over 20 million patient calls each month are confronted by the brick wall of an engaged tone.

By definition, a patient is more likely to encounter an engaged tone when a surgery is at its busiest. However, the pattern of calls received by a typical surgery is so consistent across the country, so marked and so extreme that it means there must be some logical explanation for it.
Just under 33% of all calls made to the GP surgery take place between 8 am and 10 am. This makes perfect sense. These will be people who need to contact the local surgery at this particular time of day:

— before they leave for work and cannot use the phone at work for personal use;
— before they get the children to school, childcare or playgroup;
— because they themselves or a family member have been ill during the night;
— possibly because they have secured advice from NHS Direct during the night and have been advised to contact their GP; or
— in some cases, because the local surgery retains a significant proportion of appointment times for allocation solely on the day of the booking.

This means that, while just over half a million patients get through to their local surgery at the busiest times on normal landlines, over six million patients a month are confronted with an engaged tone when they need help most.

Confronted with the engaged tone at local level, patients are faced with the options of:

— trying an alternative and inappropriate access route, for example dialling 999 or even in some cases getting into the car to drive to the surgery;
— in the future, possibly placing undue and unnecessary stress on the proposed new national 111 number for non-emergency care;
— keeping on trying to get through and possibly being late for work or missing their morning train or lift;
— using an expensive Ringback facility to jump the queue over other callers also trying to get through;
— getting the children to school, childminder or playgroup late;
— deciding not to persevere and, therefore, missing out on getting health advice which they need; or
— giving up trying to get an appointment and possibly missing out on a needed treatment, eg vaccination or health checks.

Whatever option they choose, patients are not receiving the 21st Century high quality care which they deserve. They also are being denied the easy access to local health services which the Government recognises is the top priority for patients.

Enhanced Telephony Increases the Number of Patient Calls Getting through First Time to over 98 out of 100

There are a number of factors and technology options from which surgeries adopting enhanced telephony can choose, including:

— how many lines/extensions to introduce;
— whether to introduce direct dial facilities to enable patients to call the doctor, or health visitor, or practice nurse directly rather than being managed and handled centrally by a surgery switchboard;
— whether to introduce a voice or telephone activated menu of options at the start of a patient call to lower the number of calls requiring the human intervention of a receptionist or surgery call handler; and
— whether to include pre-recorded locally tailored health information, for example about local arrangements for swine flu.

All of the options above can have an effect on the speed and efficiency with which patients experience telephone access to their local surgery—and we strongly believe that it is the local GPs and their practice staff who are best placed to make the decisions on what suits their patients best.

However, there is one overriding choice which makes the most significant difference to whether or not a patient telephoning their surgery—particularly at the busiest time of the day—encounters an engaged tone. This is whether or not to include an automatic call-queuing facility—whereby a patient who otherwise would encounter an engaged tone is placed in an automatic queue which handles each call equally and fairly.

Being placed in a queue is not to everyone’s liking. No solution ever pleases everyone. But we believe it to be infinitely preferable to not being able to get through to the surgery at all. And we believe the facts speak for themselves.

The facts are that compared with 20 million patient calls (93%) getting the engaged tone with a normal landline:

— the percentage of calls encountering the engaged tone falls modestly but not insignificantly to 56.8% if the surgery introduces enhanced telephony incorporating additional lines, but no network queuing function—this still means that less than half of patients get through first time to their doctor when they call; and
the percentage of calls encountering the engaged tone plummets dramatically to 1.2% if the surgery introduces enhanced telephony incorporating network queuing—this means that more than 98 out of 100 patients get through first time to their doctor when they call.

Around five million calls are made by patients to NEG GP sites each month and approximately 23 million calls are made each month to surgeries using normal landlines.

Using these totals, our analysis shows:

— over 20 million patient calls each month using landlines are confronted by the brick wall of an engaged tone when they try to get through to the local surgery and 1.6 million calls get through first time;
— if surgeries adopted enhanced telephony solutions, but no network queuing function, this total would fall to 13 million patient calls each month encountering the engaged tone and 10 million patients getting through first time; and
— if surgeries adopted enhanced telephony solutions with network queuing function, the total would plummet to under 270,000 patient calls each month being confronted by the brick wall of an engaged tone and over 22 million getting through first time.

**Patient Experience and Quality of Service Significantly Increases with the Use of Enhanced Telephony**

The popularity with patients of surgeries using enhanced telephony—and the significant increase in quality of experience, access and service—is further borne out by the GP Patient Survey data.

NEG has carried out an analysis of the GP Patient Survey data, comparing the returns from a cohort of over 750 surgeries using NEG Surgery Line with the Survey’s overall national findings. The NEG surgeries in this cohort serve over three quarters of a million patients.

This analysis confirms that the introduction of enhanced telephony results in transformed access and services for patients and increased patient satisfaction: showing that:

— patients at NEG surgeries using enhanced telephony find it twice as easy to get through to the surgery on the telephone;
— patients at NEG surgeries using enhanced telephony find it more than twice as easy to speak to a doctor on the telephone;
— patients at NEG surgeries using enhanced telephony find it three times as easy to obtain test results on the telephone; and
— more than nine out of 10 patients at NEG surgeries using enhanced telephony obtain test results easily on the telephone, compared with one in three nationally.

**The Secretary of State's Duty as to Improvement in Quality of Services and Mandate to the NHS Commissioning Board should include Improving the Quality of NHS Telephony**

Clause 2 of the Bill is entitled “The Secretary of State’s duty as to improvement in quality of services”. It states:

“The Secretary of State must exercise the functions of the Secretary of State in relation to the health service with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with:

(a) the prevention, diagnosis or treatment of illness, or
(b) the protection or improvement of public health.

In discharging the duty under subsection (1) the Secretary of State must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services.

The outcomes relevant for the purposes of subsection (2) include, in particular, outcomes which show—

(a) the effectiveness of the services, 
(b) the safety of the services, and
(c) the quality of the experience undergone by patients.”

Clause 19 of the Bill concerns the Secretary of State's Mandate to the proposed NHS Commissioning Board

It states: “Before the start of each financial year, the Secretary of State must publish and lay before Parliament a document to be known as ‘the mandate’. The Secretary of State must specify in the mandate the objectives that the Secretary of State considers the Board should seek to achieve in the exercise of its functions during that financial year.”
Given the evidence we have set out above, we would contend that the Secretary of State’s duty must include a recognition of the need to secure an improvement in the quality of NHS Primary Care telephony and that the Secretary of State’s Mandate to the NHS Commissioning Board should include a requirement to secure such an improvement.

A FOCUS ON OUTCOMES IS ESSENTIAL AND TELEPHONY SHOULD BE A MANDATORY ELEMENT IN THE NHS OUTCOMES FRAMEWORK

Clause 19 of the Bill sets out duties on the NHS Commissioning Board which mirror the general duties of the Secretary of State. It states:

“The Board must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with—

(a) the prevention, diagnosis or treatment of illness, or
(b) the protection or improvement of public health.

In discharging its duty under subsection (1), the Board must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services.

The outcomes relevant for the purposes of subsection (2) include, in particular, outcomes which show—

(a) the effectiveness of the services,
(b) the safety of the services, and
(c) the quality of the experience undergone by patients.

In discharging its duty under subsection (1), the Board must have regard to any document published by the Secretary of State for the purposes of this section”

We understand that this Clause provides the mechanism through which the Board can receive its mandate to have regard to the NHS Outcomes Framework.

We are only able to retain our leading market position through constant innovation in the products we provide and the high quality services we enable local GPs and Primary Care professionals to deliver to the local patients they serve.

But we also know, as a successful business in a highly competitive marketplace, that delivering quality and innovation cannot be left to chance. It has to be consciously pursued and visibly demonstrated—not just internally within an organisation, but externally to its customers.

That is why we wholeheartedly endorse the Government’s intention to create a new NHS Outcomes Framework. We recognise that the Government wants its proposed Outcomes Framework to concentrate on outcomes that matter for patients, not simply process measures. However, we strongly contend that the simple ability for a patient to be able to contact their local GP or other Primary Care setting without encountering the engaged tone is a crucial outcome in itself from which all other aspects of patient access, quality of services and experience flow.

February 2011

Memorandum submitted by the Patients Association (HS 39)

The Patients Association (PA) was founded in 1963. We are an independent national charity operating in the UK, which highlights the concerns and needs of patients. Through our Helpline, correspondence and research we learn from patients the key issues that are of concern and work towards improving the healthcare we all receive. Our work includes:

— Campaigns to support Patients’ Rights.
— Lobbying Government to address healthcare issues affecting patients.
— Speaking out for patients and carers.
— Providing information and support to help patients.

The PA accepts the intention of the Governments Health and Social Care Bill is to put the patient at the heart of the NHS and we support the overall principles of a NHS that is led by clinicians with patients at the centre. We welcome initiatives that result in a truly patient centred system of healthcare. We welcome a reduction in bureaucracy if this frees up funding to be reinvested into frontline services. We welcome a focus on patient involvement in services, if this is truly representative of ALL patients.

However, our concerns with the current Bill is that it represents a huge restructure of the NHS that needs to be delivered against a backdrop of £20 billion savings—to be achieved by the NHS by 2014. Not only do we believe this is a near impossible ask of the NHS but it is in danger of having a detrimental effect on patient care and frontline services.
The PA has identified the following main opportunities and concerns regarding the Health and Social Care Bill:

1. **ROLE OF SECRETARY OF STATE (SoS) FOR HEALTH**
   - For the first time, the SoS will publish an annual report regarding the performance of the NHS in England to be laid before Parliament. It may include an assessment on how well the NHS is doing against the outcomes set in the Outcomes Framework. We believe this should be mandatory and not optional.

2. **NHS COMMISSIONING BOARD**
   - The proposed NHS Commissioning Board will be made up of a chair plus five members appointed by the SoS and then the CEO and other member.
   - There are no details regarding the experience of the individuals who should make up this Board. We believe the Board has to include a patient representative/charity representative who can represent the views of the patient.
   - Duties of the Board will include “to reduce inequalities and promote patient involvement”. Given this remit, it is therefore essential that a patient representative has a duty to sit on the Board.
   - Commissioning guidelines will be developed based on the quality standards developed with advice from NICE. However, the quality standards are in their infancy—there only four published to date— and there is a lack of robust evidence to support the role out of these standards for use as a basis for local commissioning guidance.
   - There are also proposals for the Board to host some commissioning networks in agreement with GP consortia, suggested at this stage to be cancer, targeted health services for ill and disabled children, and coronary heart disease. However, there is a lack of clarity as to how it will be determined as to which services will be commissioned nationally and which will fall to GP consortia. If a particularly successful or ambitious consortia wishes to undertake the commissioning of a specific service in their region but other local consortia wish this to fall to the Board, how will this be resolved. The lack of clarity around what services are defined as regional is a concern—this is a really grey area that could mean services fall by the wayside or are poorly commissioned.

3. **GP COMMISSIONING**
   - **Patient-doctor relationship**
     - Patients—who have contacted us through our Helpline, via our Ambassadors network and through a survey we conducted about the White Paper—are concerned that they are going to be referred to services that are most cost-effective as oppose to services that offer the most clinically effective treatment. There is a real danger that the GP and patient relationship will be damaged as a result of this perception.
   - **Expertise**
     - GPs are generalists and we question whether they have the expertise to commission for highly specialist services. Clear pathways and guidance will need to be defined. How can GPs commission services when they may only see two to three patients a year with a rare condition?
     - An example is pain services—every year, over five million people in the United Kingdom develop chronic pain, and of that number only two thirds will recover. Our recent report highlighted that there was not a clear pathway in the NHS for pain services. Without this clearly defined it will make it very difficult for GPs to commission this service.
   - **Patient engagement**
     - We welcome that the consortia have a duty to reduce inequalities and promote patient involvement and enable patients to make choices but this needs further detail—promoting patient involvement could mean simply displaying a comments box at the reception of a GP surgery. There needs to be prescriptive guidelines in place as to how this will be achieved. The Patients Association has contacted all of the initial 52 Pathfinder consortia to ask if they have a Patient and Public Involvement Strategy in place. Preliminary results suggest that out of the 12 consortia that have responded so far, only five have a PPI strategy in place. The Patients Association would be happy to share the more detailed findings with the committee.

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80 Pain: Breaking Through the Barrier; Chief Medical Officer’s Report 2008.
81 The Patients Association, Public Attitudes to Pain, November 2010.
82 Page 30.
— The White Paper suggests that patient participation can be achieved by using Patient Participation Groups (PPG) at individual GP practices. However, a recent survey suggests that only 37% of English practices have a PPG and that this is likely to be an over-estimate as practices with a PPG are more likely to respond to the survey. How can it be expected that consortia will engage with patients if there are no prescriptive guidelines and if the current mechanisms for engagement are not being taken up by 63% of GP practices?

— Patients with long term conditions and those with complex conditions (ie the elderly and those with learning disabilities) are often the heaviest users of the NHS. It is essential that the voices of these patient groups—who are often the hardest to reach groups—are heard by consortia.

Local variability

— Consortium will form based on geographical areas to allow them to jointly commission services with LAs. However, patients may register with a GP practice but live outside the area so how will consortium meet the needs of those patients?

— Decisions on what services and treatments to buy will be made by individual consortium which raises the possibility of increasing variability—one consortium may provide treatment X whereas the one down the road may not. This could lead to patients moving practices to ensure they are within a consortium that provides the treatment/service that they want. Furthermore, patients may be unable to exercise this level of choice and move practices ie due to mobility issues or being based in a location where this is no other choice of GP consortia.

Service structure

— There is a lack of clarity as to what will happen to out of hours services once PCTs are abolished—will this go back to GPs? Moving out of hours services to PCTs created much confusion for patients and moving this back to GPs has the potential to further increase this.

— A GP practice may enter into a commissioning arrangement with a local hospital for the provision of specific services, but under the “Choose and Book” system, a patient may wish to be treated elsewhere. There is a lack of clarity as to how these then opposing priorities of the GP as “commissioner” and the patient as “chooser” will be reconciled. Details are required on how this potential conflict of interest will be addressed—it seems to go against the initiative from the Government on “patient choice”.

— We have heard from our Helpline—from patients and NHS staff—that they are concerned that elective surgical procedures such as hernia surgery and tonsillectomies are being withdrawn from patients. This obviously has a huge impact on patients’ health but also we are concerned as to what this means when GPs are commissioning these services.

— Consortia will have powers to raise additional income and may also be given a bonus in respect of good performance but there is very little detail as to how this will be carried out. We are concerned that GPs will be focused on income generation rather than patient care.

4. ANY WILLING PROVIDER

— Monitor will set prices that are to be used for the payment of health services—there will be a maximum price but flexibility to negotiate below that price. There only needs to be a minimum of two applicants per consortium and there will be no limitations on the size of consortia. But how will smaller consortium compare with large consortium? In a competitive market, smaller consortia will be unable to negotiate provider contracts to the same extent as larger consortia—this may have a detrimental effect on patient services.

— There is also a lack of details around the issue of competition and the promotion of competition. Standards of services, treatments, patient safety and levels of care should drive the commissioning of services and not whichever provider offers the lowers price.

— There are no details on how standards of care and outcomes will be used when making decisions on which provider to use, without this clearly outlined standards of patient care may suffer.

— The NHS is funded by tax payers’ money and it should not be used for profiteering which not only runs against the principles of the NHS but also the emphasis on competition takes away the focus from patient care. Healthcare professionals should be focused on working together to provide the best care for patients and should not be competing with each other in the manner of small business.

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84 Subsection 14B(6) and section 14D.
85 Sections 14S and 14T.
86 Page 26.
87 Clauses 60–62.
88 Clause 63.
— With a move to “any willing provider” there is a real concern that private organisations will cherry pick profitable slices of NHS services—private companies are not going to tender for services that do not have the potential to make a profit. The danger with this is that existing NHS services will be left with reduced budgets, and may be forced to close.

— Promoting competition may mean that consortia purchase services from private providers and not the local hospital. This is of concern as if a hospital loses the tender for a specific service it may have a knock on effect to other areas of care within the hospital. Hospital services do not operate in silos.

— Despite the emphasis on shared decision making, there is a real possibility that the option of “no treatment” may be selected over treatments such as surgery due to costs and despite the patient’s wishes. This of particular concern for the elective surgical procedures that have already been identified as being cut.

— The move of all Acute Trusts to Foundation Trusts is a huge concern. Foundation Trusts operate as small businesses and it is in their interest to attract as many patients as possible. There is a danger that this approach will result in hospitals no longer providing services to the local community but instead trying to attract patients from outside the area to generate as much profit as possible.

— We welcome the increased level of accountability that will be given to governors and directors of Foundation Trusts. There is an explicit duty for governors to hold the board of directors to account and the duty of directors to promote the success of the organisation (similar to the duty imposed on company directors under company law).

— There would no longer be a borrowing code or borrowing limits for Foundation Trusts. The SoS would no longer give financial assistance to Foundation Trusts but would make loans. This is a huge concern, we could end up in a situation where Foundation Trusts are in huge amounts of debts and are unable to provide services due to having to make budget cuts to pay back loans.

— There is no longer a cap on the amount of income a Foundation Trust can earn from private charges otherwise known as the “private patient income cap”. This is alarming—with all Trusts becoming Foundation Trusts by 2013–14 and being under increasing financial pressures, are they going to prioritise fee paying patients over the general public and stop serving the needs of their community?

5. PATIENT INVOLVEMENT

— The Bill will place a duty on the Board and GP consortia to promote the involvement of patients and their carers and to enable patients to make choices about their healthcare.

— Although the Board will have a duty to issue guidance on commissioning to GP consortia, it only state that this “could include guidance about how to fulfil their duties in relation to public and patient involvement”. So as it currently stands the Board does not have to advise consortia on how to go about Patient and Public Involvement. As stated previously, our preliminary research suggests that there is variation regarding the number of GP consortia that have a patient engagement strategy in place. GPs need clear guidance from the Board regarding how to involve patients at their consortia.

— We welcome legislation changes that will strengthen the arrangements for the Ombudsman to share more widely investigation reports and complaints information.

6. HEALTHWATCH

Local Healthwatch will cover the area of the local authority. This is of concern as some consortia will cross local authority boundaries so how is it decided which Local Healthwatch scrutinizes them?

— Of particular note in the Bill is that each local authority must make “arrangements as it considers appropriate for the provision of assistance to individuals in connection with complaints”. This is of great concern as “considers appropriate” will be interpreted differently by local authorities—support could be withdrawn after a matter of months even though we hear of complaints that can take years to get through the system.

— Mental health advocacy would not be a part of the NHS complaints advocacy services that Las will be able to commission from Healthwatch. Who will do mental health advocacy? There are no details on who will fulfill this function.

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89 Clauses 136 to 141.
90 Clause 150.
91 Part 5 of the Bill.
92 Clause 185.
93 Page 140.
94 Page 143.
Local authorities will be responsible for the performance of Local Healthwatch as the commissioners of this service. It will be the local authority’s responsibility to performance manage Local Healthwatch. There will be no nationally driven performance management of Local Healthwatch. How will consistent standards between Local Healthwatch be monitored?

Funding for Local Healthwatch will NOT be ring fenced—this is of real concern as with constraints on local authority budgets the funding could be directed elsewhere.

There is no advertising budget for Healthwatch. The majority of people have never heard of LINks—with no budget for advertising Local Healthwatch how will they be signposted to this?

We are aware that LINks are not subject to Freedom of Information (FOI) requests and we understand that this will also be the case with Local Healthwatch. However, we believe that as Local Healthwatch will be commissioned by local authorities and therefore be spending public money it should be accountable to the public for the way in which it has dispersed funds. The Bill has a focus on transparency but the inability to FOI Local Healthwatch runs counter to this principle.

There will need to be consistent branding between the Local Healthwatch organisations which will also need to comply with Healthwatch England. Also, how will local authorities signpost patients to Local Healthwatch and, if Local Healthwatch is not carrying out the advocacy function, there will need to be clear signposting to the organisation that is.

We are concerned that there is an expectation there will be a free transfer from personnel in LINks to local HealthWatch. But we hear from patients phoning our Helpline that the local LINks are not working and that the service they are providing is substandard. A free transfer of personnel is therefore not welcomed by the Patients Association. This is supported by a study from the Picker Institute and Kings Fund that suggests that in the main, LINKs have struggled to have any impact on patient involvement in general practice.

7. Integration of Services

For patients with complex needs and those with long-term conditions there needs to be real joined up planning between health and social care. Moving health care and social care to fall under the remit of local authorities has potential to do this but we are concerned that Local Authorities do not have the expertise or capacity to manage the local health budget and also that there is a real danger that health services may fall foul of local budgetary cuts.

All upper-tier local authority will establish a Health and Wellbeing Board and this will need to consist of:

- one councillor of the local authority;
- the director of adult social services for the local authority;
- the director of children’s services for the local authority;
- the director of public health for the local authority;
- a representative of the Local Healthwatch Organisation; and
- a representative of each relevant commissioning consortium.

We would like to make sure that a patient representative and/or a representative from local charity/voluntary organisations sit on the Health and Wellbeing Boards. We believe this is essential if the voice of patients is to be heard at the local level and have their needs met.

February 2011

Memorandum submitted by Michele Bohan (HS 40)

1. £20 billion in cuts is already causing rationing in the NHS—the Health and Social Care Bill will lead to further chronic cuts with potentially fatal consequences

Mr Cameron claims his reforms are not about “cutting services” but about increasing “choice” for patients. Not so. Patients will have “no choice” when rationing and frontline services are already being cut. Can the Committee explain why patients (who will drive these reforms according to Mr Cameron) have not been consulted on them?

Frances Hasler, Healthwatch Development Lead, presentation to the Patients Association, 6 January 2011.

A recent government directive has stated that: “operations which will only be carried out in exceptional circumstances include, removing tonsils, varicose veins, hysterectomies, fitting grommets, removing skin lesions, haemorrhoid surgery, wisdom teeth extraction, cataracts and joint replacements sic”. In Total 57 different procedures will only be carried out “in exceptional circumstances.” However many of these so called “minor procedures” can often mask or lead to serious, sometimes fatal conditions if left untreated, including “Peritonsillar abscess or tonsillar cancer. Skin lesions can become malignant and cancerous. Untreated cataracts can lead to blindness, yet these cuts are already being implemented in many areas of the country. So the coalition is denying patients treatments that could lead to chronic and potentially life-threatening conditions.

It has also also been stated that elective operations (including cardiac, vascular, and orthopaedic procedures) with an 80% success rate will be categorised as “of no clinical value” and will be stopped! Perhaps the Committee might want to ask the millions of patients with debilitating conditions like angina whether an “angioplasty” (one of the elective procedures at risk!) is “of no clinical value” to them and their quality of life! Not only can an angioplasty restore a patient’s quality of life (as well as their economic contribution!), but without intervention their condition will invariably deteriorate and become acute or even fatal—and will cost far more to treat in the long-term.

Can the Committee justify to long-suffering patients here in the real world,(far removed from the privileged, Palace of Westminster) why they are being refused operations which can not only clinically restore their “health and quality of life but often prevent their condition deteriorating further (thereby requiring major surgery at huge cost to the NHS)!

How is this right, compassionate or fair? The cuts proposed in the Health and Social Care Bill are wrong, uncaring, and unfair and give patients “no choice” whatsoever in how they are treated. Can patients “choose” operations/treatments that the coalition have scrapped? What right has the coalition to decide which operations/treatments are “of no clinical value” to patients?

The rationing of even minor operations can be debilitating for patients, put their lives at risk, and cost the NHS far more money to treat in the long run. This issue needs to be looked at and amended.

2. Why is £80 billion pounds of public money to be handed over to GPs with no experience of commissioning health services and why are GP’s to be awarded cash bonuses for running the consortia!

Handing the bulk of NHS spending to GP’s who are trained in medicine not business (and who are “general practitioners” not specialist, experienced consultants and surgeons) is a potential disaster which will increase rather than decrease health spending. Administration costs will simply be shifted from the PCT’s (due to be abolished) to the new GP consortia who will hire in private sector consultants and advisors to add another level of bureaucracy! GP’s are also to be given “performance bonuses” for running the consortia and will be allowed to set the payscale of their CEO’s and Directors—which could result in boardroom salaries of £250,000–£500,000! So money that should be spent on patient care will go straight into the pockets of GP’S! If the GP consortias run out of money, the Government claim they will not be bailed out and will be allowed to fail!

So apart from the inherent risk of a “postcode lottery” resulting from 500 GP consortia all being free to set their own priorities for the healthcare they commission, patients will find that the care they receive will depend not on their “clinical need” but on the financial success of their GP consortia. Also, if GP’s are going to be engaged in running multimillion pound empires—when will they actually see their patients which is what they are paid to do? There are rumours that patients will soon have to ring a call-centre to book a GP appointment—how long before the call centre will be moved to India and the GP consortia to an oversease tax haven? These reforms will destroy the relationship between GP’s and their patients or “customers” as they will soon be called! If GP’s spend all their budget (on bonuses and private advisors)—patients requiring hospital treatment will be told “sorry, but you’ll have to wait until the next financial year”—resulting in prolonged pain and misery and a decreased quality of life.

Can the Committee explain how handing the bulk of the Health budget to GP’s as well as huge performance bonuses (for doing a job they have chosen to do!)—then allowing them to go bust if they run out of money—is going to enhance patient “choice”, improve our “quality of care” and provide a better deal for the taxpayer?

Can you also advise what will happen if and when GP Consortias do fail? What will happen when sick and vulnerable patients need treatment but there is no money left? What will the Coalition do then, stand aside and allow people to die? We need to know because these are your policies and you will be held responsible. What controls will be put in place to stop GP consortia squandering public money on themselves and their bonuses rather than patient care? This issue needs amending to prevent this happening.
3. Why are private health firms to be paid 14% more for providing services to the NHS despite the danger to the equity, value and quality of care to patients posed by profit-led companies?

Under this Bill, “AWP’s” — “Any Willing Provider” from Europe and beyond will be free to bid for and run services in this country and are to be paid 14% more for their services — Why? Unknown, untested, companies with possibly unqualified, untrained, staff will be free to cherry-pick the less complex (more profitable) patients. There is a huge risk to patient care posed by unregistered companies motivated by profit with no evidence of the quality of their services and their clinical outcomes? The quality of work done in private treatment centres with NHS contracts has been criticised by NHS surgeons and the cost to the taxpayer is much more!

FACT

My sister was referred by her GP to a Private Sector Provider in Manchester for minor “keyhole surgery” on her knee. She was coaxed with claims of no waiting time, simple day-case procedure, carried out at a local private hospital by a reputable surgeon. She was left crippled, in constant pain and on morphine as a result of her “private” operation! She had to be re-referred to an Orthopaedic Surgeon at the Manchester Royal Infirmary and is now on the waiting list for a full knee replacement as a result of her botched keyhole surgery! How is this an example of “better patient care” and a “better deal for the taxpayer”? How many other “second rate” private sector procedures are having to be put right by qualified, reputable NHS surgeons up and down the country? How much is this reparative surgery costing the NHS? Perhaps the Committee could find out?

I also enclose for your information some articles about two private sector companies: “Manchester Cats” and “Netcare” — both of whom were paid huge amounts of public money upfront for services they failed to provide— because patients didn’t want to use them!

Can the Committee explain exactly how this is an example of both “competition improving services” and “good value” for the taxpayer when Private Companies are being paid over the odds for services they don’t provide, courtesy of the public purse?

What measures will be taken to ensure that the quality of care to patients is not jeopardised by unchartered independent providers trying to undercut local hospital with “cut-price” substandard treatment? These companies must never be paid more money for their services!

Will these companies have to operate under the same stringent “Clinical Governance” guidelines as the NHS? How will data on their training, treatments, clinical practices and clinical outcomes be gathered to ensure quality of care? Will patients be able to access this information in order to decide whether they wish to be referred to one of these services? Will GP’s be coerced into using “AWP’s” at the expense of their local hospitals to satisfy the “market competition” criteria? This issue needs scrutinising and amending.

4. Who will regulate these Private Sector Businesses and Advisers and oversee their business practices?

Who is going to be responsible for vetting these “AWP’s” and holding them to account in order to protect the interests of patients and the NHS itself? How are we to prevent unscrupulous companies like United Healthcare (an American firm bidding to run services here) — which has been fined millions of pounds over a number of years for defrauding the American healthcare system doing the same thing here in the UK? Their offences involved “cheating patients out of money”, “denying treatment” and “overcharging”! Should firms like this be even be allowed to operate in this country, let alone be allowed anywhere near the NHS budget?

What policing and vetting procedures will be put in place to prevent fraud and abuse by Private Sector Companies. This is a hugely important issue that could have devastating consequences for the safety of patients, the NHS itself and the public purse? There needs to be stringent monitoring of these companies, the quality of their services and the price of their services.

5. Who will be held to account when it all goes wrong?

What happens when the governing bodies have all gone? When the Strategic Health Authorities, the PCT’s, NICE are all abolished? Who will be overseeing and taking responsibility for this new NHS? Who will be held to account when the GP consortias run out of money and fail, when waiting lists are growing, when operations are being cancelled, when treatment is denied, when medication is withdrawn, when services are cut, when frontline staff are axed, when hospitals are closed, when patients suffer and patients die?

The Coalition Government (unelected and with no mandate) will be held responsible by the British Public and will pay the price for this ill-conceived, ideologically driven, destruction of the NHS. Mr Cameron claims that “patients will drive the reforms” yet we have not been consulted, why? The Coalition government is gambling with the NHS and gambling with our lives— surely we have the right to have our say?

The Committee must consider the implications of these reforms and how each and every one of us will be affected by them. Amendments to the Bill need to be made to protect the quality of care patients receive and to ensure that rationing of operations which can cure conditions and restore a patient’s quality of life is
stopped! GPs should not be paid bonuses, nor profit from public money that should be spent on patient care. Private companies need rigorous policing to protect patients and to ensure the highest quality of care and they must never be paid more for services they provide to the NHS.

February 2011

Memorandum submitted by the Royal College of Midwives (HS 41)

1. England has a shortage of midwives. The country needs the equivalent of an extra 4,700 full-time midwives, according to estimates using the independent Birthrate Plus midwifery workforce planning model; these are needed to give women the birth experience they want and deserve from the NHS. Last year David Cameron pledged to recruit 3,000 additional midwives. Since then the Government has produced the Health and Social Care Bill that places responsibility for workforce planning firmly in the hands of local health economies. In the absence of a national standard for maternity care provision, mothers will inevitably be faced with a “postcode lottery” in respect of the quality of midwifery care they receive.

2. The Royal College of Midwives (RCM), which represents over 39,000 midwives across the UK, believes that the NHS needs a period of structural calm, not least so it can deliver on the requirement to achieve significant financial efficiencies over the next few years. This bill, sadly, is set to deliver the opposite: a prolonged period of massive, profound and expensive upheaval.

3. Despite these and other concerns, we do see opportunities in the bill to drive improvements in healthcare. The focus of this briefing, for the public bill committee stage, is therefore on the areas where we see those opportunities.

Government Approach to Maternity Care

4. The Government has indicated that Maternity Matters (the comprehensive strategy for NHS maternity services in England, published by the last Government in 2007) is no longer government policy. That is unfortunate as that policy brought together all parts of the NHS and the public sector with a role to play in improving maternity care.

5. According to the NHS White Paper, published last summer, the only official policy of the current government is choice over where to give birth. We would like to see this assessment of Government policy on maternity care tested during the Public Bill Committee stage of the bill.

Opportunities for Improving Care

6. Whilst it is true that the RCM would prefer not to see the NHS reorganised in such a profound manner at this time, we do see some opportunities and potential within the planned changes for levers to drive improvements in maternity care.

7. The bill does create some new levers open to ministers to pull in an attempt to improve care: these levers include the standing rules (Clause 16), the mandate (Clause 19), and NICE quality standards (Clause 218).

Clause 16: The Standing Rules

8. The standing rules will enable the Secretary of State to impose rules on the NHS Commissioning Board and the GP-led consortia over how they carry out their work. By using these rules it may be possible to ensure that the Government’s commitment, made in its White Paper (Equity and Excellence: Liberating the NHS), to choice for women over the maternity care they receive—to include, for example, birth at home or in a midwife-led unit—is commissioned by all local consortia.

Clause 19: The Mandate

9. The Secretary of State will be required to publish and lay before Parliament an annual mandate, setting out what s/he wants the NHS Commissioning Board to achieve in the coming year. Extra leverage is provided by Clause 104(9), which would require Monitor to consider this when setting tariffs.

10. Specific priorities could be included in the mandate, and the RCM would like to see improvements in maternity care and guidance on how the policy of choice in maternity care can be achieved in the initial and subsequent editions.

Clause 218: NICE Quality Standards

11. Clause 218 enables the Secretary of State or the NHS Commissioning Board to commission NICE to develop quality standards, which can help drive improvements in care. The RCM welcomes this, and would support the development of standards on maternity-related care to be commissioned at the earliest opportunity.
12. Those are the three levers—the standing rules, the mandate, and the NICE quality standards—that we see as key to achieving a step change in quality improvements in maternity care. Nonetheless, there are other aspects of the bill that we would like to see clarified with respect to their potential effect on maternity care.

Clause 136

13. This Clause makes small changes to arrangements for foundation trusts’ boards of governors—to be renamed, councils of governors—and leaves in place the legal requirement in the National Health Service Act 2006 for at least three members of a foundation trust’s board of governors to be members of staff.

14. The RCM supports the retention of rules on the representation of staff on what are set to become councils of governors, but we believe that in the interests of engaging staff in the running of foundation trusts and potentially encouraging interest in establishing social enterprises, the minimum staff representation should be raised.

Clauses 242 and 243: Health and Social Care Information Centre

15. Fundamental to improving care and making choices about care is information. The RCM is therefore supportive of Clause 242, which will empower the Health and Social Care Information Centre to obtain information on clinical performance from any healthcare provider, including private providers. Clause 243, ensures the default position is that this information is made publicly available. This is very much welcomed by the RCM.

Clause 166 and Schedule 13: Healthwatch

16. Healthwatch England (established as a statutory committee of the Care Quality Commission (CQC) by Clause 166) and Local Healthwatch organisations (detailed in Schedule 13) offer a new opportunity for patients to have a meaningful role in addressing problems within the NHS.

17. Indeed, the Explanatory Notes accompanying the bill cite maternity services as an area of NHS care that could come under the spotlight of both the Healthwatch national committee and also the local organisations; we hope that there will be scope for the CQC or others to task Healthwatch at all levels to examine clinical performance in maternity services.

18. Many trusts have Maternity Services Liaison Committees (MSLCs), which bring into decision-making the voice of the women who have used local maternity care. The RCM believes that Local Healthwatch organisations should be actively encouraged to engage closely with these valuable groups, ideally embedding them in the systems established to generate feedback from service users.

February 2011

Memorandum submitted by the Royal College of Surgeons (HS 42)

Introduction

This briefing document follows the evidence that Mr John Black, President, the Royal College of Surgeons’ gave to the Health and Social Care Bill Committee on 10 February. It covers the items of legislation which are relevant to NHS surgical services and patients. It suggests amendments to certain clauses of the Bill to take into account our views and those shared by other Royal Medical Colleges.

National Commissioning Board Representation

Given the overarching powers of the NHS Commissioning Board to oversee commissioning in the NHS, the RCS is surprised and concerned that there is no requirement for clinical representation on the Board. In view of the Secretary of State’s repeated reassurances that the NHS will be clinician led, this is a fundamental flaw. Therefore the RCS believes that the involvement of practising clinicians, particularly those in hospital-based care, is necessary and would strengthen the effectiveness of this section of the legislation. We suggest that the following clause is amended to reflect this:

Clause 19: subsection 13G—“Duty to obtain appropriate advice”

The Board must make arrangements with a view to securing that it obtains advice appropriate for enabling it effectively to discharge its functions from (practising clinicians and other appropriate) persons with professional expertise relating to the physical or mental health of individuals.

Furthermore to ensure the duty to take on advice from practising clinicians is upheld through all the activities of the NHS Commissioning Board, the Board should be required to report how this has been achieved through its annual report (Clause 19; subsection 13P). We propose that the following clause is amended to reflect this:
Clause 19; subsection 13P—“annual report”

Paragraph 2

The annual report must, in particular, contain an assessment of:

(a) the extent to which it met any objectives or requirements specified in the mandate for that year,
(b) the extent to which it gave effect to the proposals for that year in its business plan,
(c) how effectively it discharged its duties under sections 13D and 13L; and
(d) (the extent to which it obtained and used advice from practicing clinicians to effectively fulfil its functions).

COMMISSIONING OF REGIONAL SERVICES

We remain concerned about the commissioning of regional services, such as trauma, children’s surgery and acute emergency surgical services. We would like to see a defined regional role for the NHS Commissioning Board in order that regional based commissioning is not lost entirely, as it is the appropriate model for many services, with collaboration and coordination across a wide geographical area.

We would suggest the following clause is added to the general duties of the Board, to ensure that consortium work together to commission services that can only be delivered at a regional basis:

14A General duties of Board in relation to commissioning consortia

(8) The Board must ensure that consortia work together to commission services that can only be delivered at a regional basis, taking advice from practising clinicians

CONSORTIA SEEKING CLINICAL ADVICE

Given the responsibilities of commissioning consortia (Clause 14A), we are concerned that there is no mention of engagement between these consortia and their respective local hospital-based clinicians, including surgeons. Specifically there is no mention of a minimum level of engagement, which would act as a key safeguard for the standards of patient care.

Therefore we would suggest the following clause is added to clause 14A:

14A General duties of Board in relation to commissioning consortia

(9) The Board must ensure that consortium engage with practising clinicians to obtain and use advice when commissioning services for patients

COMPETITION REQUIREMENTS

The RCS is concerned by the lack of detail on competition (Clauses 60–62) and the promotion of competition (Clause 63). We believe that a defined standard of treatment and care should drive commissioning and not the lowest price. Without detailed information on how standards of care and outcome requirements are incorporated into the decision-making process for tendering services, the RCS is concerned that standards of patient care may be compromised. We therefore suggest the following amendment to clause 63 to ensure that there is a level playing field:

63 Requirements as to good procurement practice, etc

(1) (d) ensure that all providers have a duty to provide training and education, participate in audit, research and the measurement of outcomes and have the capacity to deal with all aspects of care of the patient, both elective and emergency.

February 2011

Memorandum submitted by Moira Gommon (HS 43)

BACKGROUND

(a) I have recently retired from the NHS where I worked as a CAMHS (Child and Adolescent Mental Health Services) Therapist.
(b) I am the mother of a child who, before his death age 10, received a great deal of treatment from the NHS due to his having a degenerative brain condition and not fully controlled epilepsy.
(c) I am the wife of a man who last January was diagnosed with pancreatic cancer and who underwent a very successful eight hour whipple section operation at the Royal Liverpool Hospital and who has now completed a course of chemotherapy.
(d) I am part of a campaigning group on Merseyside “Defend Our NHS”.

Background
EVIDENCE

I am concerned that moving commissioning from PCTs to GP Consortia and stating that new contracts will be put out to competitive tendering will mean that all new contracts will be subject to European competition laws and could result in private health care companies from Europe, the US or elsewhere, both actually running some GP consortia and some services. I do not feel that sits well with the government’s “Localism” policy.

I am concerned about the lack of accountability to local people and to patients of the proposed GP Consortia and of any services run by private health care companies. Local representatives do need to be on the management boards of these companies and GP consortia.

I am concerned that those with mental health issues and long term chronic conditions, such as those suffered by my son, will not be financially attractive areas of activity to private health care providers and so will be come even more Cinderella services. Private firms will be able to “cherry pick” leaving these complex or unpopular areas to a shrinking NHS.

I am concerned that these reforms will break up the NHS services and lead the way to privatisation. In this case private companies will be running services for profit and not for the benefit of all patients.

I am concerned that the reforms will result in people having to travel to get the treatment they need, which may be OK for those with good salaries, but not for those who are poor and vulnerable, or for those wanting to visit friends and family.

I think that the problems within the NHS should be sorted out within the current structure. Moving from PCTs to GP consortia will be very expensive. This is unforgivable at a time of such ferocious cuts. There is no guarantee that GP consortia will be any better at managing their contracts than PCTs. Many, including me, feel that they will be worse.

I cannot see how having more GP consortia that there were PCTs will save money. I think this will increase bureaucracy and administration costs.

February 2011

Memorandum submitted by Dr Philip Howard (HS 44)

SUMMARY

1. There are currently well over one million adults with mental incapacity in the UK. The medical and nursing care of these individuals may prove difficult. Disagreements not uncommonly arise between the carers and relatives of adults lacking mental capacity regarding both medical treatment and placement. Resolution of such disputes is often costly, time-consuming and adversarial. Above all current complaints procedures apply retrospectively so that the incapacitated person’s condition and circumstances cannot be improved. Dispute resolution should include contemporaneous independent medical mediation in order to resolve the issues to the benefit of the patient at the material time. The Health and Social Care Bill accommodates improved complaints procedures and advocacy services but does not include medical mediation.

2. Relatives and carers of those who lack capacity often find that decisions are made by those in “authority” on their behalf. In the case of many adults and most patients with learning difficulty, powers of attorney have not been obtained or conferred on relatives or the primary carers. The system of applying for court appointed deputyship should be simplified. There should be a legal presumption that longstanding relatives and carers, who can demonstrate their prior responsibilities in caring for those that lack capacity, should be made court appointed deputies.

3. I have illustrated the need for independent medical mediation and a simplified application system to become a court appointed deputy by reference to the care and placement of a young man (“Sam”) with profound learning difficulty and very serious mental and physical disability who has been largely cared for by his mother. The mother has given her written permission for disclosure of information and has given details of her problems to Mr Tom Brake MP and Mr Paul Burstow, Minister for Health and Social Care.

INTRODUCTION

4. I have been a consultant physician in General Medicine and Gastroenterology and Senior Lecturer in Medicine for 18 years. I have a LLM degree from Cardiff University in Medical Law and am the principal co-author of an undergraduate textbook entitled Medical Law and Ethics Blackwells 2006. I have both an academic and clinical interest in mental incapacity legislation. I presented evidence to the Scottish Parliament during the passage of the Adults with Incapacity (Scotland) Bill in November 1999 and to the Joint Scrutiny Committee in the case of the Mental Capacity Bill in October 2004 and the Mental Health Bill in 2009. I have acted as an expert witness in the Coroner’s Court, High Court, Judicial Reviews and in the Appeal Court in the case of Burke in 2005.
5. My submission is concerned with the resolution of disputes and disagreements regarding the care and management of patients with mental incapacity arising from either learning disability or an acquired condition such as dementia. There are said to be between 200 and 400 thousand patients with learning disability in the UK. According to the Alzheimer’s Society, there are already more than 750,000 people in the UK suffering from dementia. Those with mental incapacity are disproportionately represented amongst hospital patients.

6. This submission will therefore focus on two separate but related issues concerned with the difficulties faced by the carers and relatives of those who lack mental capacity to make decisions for themselves.

7. These issues relate to what I shall describe as independent medical mediation and the need to facilitate the appointment of the primary carer as a court appointed deputy.

Medical Mediation

8. I shall begin by illustrating the need for medical mediation with reference to a case. The first involves a 22 year old man with profound learning disability called “Sam”. His mother has given written permission for his details to be described, though I shall not reveal his exact identity.

Case history
Sam’s story

9. Sam suffers from an extremely rare neurodegenerative disorder which will ultimately prove fatal. He cannot speak and is tube fed. He suffers from behavioural disturbances, especially when he is ill or his mother is under stress. He also has both real epileptic fits and “pseudo” seizures which can be difficult to distinguish from true epilepsy and behaviour disturbance. He is totally dependent on his mother for his personal needs. He lives with her and his younger brother and sister.

10. Sam’s mother looks after him on a 24 hour basis and sleeps in his room. He is at risk of epilepsy, aspiration pneumonia, epileptic fits and pressure sores as well as unintended self harm. He can barely walk with assistance and is at risk of falls. He tends to be overactive. In the final stages of his disease his over activity will turn to increasing apathy and he will eventually die of his condition. Sam is terminally ill.

11. His mother has been troubled by neighbours and had to move house last year because of what she perceived as harassment. She does not rely for assistance on social services or district nurses and provides all Sam’s personal and nursing care needs herself on a round the clock basis. In the last four years he has been admitted to hospital only twice, and then only for a day at his mother’s insistence. Her care has been heroic and the attention given by his younger brother and sister has been remarkable.

12. Since contacting her constituency MP in mid December and the involvement of Mr Paul Burstow, her circumstances have been considerably improved and she plans to move to more suitable accommodation in the beginning of March.

Background

13. Under the Mental Capacity Act 2005 (MCA), where adult patients lack capacity, decisions may be made in their “best interests” regarding medical treatment and care. Deprivation of liberty safeguards (DOLS) may be instituted if decisions regarding placement need to be made in order to provide treatment or care.

14. Disagreements regarding medical treatment and placement may arise between the family, friends or carers of those who lack capacity and those who have legal responsibility for their care. This may be particularly the case with end-of-life decision making, decisions regarding life sustaining treatment and “do not resuscitate orders” as outlined in the GMC document Treatment and care towards the end of life: good practice in decision making July 2010.

15. Under the Adults with Incapacity (Scotland) Act 2000, there is statutory provision for a second opinion procedure. Where there is a disagreement regarding the treatment of an incapacitated person between the doctor and welfare attorney, the medical practitioner may request the Mental Welfare Commission to nominate a medical practitioner (the “nominated medical practitioner”) from the list established and maintained by them to give an opinion as to the medical treatment proposed. No such provisions apply under the Mental Capacity Act 2005.

16. In the case of those with learning disability who have become adult at the age of 18 years, parental responsibilities remain but the legal responsibility for treatment changes. It is not possible for the person with learning disability to confer powers of attorney so that another person can make decisions on their behalf. Hence, Sam’s mother, having had parental responsibility up to his 18th Birthday cannot obtain from him powers of attorney and currently finds the process for applying for court appointed deputyship cumbersome. Furthermore she is concerned that powers could be conferred on a representative of the local authority.
17. Similar problems may arise for adult with acquired cognitive impairment eg due to dementia. Relatives and carers may wish to be involved in treatment and placement decisions. For example, relatives may wish to continue to look after an incapacitated person at home. Disagreements may arise concerning the appropriateness of such arrangements and deprivation of liberty safeguards (DOLS) may be instituted by the relevant authority to effectively enforce placement in the individual’s best interests for care or treatment. Relatives may complain about the quality of treatment and care to the incapacitated patient.

GMC, BMA AND GOVERNMENT RECOMMENDATIONS

18. The GMC recommends that where disagreements arise between relatives and those caring for patients who lack mental capacity an independent advocate should be involved. Whilst there are mental health advocates under the Mental Health Act 1983, independent medical mediation is not yet available under the Mental Capacity Act 2005.

19. In 2008 the BMA recommended mediation when other means had failed.

“Where the methods outlined above do not successfully resolve the dispute, it may be good to involve a mediator. Any dispute that is likely to be settled by negotiation is probably suitable for mediation. A mediator is an independent facilitator. It is not the role of a mediator to make decisions or to impose solutions. The mediator will seek to facilitate a decision that is acceptable to all parties in the dispute”.


20. In the White Paper Equity and Excellence: Liberating the NHS (para 2.24), it was proposed to set up a patients’ complaints system which included advocacy. A complaints and advocacy service was to be the responsibility of Health Watch. However, the White paper did not specify how this service would apply to the relatives and carers of incapacitated patients who were concerned about their care or treatment or placement decisions.

“2.24 We will strengthen the collective voice of patients, and we will bring forward provisions in the forthcoming Health Bill to create HealthWatch England, a new independent consumer champion within the Care Quality Commission. Local Involvement Networks (LINks) will become the local HealthWatch, creating a strong local infrastructure, and we will enhance the role of local authorities in promoting choice and complaints advocacy, through the HealthWatch arrangements they commission.”

COSTS OF LITIGATION.

21. The costs of litigation are rising. In 2001 the National Health Service was facing a clinical negligence bill of nearly £4 billion, equivalent to about 10% of England’s annual health care budget. The anticipated bill for actual and anticipated claims had risen sevenfold in five years. According to the NHSLLA Annual Report in 2009–10 £296.59 million were paid out in damages, excluding £121.48 million in claimant legal costs and £42.23 million in defence costs.

DISADVANTAGES OF CURRENT SYSTEM OF COMPLAINTS/DISPUTE MANAGEMENT

22. The costs, time and emotional investment in complaints are excessive for both the claimants and health care professionals. The current system of investigation into complaints are retrospective and ineffective in obtaining satisfactory solutions as the complaints system focuses on problems that have occurred in the past—and often up to years previously. Complaints often arise when there has been a significant or irretrievable breakdown of communication and trust between relatives and/or patients and health care professionals. The current system of investigation into complaints are retrospective and ineffective in obtaining satisfactory solutions as the complaints system focuses on problems that have occurred in the past—and often up to years previously. Complaints often arise when there has been a significant or irretrievable breakdown of communication and trust between relatives and/or patients and health care professionals. In Scotland, the Mulcahy Report on the NHS Mediation Pilot reported that a 70% sample of claimants were totally or very dissatisfied with the normal claims process, even where compensation was awarded.

97 You should aim to reach a consensus about what treatment and care would be of overall benefit to a patient who lacks capacity. Disagreements may arise between you and those close to the patient, or between you and members of the healthcare team, or between the healthcare team and those close to the patient. Depending on the seriousness of any disagreement, it is usually possible to resolve it, for example, by involving an independent advocate, seeking advice from a more experienced colleague, obtaining a second opinion, holding a case conference, or using local mediation services. In working towards a consensus, you should take into account the different decision-making roles and authority of those you consult, and the legal framework for resolving disagreements.

98 If, having taken these steps, there is still significant disagreement, you should seek legal advice on applying to the appropriate statutory body for review (Scotland) or appropriate court for an independent ruling. The patient, those authorised to act for them and those close to them should be informed, as early as possible, of any decision to start such proceedings, so that they have the opportunity to participate or be represented.

99 From April 2009, statutory access to an Independent Mental Health Advocate (IMHA) has been available to patients subject to certain aspects of the Mental Health Act 1983. IMHAs exist to help and support patients to understand and exercise their legal rights. IMHAs are available to most detained patients as well as patients on supervised community treatment or guardianship. Other patients whose treatment is subject to the special safeguards provided by the Act are also eligible for the services of IMHAs.

100 http://www.bma.org.uk/images/MentalCapacityToolKit July2008_tcm41-175571.pdf

23. The importance of non-monetary benefits such as apology, explanation and reassurance of changes in procedure, together with the opportunity for patients, relatives and clinicians alike to be heard informally and privately, are all substantiated, as is the possibility of creative outcomes. Often relatives, friends and family are in a state of shock and cannot always determine the issues with detachment.

**Proposal: Independent Medical Mediation (IMM)**

24. Currently, second medical opinions may not always be truly independent but may simply back up the views of the supervising clinicians. Therefore, where there are disputes between the relatives and carers of those with incapacity and their medical attendants should be a system of independent medical mediation (IMM). Where disputes or disagreements arise between relatives or carers and healthcare professionals, an IMM could be called in a timely fashion to try and mediate between the parties.

25. The independent medical mediator ought normally to be someone who is not directly involved in the patient’s care. Independent means that (s)he would be acceptable to the relatives or carers who were disagreeing with the decisions of healthcare professionals or social services. The mediator should be medically qualified but not necessarily a Consultant. Indeed, it could be that an experienced General Practitioner would have a good overall perspective of the patient’s circumstances, including the social care needs.

**Advantages of IMM**

26. It would allow an independent medical opinion to review the situation. The emphasis would be on obtaining a satisfactory outcome for the patient and would hopefully mean that the misunderstandings between the disputants would become a secondary consideration, or preferably not be considered at all in the interests of the patient. Current complaints systems are adversarial and often aggravated by the time taken to resolve the issues and the increasingly ingrained feelings of hostility and frustration that can arise. Moreover, it may be difficult for a relative to complain about the very people who are responsible for the care of the incapacitated person and the doctor-patient relationship may deteriorate.102

27. “BMA Council recognises the value of mediation in terms of the benefits conferred on claimants and clinicians by both the process itself and the flexible outcomes which it makes possible, and supports a campaign to raise awareness of the benefits of mediation across the medical profession and to supporting its use by clinicians and their legal representatives, wherever possible, to resolve clinical negligence and other disputes. (BMA Council 9 May 2001)”.

28. Since the provision of IMM might mean that decisions would be open to independent scrutiny, it would encourage a spirit of openness and discourage “medical paternalism” and the idea that “doctor knows best”. Once medical professionals realise that their decisions may be scrutinised it would encourage greater care in decision making and in particular consideration of the views of family and carers.

29. No particular sanctions would be immediately applicable which would encourage a flexible and informal process, which could be adapted to the circumstances of the case. Nevertheless, information derived at mediation could subsequently be used by the Court of Protection or other legal proceedings. Moreover, under the Civil Procedure Rules, (CPR 44.5) mediation is increasingly seen as a necessary preliminary to court proceedings. The Civil Procedure Reforms (CPR) in England & Wales make it clear that trial is to be a last resort, and will encourage the use of mediation if necessary by court order.

30. Since IMM would be contemporaneous it would enable resolution of problems at the material time. Current complaints procedures are retrospective and therefore cannot provide solutions to patient’s difficulties.

31. Whilst there should be appropriate remuneration for the mediator, the process would be less costly than current complaints procedures and would not normally entail the services of lawyers, with the attendant costs. It would mean that healthcare professionals might be able to make suggestions and alterations to management plans at the material time.

**Suggested Amendments to Clause 170.**

32. Proposal

Changes to clause 170 (Changes in italic)

170 Independent advocacy and medical mediation services.

(1) After section 223 of the Local Government and Public Involvement in Health Act 2007 insert—

“223A Independent advocacy and medical mediation services.

After Clause (2)(d)(ii) insert—

(3) in this section, “independent medical mediation services” means services providing medical expertise and advice by an independent registered medical practitioner regarding serious medical treatment and placement decisions, for the assistance and benefit of an adult who lacks mental capacity.

(4) “Serious medical treatment” means treatment which is considered necessary to sustain life or prevent longterm mental or physical disability.

(5) “Placement” means the placement of the mentally incapacitated person in a place of residence such as a hospital, hospice, residential or nursing home or other accommodation.

(6) An “independent registered medical practitioner” means a registered General Practitioner or Consultant with the relevant knowledge and expertise who is not primarily responsible for the treatment or placement of the mentally incapacitated person and whose involvement is acceptable to the primary carer, or carers, involved in the dispute.

Explanatory Notes

33. The mediator need not be a specialist. Providing (s)he has sufficient understanding of the medical issues, an experienced General practitioner would be in a position to understand the overall circumstances of the patient including the need for placement and the views of relatives. The purpose of the mediator is to achieve the best solution for the patient.

34. The mediator would be “independent” if not directly involved with the care and treatment of the patient and would be acceptable to those in dispute, particularly the claimants. Where complaints arise, there is often a suspicion that an “expert” will be called who will side with the medical and nursing staff. By exploring all the issues including misunderstandings and poor communication in a non-judgemental way, the mediator is in a position to arrive at a contemporaneous decision and foster a “no blame” approach. The fact that decisions made on behalf of the incapacitated might be open to independent scrutiny might have collateral benefits in improving the quality of decision-making in other cases, knowing that there may be independent scrutiny.

35. Since, the mediator is medically qualified, if there was a failure to reach agreement, the views of the mediator would be influential in providing a contemporaneous account and opinion for any future legal proceedings.

Presumption in Favour of the Primary Carer to Become the Court Appointed Deputy

Background

36. The parents of those with learning difficulty often face enormous difficulties when their child becomes an adult at 18 years of age. This has been highlighted in a number of reports and is a matter of everyday experience for those who deal with adults with learning difficulty. For example, according to the Mental Welfare Commission for Scotland Report expresses the views of many such parents:

“The issues parents face when their child with a learning disability moves from child to adult health and social care services are quite considerable. Services their child has been receiving from familiar staff are suddenly at risk. It is not always clear what will be put in place and who will step in to continue to provide this care and support. A number of important case conferences and case discussions are held during this transition period. Key decisions have to be made and actions taken by, or on behalf of, the young person that may have a long lasting impact on their health and welfare. Parents understandably may fear a loss of control”.

37. The partners, sons or daughters of adults with acquired mental incapacity eg arising from dementia may also experience feelings of alienation when decisions are made for the mentally incapacitated person regarding treatment or placement. The responsibility for medical decisions rests with the doctor in charge providing that there is a reasonable belief that the person lacks capacity (S 5.1.(b)(i)) and that the doctor is acting in the patient’s best interests (s 5.1(b)(ii)). Institutional and domiciliary care and treatment may both have considerable financial and social implications for the relatives and primary carers.

38. The overwhelming majority of elderly patients have not created powers of attorney for others to make decision on their behalf in the event of incapacity. Parents of those with learning difficulty can only acquire legally recognised decision-making powers by applying to become a court appointed deputy. Nevertheless for many elderly relatives the application process seems complex and there is a worry that the Court may favour an official from Social Services as deputy. For example, in Scotland where the guardianship order is to relate only to the personal welfare of the adult, the chief social work officer of the local authority may be appointed by the Sherriff as guardian(s 59 (b)).
PROPOSAL: PRESUMPTION IN FAVOUR OF THE PRIMARY CARER AS COURT APPOINTED DEPUTY

39. There should be a rebuttable presumption, that if the primary carer agrees to the appointment and can demonstrate that they have taken responsibility for the care of the incapacitated person, that the primary carer should become the court appointed deputy.

PROPOSED AMENDMENT TO THE MENTAL CAPACITY ACT 2005

40. After S 19(1)(b) insert—

Presumption in favour of the primary carer as court appointed deputy.

(1) The Court of Protection should appoint the primary carer as Court appointed deputy, subject to section 2, where it has been established to the satisfaction of the Court that the person to be appointed has—

(a) demonstrated their knowledge of the incapacitated person’s condition and circumstances,

(b) demonstrated their involvement with the care of the incapacitated person,

(c) demonstrated their ability to carry out the functions of deputy,

(d) understood the roles and responsibilities of being a deputy,

(e) not been paid in a professional capacity to look after the incapacitated person, and

(f) consented to the appointment

(2) The Court shall not appoint any individual as deputy where—

(a) there would be a risk of a serious financial conflict of interest between the proposed deputy and the incapacitated person regarding their care, treatment or residence, or

(b) the appointment would be contrary to the best interests of the incapacitated person having considered all the relevant circumstances, or

(c) there would be a risk of serious harm to the physical or psychological wellbeing of the incapacitated person.

(3) Where there is serious doubt concerning the suitability of a primary carer as deputy, the Court should take into account the views of the incapacitated person’s general medical practitioner, or other suitable medical opinion, in matters relating to the health or welfare of either the incapacitated person or of the carer.

(4) Subsection 2(a) shall not be regarded as applying to an individual merely by reason of being a close relative or residing in the same place as the incapacitated person.

(5) The term “primary carer” means the person who has been mainly responsible for providing care for the incapacitated person. There shall be a rebuttable presumption that the parent, or parents, of an adult with learning disability are the primary carer(s).

(6) Being “paid in a professional capacity” means caring for the incapacitated person whilst receiving a salary but excludes being in receipt of statutory grants and allowances for care and maintenance.

CONCLUSION

41. The NHS relies heavily on informal carers to provide help and assistance for relatives who lack the mental capacity to care for themselves. The monetary savings of the services of informal carers is unknown but has been estimated to be over £30 billion per year. The Government quite rightly has promoted the view that there should be “no decisions about me without me”. This should be extended to the relatives and carers of those who lack the capacity to make decisions for themselves.

42. In view of the importance of unpaid “informal” carers for those who lack capacity, there should be a presumption in favour of the primary carer, or carers, to be appointed deputy. There should also be provision within the Bill for independent medical mediation to resolve any disagreements concerning serious medical treatment and placement at a time when resolution of such difficulties can still benefit the incapacitated person.

February 2011
Memorandum submitted by Breakthrough Breast Cancer (HS 45)

1. INTRODUCTION

1.1 Breakthrough Breast Cancer welcomes the opportunity to submit written evidence to the Public Bill Committee of the Health and Social Care Bill. Further to the points raised below, please also see the submission Breakthrough has made jointly with a number of other national charities.  

1.2 Breakthrough Breast Cancer is a pioneering charity dedicated to the prevention, treatment and ultimate eradication of breast cancer. We fight on three fronts: research, campaigning and education. Our aim is to bring together the best minds and rally the support of all those whose lives have been, or may one day be, affected by this disease. The result will save lives and change futures—by removing the fear of breast cancer for good.

1.3 Over the last 20 years, mortality rates for people diagnosed with breast cancer in the UK have improved significantly. This is thanks to a combination of better breast awareness, screening and improved treatments. However, with nearly 48,000 women diagnosed each year, and over half a million women now living in the UK following a diagnosis of breast cancer, it is vital they receive a standard of care that will offer them the best chance of beating this disease.

1.4 This submission reflects the views of Breakthrough, based on our experience of working with people with personal experience of, or who are concerned about, breast cancer. We regularly consult with members of our Campaigns & Advocacy Network (Breakthrough CAN) for their views on a range of breast cancer issues. Breakthrough CAN brings together over 1,500 individuals, regional groups and national organisations to take action locally on our national campaigns to secure important improvements to breast cancer research, treatments and services.

1.5 In preparing this evidence, Breakthrough consulted with a number of our CAN members who have experience of working within the current NHS patient and public involvement mechanisms. We hope their views will highlight the importance of involvement, as well as providing valuable insight into the keys to success for meaningful engagement with patients and the public.

2. SUMMARY OF EVIDENCE

2.1 The Health Bill represents the most ambitious and radical set of changes to the NHS since it was established in 1948. We welcome the Government’s aim for a health service that puts patients at its heart and we look forward to working with the Government to realise its vision of “no decision about me without me”.

2.2 We want to ensure that the NHS Commissioning Board and Commissioning Consortia design and commission the best possible breast cancer services and that outcomes are measured and continue to improve.

2.3 We also want to make sure that robust and meaningful patient involvement is integrated into the set up of both the NHS Board and all Commissioning Consortia as well as HealthWatch to ensure that the needs and views of people affected by breast cancer are taken into account.

2.4 We would urge the Bill Committee to consider amendments to the Bill to:

- strengthen patient and public involvement;
- harness existing expertise from the cancer sector; and
- promote best practice through guidance.

3. STRENGTHENING PATIENT AND PUBLIC INVOLVEMENT

3.1 Clauses 13L and 14P place duties on the NHS Board and Commissioning Consortia to involve the public in the design and implementation of their work (whether by consultation, being given information or other ways). As a patient organisation that represents people affected by breast cancer, Breakthrough supports proposals that seek to strengthen the collective voice of patients. Over the years, there have been a number of initiatives to encourage greater patient and public involvement. In order for any involvement mechanism to succeed, it is essential that these initiatives and activities are seen as integral to service development and design.

Partnering working is vital to effectively put patients first and allow them to voice their views and concerns without fear. People need to feel comfortable to offer their view, be it criticism or praise. It is important that they are aware of how their information will be used and the outcomes achieved.

Member of Breakthrough CAN from Lancashire

3.2 Since the publication last summer of the Government’s White Paper, Equity and Excellence: Liberating the NHS, members of our Campaigns & Advocacy Network (CAN) have raised a number of issues around the future of patient and public involvement (PPI). The key themes in the feedback we have received are:

- Reforming the current patient and public involvement system.

103 Age UK, Alzheimer’s Society, Asthma UK, British Heart Foundation, Diabetes UK, National Voices, Rethink, and the Stroke Association.
3.3 Reforming the current patient and public involvement system

3.3.1 We welcome the Government’s aim for a health service that puts patients at its heart and recognise that much has been done over the past 10 years to move this agenda forward. However, anxiety has been expressed about the scale of change, the impact on current arrangements and the current lack of clarity about how new arrangements will work.

I’m worried that we, the patients, will end up with less say in the way services are run as there seems to be too many “hoops” to jump through. Patients need to be involved in the earliest possible stages of setting up HealthWatch—especially with local groups.

Member of Breakthrough CAN from Middlesex

3.3.2 Many of the people we consulted to inform this submission have been affected, over the last 10 years, by the abolition of Community Health Councils (2003), the subsequent abolition of the Patient and Public Involvement Forums (PPI Forums), which replaced them, and the set-up of Local Involvement Networks (LINks) in 2008. This constant change has impacted the ability of patients and public to contribute at each stage, so the prospect of further change causes apprehension.

The key is meaningful patient involvement. Why are good LINks being shut down when in some areas they are a system that is working extremely well with local patients and members of the public fully involved?

Member of Breakthrough CAN from London

3.3.3 Respondents are reassured to hear that the proposed local HealthWatch will be an evolution of LINks, but are keen for more detail. There is a strong feeling that much has been invested by local communities in developing strong PPI pathways with their PCTs and that this investment will be lost as PCTs are abolished.

Our group focused on the issue of hospital discharge and follow-up procedures. Following research with patients, public and service providers, we put a report together with recommendations. Not only did we receive positive feedback, new processes have been introduced and are being rolled out throughout the main hospital in our area.

Member of Breakthrough CAN from South Yorkshire

3.3.4 There is overwhelming consensus that the best way forward is utilise the lessons learnt from the past decade in two areas; helping patients and the public manage the process of change, and building on best practice from previous PPI Forums and LINks.

My local LINk is a way that patients can genuinely become involved with changing NHS practices and get their voices heard—they are independent so patients trust their procedures. We can see what is happening, get feedback and liaise with staff to make sure something is being done.

Member of Breakthrough CAN from London

3.3.5 Our CAN members identified several key ways in which PPI Forums and/or LINks had been effective in their ability to represent their patients and communities, lessons which they hope will be taken forward in the new PPI mechanisms. The first of these are good working relationships with senior decision-makers within the local NHS (eg having a place on a PCT board, being sent PCT Board papers, having a PCT Director attend LINks meetings, etc).

Previously when I’ve tried to deal with the maze of local health services, it was forever knocking on closed doors. With LINk doors were not only open, but we were welcomed in and often before we had even approached the local services. I felt here was a real opportunity to achieve and influence service improvements.

Member of Breakthrough CAN from South Yorkshire

3.4 Ensuring patient’s voices are heard in new local NHS structures

3.4.1 Our CAN members identified several key ways in which PPI Forums and/or LINks had been effective in their ability to represent their patients and communities, lessons which they hope will be taken forward in the new PPI mechanisms. The first of these are good working relationships with senior decision-makers within the local NHS (eg having a place on a PCT board, being sent PCT Board papers, having a PCT Director attend LINks meetings, etc).

Previously when I’ve tried to deal with the maze of local health services, it was forever knocking on closed doors. With LINk doors were not only open, but we were welcomed in and often before we had even approached the local services. I felt here was a real opportunity to achieve and influence service improvements.

Member of Breakthrough CAN from South Yorkshire

3.4.2 The second area identified was in LINks effectively engaging with the public, through promoting PPI opportunities as well as being a conduit of information about key primary and secondary care decisions. This ensured that a wider audience was reached and more people can have a say about local services. We hope that local HealthWatch will go further in this area in finding innovative ways to engage the wider public.

Despite the large publicity in my area I’ve found that many people, across all age groups, are still unaware of LINks and the strong consumer voice it potentially has to help shape local health and social care services. Trying to reach the right people and engage with the local population is a huge task in itself.

Member of Breakthrough CAN from Lancashire
3.4.3 The third effective element was investment to capacity-build and support PPI Forums/LINks, so they can effectively engage, involve and represent service users and the wider community.

"I welcome the focus on involving local people but there is a lot to cover and so effort is spread too thinly—the resources need to be in place."

Member of Breakthrough CAN from Buckinghamshire

3.4.5 Current proposals appear to be complex and unclear from the perspective of patients and the public. There is some confusion over the roles of local authority Overview and Scrutiny Committees and the proposed Health and Wellbeing Boards. A significant number of respondents felt that local HealthWatch should evolve to be a “one-stop shop” for PPI in health and should encompass all the engagement mechanisms relating to commissioning, scrutiny, and complaints advocacy.

"There needs to be good working relationships with all the local organisations and agencies. They need to be able to attend meetings and have a full understanding of what is going on—especially with the new GP consortia."

Member of Breakthrough CAN from Buckinghamshire

3.5 SUPPORTING PUBLIC AND PATIENTS IN SHAPING NHS SERVICES

3.5.1 There is a strong view that the expertise of current patient representatives on PCTs should be used to support the development of new commissioning arrangements both locally and nationally. In order to give patients and the public a voice in shaping NHS services, the role of PPI in commissioning should be defined in statute to give Commissioning Consortia a duty to involve patients and the public in the same way the duty was defined for PCTs.

"We’ve developed a lot of expertise over the years and because no-one knows how HealthWatch is to be formed and who is going to be a part of it, it feels as if we are no longer required."

Member of Breakthrough CAN from South Yorkshire

"The best aspect of being involved with my local LINks group is having an open forum to affect changes. When I attend the meetings, I know my voice will be heard if I have any issues to raise. We don’t kow what form HealthWatch is going to take but it seems that it might be more difficult for volunteers to take part."

Member of Breakthrough CAN from Middlesex

3.5.2 There is overwhelming consensus amongst the CAN members we consulted that training and support should be provided to PPI Forums/LINks members to support them in managing the process of change and to prospective national and local HealthWatch members. They also felt training and support should be provided to the members of Commissioning Consortia to ensure they are aware of their obligations with respect to PPI and to train them on how to effectively involve patients and the public. This training and support should come from the Government and specialist bodies such as Breakthrough Breast Cancer, who have a key role in promoting breast cancer advocacy.

"HealthWatch members need to have good working relationships with all the local organisations and agencies. They need to be able to attend meetings and have a full understanding of what is going on—especially with the new GP consortia."

Member of Breakthrough CAN from Merseyside

3.5.3 HealthWatch, at both a national and local level, needs to provide appropriate support and training to allow a wide range of patients and members of the public to be able to effectively take part in engagement initiatives.

"I think there should be clear guidelines on how the new HealthWatch scheme will operate. Charities with expertise could advise the Government on how to organise and implement HealthWatch. There was virtually no guidance from central government about how the LINks were formed and organised."

Member of Breakthrough CAN from Buckinghamshire

"Patients need to know about what they can do. An approachable and supportive HealthWatch could be an appropriate mechanism for patients to seek help and inform services."

Member of Breakthrough CAN from Greater Manchester

4. HARNESING EXPERTISE FROM THE CANCER SECTOR

4.1 Breakthrough is keen to ensure that the expertise of Cancer Networks and third sector organisations is utilised by the NHS Commissioning Board and GP Consortia. We are pleased that funding for Cancer Networks will continue as GP Consortia are set up and urge the Government to promote a new role for Cancer Networks in providing expertise to GP Consortia in how best to commission for cancer, a particularly complex condition.

4.2 Clauses 13G and 14O place a duty on the NHS Commissioning Board and Commissioning Consortia to seek appropriate advice to enable them to effectively discharge their functions from persons with professional expertise relating to the physical and mental health of individuals. These duties must be
strengthened to ensure that the people consulted have either relevant clinical expertise or expertise in patient involvement (including patient groups). We feel that multi-disciplinary involvement in commissioning will help ensure services are integrated and reflect the needs and views of patients.

5. Promoting Best Practice through Guidance

5.1 We understand the Government’s aim to devolve decision making and ensure that GP Consortia are able to act in the best interests of their local population. We also feel that Commissioning Consortia should have access to guidance highlighting current best practice, to assist them in providing the best possible services for the populations they serve.

5.2 As highlighted in section 3.5.3, one of the criticisms of the current LINks system was the lack of guidance provided to groups. As GPs will have many new duties to deal with in commissioning services, we think they should have a helping hand in setting up appropriate and meaningful patient involvement.

5.3 According to clause 45A in the Bill, HealthWatch England has the following functions: to provide advice and assistance to local HealthWatch in the exercise of their functions; to provide information and advice on the views of patients and the public and; to provide information on the views of local HealthWatch to the Secretary of State, Monitor, NHS Commissioning Board and English local authorities.

5.4 We would urge the Bill Committee to add another function for HealthWatch England—to provide guidance to the NHS Commissioning Board (and through them to Commissioning Consortia) on best practice for patient and public involvement.

5.5 This guidance should be drafted in collaboration with external experts, including third sector organisations. These guidelines must be dynamic in their methods and approach to user-involvement, drawing on examples of patient and public involvement from voluntary and community sectors. The NHS Board, Commissioning Consortia and HealthWatch will need to innovate in order to mobilise patients, advocates and active citizens who cannot or would not normally engage in traditional, committee-based roles, in order to create health services which reflect the needs and views of the population.

February 2011

Memorandum submitted by the National Federation of Occupational Pensioners (HS 46)

1. The National Federation of Occupational Pensioners (NFOP) is the oldest and largest occupational pensioners’ organisation in the UK, with 90,000 members nationwide organised into 185 branches.

Summary

2.1 We welcome the Bill’s aim of increasing patient choice and empowerment, and we support any moves to allow older people to feel that services are more responsive to their—often complex—needs.

2.2 However our members are concerned about the impact the Bill will have on the quality of services they receive through the NHS. Many pensioners are not able to take advantage of the promise of greater choice as many are not able to make use of the internet to research providers, treatment or drugs. They will continue to rely on their GP or other health practitioner to guide them—and will want to be entirely confident that the advice they receive is not based upon a potential conflict of interest or motivated by budgetary considerations.

2.3 The Bill contains provisions to give GP commissioning consortia control over a vast proportion of the NHS budget, amounting to around £80 billion. Given that consortia will be responsible for such a large amount of public money, it is surprising that the Bill does not contain more detail on how consortia will be held to account. We believe that better mechanisms should be put in place to help local communities and patients oversee and play a role in the commissioning decisions made by consortia.

2.4 The Bill will give Monitor a new role as both an economic regulator and promoter of competition. We believe that this dual role may be damaging to the provision of high quality health services. As the sole organisation representing Royal Mail pensioners, NFOP is in a unique position to advise upon the lessons that can be learnt from the actions of Postcomm in regulating postal services.

2.5 Whilst welcoming some of the broader sentiments behind the reforms in the Bill, we firmly believe that more thought, care, and consultation must go on before these irrevocable and expensive changes to the NHS are made.

GP Consortia and Local Accountability

3.1 Many older people have a good relationship with their GP, and may welcome a greater role for their trusted local doctor in the commissioning process. But Clauses 21 and 22, which lay out the role and structure of the new commissioning consortia are very light on detail, including how big the consortia will be, who will be involved in them, and how patients and local people can be involved in decision making. This lack of detail in the Bill creates uncertainty for older people concerned about how the reforms will affect the care they receive.
3.2 We believe that further detail is needed on how commissioning consortia will be held to account. For example, there should be more prescriptive detail in the Bill to ensure that the needs of distinct groups within local communities, such as older people, young people or ethnic minorities, are properly taken into account in the decisions taken by commissioning consortia. Clause 22 states that consortia must “have regard to the need to promote the involvement of patients and their carers in decisions about the provision of health services to them”. We feel that this requirement does not go far enough. There should be an explicit requirement in the Bill for the proper representation of patients in the GP consortia management bodies.

3.3 The Bill will require local authorities to establish a Health and Wellbeing Board which has as its main duty to prepare with the commissioning consortia a joint statement of strategic needs and a health and wellbeing strategy, to which the commissioning consortia must have regard (Clauses 176 to 178). However we foresee three problems with this approach:

(i) only one councillor is required to sit on the Board, raising the question of whether this provides sufficient accountability;

(ii) with local authority budget reductions, the Health and Wellbeing Board may not have the resources to hold consortia to account; and

(iii) the duty on the consortia to have regard to the needs assessment and strategy is too weak. The wording in the Bill, “must take account of”, could be strengthened.

3.4 Furthermore, we are very concerned the reforms may result in greater inequalities in healthcare provision and an increased “postcode lottery”. Whilst we recognise that local discretion can be an important part of meeting the needs of local people, we fear that older people will be more likely to suffer from inequalities as they may be reluctant, or unable, to change their GP even if the service they receive is of a lower standard. We would welcome a clear statement of intent from the Government on this important issue.

4.1 The Bill will see a big increase in competition at all levels of the NHS. Chapter 4 of the Bill outlines the role that competition will play in the new NHS, with the economic regulator Monitor having its first duty as “promoting competition”. We have concerns that if Monitor follows the same route as Postcomm in the postal services sector then promotion of competition will lead to severe damage being done to the NHS in the same way that Postcomm has damaged Royal Mail.

4.2 While there has already been some private involvement in certain specialist services, the move towards greater competition will transform the way that health services are delivered. With private companies able to “cherry pick” services they provide, it is likely they will focus on straightforward procedures with a high success rate leaving NHS providers with more complex or challenging cases, which are less profitable.

4.3 There are obvious parallels here with the postal services sector, where the state provider has an obligation to deliver those services which are not profitable enough to tempt private sector involvement. If the NHS loses its most profitable services to more competitive providers, whilst obliged to retain the least profitable, there is a real fear that cash-strapped NHS services will be less able to provide the high quality treatment for complex and longer term conditions upon which older people rely.

February 2011

Memorandum submitted by Rethink (HS 47)

Overview

This briefing has been produced by a range of national charities, including Age UK, the Alzheimer’s Society, Asthma UK, Breakthrough Breast Cancer, British Heart Foundation, Diabetes UK, National Voices (and through them over 100 charities), Rethink mental illness and the Stroke Association.

We would like to take this opportunity to welcome the Government’s aim for a health service that puts patients at its heart. However, we have noted several areas where we feel the Bill needs to be amended to make their aims a reality. Our specific amendments are outlined below, broadly listed under patient and public involvement in commissioning; strengthening local scrutiny; and integrated care.

1. Strengthening Patient and Public Involvement in Commissioning

The involvement of the local population in commissioning and service design is fundamental to making the Government’s promise of “no decision about me without me” a reality. The Bill sets duties to promote Patient Involvement but provides no definition of what this should entail.

Public Involvement is set out in terms of local HealthWatch and HealthWatch England. However, HealthWatch should be just one aspect of a much wider range of involvement opportunities. This is particularly important for those more vulnerable or disabled people who may be less likely to be represented by either their local HealthWatch or on the National Commissioning Board.
Also, whilst the new Health and Wellbeing Boards will involve a representative from HealthWatch, the role of these Boards is to: encourage integration between health and social care; provide advice, assistance or other support for the arrangements for service provision; and encourage persons working in health services to work with the Health and Wellbeing Board. As such, Health and Wellbeing Boards are not the central decision making bodies in health and social care. Below outlines our specific recommendations to improve patient and public involvement in commissioning:

A. Duty as to reducing inequalities, promoting patient involvement etc (Board)

Amendment 1

Section 19 (Clause 13F), Page 17, line 4

Add sub-clause:

(3) In this section, “patient involvement” means the participation of the groups referred to in (1)(c) in:

(a) commenting, by complaints or comments made or views expressed (including the descriptions of their experiences of care and treatment) on the quality of the commissioned services for the purposes of monitoring and quality improvement;

(b) being provided with appropriate information and support in relation to their care or treatment by the services commissioned by the Board;

(c) being encouraged by those who provide the commissioned services to understand the care or treatment choices available to them, and to discuss with an appropriate health care professional, or other appropriate person, the balance of risks and benefits involved in any particular course of care or treatment;

(d) being enabled to make, or to participate in making, decisions relating to their care or treatment;

(e) being provided, where appropriate, with opportunities to manage their own care or treatment; and

(f) giving consent in relation to the care and treatment provided for them.

Explanation

The Government has stated a clear intention that the Bill should introduce a more significant role for the patient in their own care and treatment. It is essential, therefore, that the Bill defines “patient involvement” where duties to commissioning consortia and the Board are applied.

B. Duty to obtain appropriate advice

Amendment 2

Section 19, Clause 13G (Page 17, line 19)

We propose deleting the current clause heading and text and inserting:

13G Duty to involve multi-disciplinary professionals and patients

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by the Board (“commissioning arrangements”).

(2) The Board must make arrangements to secure the involvement of—

(a) a range of multidisciplinary health and social care professionals, including those with expertise in the conditions for which services are being commissioned; and

(b) groups representing patients and carers with expertise in the conditions for which services are being commissioned.

(3) The reference in subsection (5)(b) to the delivery of services is a reference to their delivery at the point when they are received by users.

(4) In this section, “health services” means any services that are (or are to be) provided as part of the health service.

(5) In this section, “involvement” means participation of the groups listed in 2(a) and (b).

(a) in the planning of the commissioning arrangements by the Board;

(b) in the development and consideration of proposals by the Board for changes in the commissioning arrangements where the implementation of the proposals would have a significant impact on the manner in which the services are delivered to the individuals or the range of health services available to them and

(c) in decisions of the Board affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact;

(d) in decisions about the priorities and strategy for commissioning by the Board in relation to its mandate;
(e) in identifying and assessing the needs and demands for services of relevant populations and groups of conditions;

(f) in the preparation of plans for commissioning health services;

(g) in decisions about which services to commission;

(h) in the preparation and publication of guidance as to how these services should be designed to meet people’s needs;

(i) in monitoring the quality and effectiveness of the commissioned services”.

Explanation:

Currently the Bill states that the National Commissioning Board “must make arrangements with a view to securing that it obtains advice appropriate for enabling it effectively to discharge its functions from persons with professional expertise relating to the physical or mental health of individuals”.

To “involve” is a much stronger duty which will lead to greater involvement of professional and patient groups, which the Government has stated as an aim of the Bill.

We also consider it essential that this duty be extended to “involving patients and carers” in addition to expert professionals.

Alongside wanting to ensure that the new NHS offers patients and their representative groups an opportunity to be heard, our organisations are concerned about the lack of emphasis on input into local service design and commissioning from a range of expert health and social care professionals.

The commissioning of whole pathways of care for some conditions will fall under the remits of public health, the NHS Commissioning Board and GP consortia, which risks the fragmentation of service provision. Multi-disciplinary involvement of specialists, Allied Health Professionals, education, social care and patients is required to enhance continuity of care and improve quality standards for patients. As such we would like reassurances that “persons with professional expertise” will apply to the full range of health and social care professionals.

C. Public Involvement and consultation by the Board

Amendment 3

Section 19 Clause 13L (page 18, line 22):

Delete “(whether by being consulted or provided with information in other ways)”

Explanation:

The Bill currently suggests that: “The Board must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information in other ways)”.

We feel strongly that “providing information” is not meaningful involvement and therefore this text must be significantly strengthened. However, regulations must provide for exceptional circumstances in which normal consultation cannot occur for reasons of safety or similar (ie an outbreak of swine flu would require information to be quickly disseminated and full consultation would not be possible).

Amendment 4

Section 19 Clause 13L (page 18, line 20): delete (a) and add additional sub-clauses

(a) in decisions about the priorities and strategy for commissioning by the Board in relation to its mandate;

(b) in identifying and assessing the needs and demands for services of relevant populations and groups of conditions;

(c) in the preparation of plans for commissioning health services;

(d) in decisions about which services to commission;

(e) in the preparation and publication of guidance as to how these services should be designed to meet people’s needs;

(f) in monitoring the quality and effectiveness of the commissioned services”.
Explanation:
The amendment above proposes a stronger clarification of expected involvement activities to help ensure that such involvement is meaningful.

D. Duty on GP consortia to reduce inequalities, promote patient involvement
Amendment 5
Section 22 Clause 14N (Page 30, line 29)
Add new sub-clause
(3) In this section, “patient involvement” means the participation of the groups referred to in (1)(c) in:
(g) commenting, by complaints or comments made or views expressed (including the descriptions of their experiences of care and treatment) on the quality of the commissioned services for the purposes of monitoring and quality improvement;
(h) being provided with appropriate information and support in relation to their care or treatment by the services commissioned by the Board;
(i) being encouraged by those who provide the commissioned services to understand the care or treatment choices available to them, and to discuss with an appropriate health care professional, or other appropriate person, the balance of risks and benefits involved in any particular course of care or treatment;
(j) being enabled to make, or to participate in making, decisions relating to their care or treatment;
(k) being provided, where appropriate, with opportunities to manage their own care or treatment; and
(l) giving consent in relation to the care and treatment provided for them.

Explanation:
The Government has stated a clear intention that the Bill should introduce a more significant role for the patient in their own care and treatment. It is essential, therefore, that the Bill defines “patient involvement” where duties to commissioning consortia and the Board are applied.

E. Duty to obtain appropriate advice (Commissioning Consortia)
Amendment 6
Section 22 (Clause 14O) Page 30, line 32
We propose deleting the current clause heading and text and inserting:
14O Duty to involve multi-disciplinary professionals and patients
(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by the commissioning consortium (“commissioning arrangements”).
(2) The commissioning consortium must make arrangements to secure the involvement of—
(a) a range of multidisciplinary health and social care professionals, including those with expertise in the conditions for which services are being commissioned;
(b) groups representing patients and carers with expertise in the conditions for which services are being commissioned.
(3) The reference in subsection (5)(b) to the delivery of services is a reference to their delivery at the point when they are received by users.
(4) In this section, “health services” means any services that are (or are to be) provided as part of the health service.
(5) In this section, “involvement” means participation of the groups listed in 2(a) and (b)—
(a) in the planning of the commissioning arrangements by the commissioning consortium;
(b) in the development and consideration of proposals by the commissioning consortium for changes in the commissioning arrangements where the implementation of the proposals would have a significant impact on the manner in which the services are delivered to the individuals or the range of health services available to them; and
(c) in decisions of the commissioning consortium affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact;
(d) in decisions about the priorities and strategy for commissioning by the commissioning consortium in relation to its mandate;
(e) in identifying and assessing the needs and demands for services of relevant populations and groups of conditions;
(f) in the preparation of plans for commissioning health services;
(g) in decisions about which services to commission;
(h) in the preparation and publication of guidance as to how these services should be designed to meet people’s needs; and
(i) in monitoring the quality and effectiveness of the commissioned services”.

F. Public involvement and consultation by commissioning consortia

Amendment 7

Section 22 Clause 14P (page 30, line 44)
Delete “(whether by being consulted or provided with information in other ways)”

Explanation:
As noted in Amendment 3 of this briefing we feel strongly that “providing information” is not meaningful involvement and therefore this text must therefore be significantly strengthened. However, regulations must provide for exceptional circumstances in which normal consultation cannot occur for reasons of safety or similar (ie an outbreak of swine flu would require information to be quickly disseminated and full consultation would not be possible).

Amendment 8

Section 22 Clause 14P (page 30, line 44) delete (a) and add additional sub-clauses
(a) in decisions about the priorities and strategy for commissioning by the consortium;
(b) in identifying and assessing the needs and demands for services of relevant populations and groups of conditions;
(c) in the preparation of plans for commissioning health services;
(d) in decisions about which services to commission; and
(e) in monitoring the quality and effectiveness of the commissioned services.

Explanation:
The amendment above proposes a stronger clarification of expected consultation activities to help ensure that such involvement is meaningful.

G. Constitution of commissioning consortia and lay representation

Amendment 9

Schedule 2, Part 1, page 227 line 12
Insert new Section (3)(1) and (2):
(1) The Constitution must specify the arrangements made by the commissioning consortium to establish a governing Board.
(2) The governing Board of each commissioning consortium must comprise of equal numbers of consortium member representatives and lay representatives of the population served by the consortium.
(3) The lay representatives on the governing Board must have the sole function of representing the interests of the population and must have no professional or pecuniary interest in the matters for which the consortium is responsible.
(4) The governing Board should meet in public, make relevant documents publicly available, and report its decisions publicly.

Explanation:
Given the Government’s commitment to strengthening the role of the public and patients in the NHS, it is essential that they can play a meaningful role in governing their local GP Consortia through its governing Board. Public governance and scrutiny of these operations is especially important given that the bulk of the NHS’ finances will be managed by GP Commissioning Consortia. This will ensure that members of the public can play a role in their decision making processes.

We would expect lay representatives to be at least as numerous as consortium representatives. Precedent for this is well established given that all other NHS bodies have lay involvement on their Boards, eg through non-executives or elected members of Primary Care Trusts/Foundation Trusts; all health professional regulatory bodies must have a lay majority by law and the Coalition Government Agreement promised that local health boards would be democratically elected.
H. Annual reporting of the Commissioning Board re: patient involvement
Amendment 10

Section 19, Clause 13P (page 20, line 10)
Delete current wording for (c) and insert:

“how effectively it discharged its duties 13C–13N”

Explanation:
The Bill sets out the content of the annual report of the Board in the discharge of their duties. The current draft requires only for them to report on duties relating to quality of services (13D) and public involvement (13L).

We argue that the increased devolution of responsibility calls for greater accountability and transparency, and therefore the Board should report on the discharge of all their legal duties.

This would cover the Board’s duties to be effective and efficient (13C); its duty to promote autonomy (13E); its duty to reduce inequalities and promote patient involvement (13F); its duty to obtain appropriate advice (or as this briefing’s Amendment 1 requests “involve”); its duty to promote innovation (13H); its duty in respect of research (13I); its duty to encourage integrated working (13J) and its duty to have regard to impact on services in certain areas (13K); its information on safety of services provided by the health service (13M) and guidance in relation to the processing of information (13N). 13F and 13J are considered particularly important for this group.

I. Consortia commissioning plans
Amendment 11

Section 21, Clause 14Y (Page 34, line 10)
After “14L,” insert new sub-clause

“(b): 14P”

Explanation:
Similar to the above amendment for the National Commissioning Board, the Bill currently requires that commissioning consortia must set out proposed discharge of certain duties, relating only to improvement to services (14L) and financial efficiency (223I–223K).

We argue that consortia must be transparent about their plans for the discharge of their duty on public involvement, hence our addition of (14P—Public involvement and consultation by commissioning consortia).

Amendment 12

Section 21, Clause 14Y (page 34, line 12)
After “223K” insert new sub-clause (3):

(3) “In preparing the plan, and in pursuit of its duties 14L and 14P, each commissioning consortium must consult with the persons mentioned with reference to duties 14K to 14P inclusive and with HealthWatch.”

Explanation:
This amendment will ensure that local HealthWatch bodies will have an opportunity to feed into the plans of GP Commissioning Consortia. Given that these plans will outline the detail of local NHS provision for the year ahead (including the budget allocated to set areas), it is essential that HealthWatch has a timely opportunity to feed into this.

J. Assessing the performance of consortia
Amendment 13

Section 21, Clause 14Z1 (Page 35, line 17)
Delete “(a) section 14L, and” and insert—

“(a) sections 14K to 14P inclusive

Explanation:
Similar to Amendment 11, the Bill sets out the arrangements for the assessment of GP commissioning consortia by the Board. Currently, the Bill only requires that the consortia should be assessed on areas relating to service improvement and financial efficiency. To ensure transparency, we argue that consortia should be assessed on all of their duties, including public involvement.
K. Procedural requirements in connection with certain powers (the National Commissioning Board)
Amendment 14

Section 21, Clause 14Z7 (page 38, line 5)
Add new sub-clause (c):

“relevant local Healthwatch organisations”

Explanation:

The National Commissioning Board has certain powers set out, such as powers to give directions and dissolve consortia. The Board must consult with the Commissioning Consortia, relevant authorities and “any other persons” currently. We argue that plans to carry out these powers should also be shared with local Healthwatch and that they must be consulted.

L. Joint Strategic Needs Assessments
Amendment 15

Section 176, Clause 6 (page 149, line 24)
After “appropriate”, add “and must consult Healthwatch organisations in that area”

Explanation:

The Joint Strategic Needs Assessment represents a key opportunity for public involvement in local strategy and provision. The authority or commissioning consortia are currently only permitted to consult “any person it thinks is appropriate”. We consider that a duty to involve local Healthwatch would be more appropriate.

2. Strengthening Local Scrutiny and Accountability

The Bill provides greater flexibility for local authorities to carry out scrutiny of the local health service as they see fit. There may be provision for local overview and scrutiny committees, but these will not be mandatory.

This element of the Bill runs counter to the emphasis placed on independent scrutiny of health decisions in the Government’s Coalition agreement, published in May 2010. This document stated:

We will ensure that there is stronger voice for patients locally through directly elected individuals on the board of their local PCT. The remainder of the PCT’s board will be appointed by the relevant local authority or authorities . . . this will ensure the right balance between locally accountable individuals and technical expertise.104

Here, the Government acknowledges the importance of directly elected individuals being involved in the scrutiny of PCT boards. Whilst the policy landscape has shifted in terms of commissioning responsibility, there is no reason why the principle of local accountability should not remain the same. Provision must be made to remedy this on the face of the Bill through ensuring that the proposed approach to scrutiny will be adequately independent, elected representative-led and accessible to the public.

Health and Wellbeing Boards offer strategic direction rather than scrutiny; HealthWatch has limited powers and its funding is not ringfenced and therefore vulnerable; and local authorities have a great deal of freedom to decide how their decisions will be scrutinised. Through this Bill huge power is being devolved locally with potentially less scrutiny than in the existing system. As such, we urge the Government to consider the amendments below to ensure that the new system has an effective scrutiny function.

M. Local authority scrutiny function
Amendment 16

Section 175 (page 148, line 11)—After 2ZD, insert:

Regulations must require scrutiny function arrangements made by the local authority to be independent and led by elected representatives.

Health and Social Care Bill

Explanation:
As noted, the Bill is not strong enough with regard to the way in which local authorities' decisions will be scrutinised. Independent scrutiny, led by elected representatives, is essential.

N. Local HealthWatch organisations
Amendment 17
Section 168 Clause (3) (page 141, line 14)
Insert new sub-clause (i) (outlined below)

(i) making views known to relevant Health and Wellbeing Board and relevant local authority scrutiny function, which must respond within 21 working days.

Explanation:
Local HealthWatch organisations should play a more significant role in local scrutiny.

The current Bill is focused only on the role of local HealthWatch in reporting issues to Healthwatch England and the Care Quality Commission. However, they will be in a position to monitor local issues relating to health and social care, which may be of concern and in need of attention from the local authority’s scrutiny function and the local Health & Wellbeing Boards.

This amendment would ensure that all agencies are kept updated of local concerns, and also puts an onus on these agencies to update the Local HealthWatch on action it plans to take.

Amendment 18
Section 168 Clause (3) (page 141, line 8)
At end sub-clause (g)—before “and”, insert “and inform relevant local authority scrutiny function on these recommendations”.

Explanation:
As highlighted above, the local authority’s scrutiny function needs to maintain good levels of communication with HealthWatch to scrutinise effectively. As such, this amendment will ensure that if Local HealthWatch is passing recommendations to HealthWatch England and the Care Quality Commission about areas where Local HealthWatch feel they should undertake special investigations, the scrutiny function of the local authority will be informed of this.

O. Advice given by Healthwatch England
Amendment 19
Section 45B, Clause 5 (page 139, line 35)
Delete “may” and insert “must”

Explanation:
It is essential that HealthWatch England must be accountable in terms of the discharge of its functions. The current draft states that the Secretary of State may give direction, but this should be strengthened so that the patients across the country can be assured that there will be an intervention, should Healthwatch England fail to function adequately.

3. Duties to Encourage Integrated Working
As referenced under Amendment 2, we have concerns around how the Bill will ensure multi-agency commissioning and integrated working, which are essential if patients are to get the care they need. The Commissioning Board and the Health and Wellbeing Boards are required to “encourage” integrated working between health and social care, and GP Commissioning Consortia and local authorities required to “work closely together”. Neither of these sets out a clear aim to ensure the provision of integrated services, and we urge the Government to strengthen this.

Amendment 20
Section 19, (Clause 13J) Page 17, line 40
Insert “integrated” before final word of paragraph “services”

Amendment 21
Section 179 (Clause 2) Page 152, line 33
Insert “integrated” before the final word of the paragraph “services”
Explanation:
The inclusion of the word “integrated” will ensure that the duties to promote integrated working are for the purpose of the provision of integrated services.

Quick summary of amendments:

Patient involvement
1. Duty as to reducing inequalities, promoting patient involvement etc. (Board)
   Introduce definition
   Section 19 (Clause 13F)

5. Duty on GP consortia to reduce inequalities, promote patient involvement
   Introduce definition
   Section 22 (Clause 14N)

Public involvement
3. Public involvement and consultation (Board)
   (remove “provide with information” etc.)
   Section 19 (Clause 13L)

4. Public involvement and consultation (Board)
   Definition of involvement
   Section 19 (Clause 13L)

7. Public involvement and consultation (commissioning consortia)
   (remove “provide with information” etc.)
   Section 22 (Clause 14P)

8. Public involvement and consultation (commissioning consortia)
   Definition of involvement
   Section 22 (Clause 14P)

2. Duty to obtain appropriate advice (Board)
   Replace with “involve” and extend to patient and carer groups
   Section 19 (Clause 13G)

6. Duty to obtain appropriate advice (commissioning consortia)
   Replace with “involve” and extend to patient and carer groups
   Section 22 (Clause 14O)

9. Constitution of commissioning consortia and lay representation
   Lay representation on consortia governance
   Schedule 2, Part 1

10. Annual reporting of the Commissioning Board
    Reporting on ALL duties not just improvement and public involvement
    Section 19 (Clause 13P)

11. Consortia commissioning plans
    Publish plans for the discharge of public involvement duty, not just improvement and efficiency
    Section 21 (Clause 14Y)

12. Consortia commissioning plans
    Consult local Healthwatch in commissioning plans
    Section 21 (Clause 14Y)

13. Assessing performance of consortia
    Consortia to be assessed on ALL duties, not just improvement and finance
    Section 21 (Clause 14Z1)

14. Procedural requirements in connection with certain powers (Board)
    Consult local Healthwatch should Board intervene in consortia
    Section 21 (Clause 14Z7)

15. Joint Strategic Needs Assessments
    Add duty to consult local Healthwatch
    Section 176 (Clause 6)

Scrutiny
16. Local authority scrutiny function
    Independent, elected representative led
    Section 175

17. Local Healthwatch organisations
    Link local Healthwatch to local scrutiny
Section 168 (Clause 3)

18. Local Healthwatch organisations
   Local Healthwatch to inform local scrutiny when referring to CQC
   Section 168 (Clause 3)

19. Advice given by Healthwatch England
   Duty to direct HWE if failing
   Section 45B (Clause 5)

Integrated working

20. Duties to encourage integrated working (Board)
   For the purpose of providing integrated services
   Section 19 (Clause 13J)

21. Duties to encourage integrated working (Health and Wellbeing Boards)
   For the purpose of providing integrated services
   Section 179 (Clause 2)

February 2011

Memorandum submitted by the Medical Schools Council (HS 48)

The Medical Schools Council is the authoritative voice of the UK’s 31 undergraduate medical schools. Council has serious concerns that with insufficient time for orderly transition, the functions and roles of the post-graduate (PG) Deaneries currently discharged through the SHAs will be lost. In addition, the wider national roles of PG Deans as senior educationalists and professional advisors are ignored. If both sets of roles and functions are lost there may well be dire consequences for post-graduate medical education and the future medical workforce.

The Bill requires amendment to safeguard the effective discharge of the responsibilities with which the PG Deaneries are charged even after abolition of the SHAs. This includes the recently legislated responsibility for the revalidation of doctors in training; with the PG Deaneries being designated bodies and the PG Deans described as the Responsible Officers.

Workforce Issues for Medicine

1. Medicine is a national resource with educational requirements that must meet national and international standards and which, for all doctors, must be rooted in a deep understanding of science. Funding must be ring fenced and allocated transparently and in sufficient volume to meet the requirements of the numbers commissioned centrally—decisions cannot be left to local Skills Networks. High quality education requires national coordination and regulation.

2. Medical Education is a continuum from Medical School to retirement, overseen by the GMC, and so Medical Schools need to be true partners of NHS colleagues in primary and secondary care—designing new systems together—and preparing doctors for the myriad, ever-changing roles required of them—see the Consensus Statement on the Role of the Doctor.

3. The extent of the proposals for Skills networks is too large for them to be effective. They could be advisory bodies providing intelligence on workforce needs, but contracting must be done in a profession specific way. Employers must not quality assure the posts that they themselves provide to train the staff whom they also employ. Ring fenced budgets for quality control, quality management and quality enhancement should sit with the post-graduate deans in the universities.

4. Post-graduate deans could have Honorary contracts with Medical Schools and be physically located in the Medical School to facilitate the continuum of education, improve the transition process from student to employee, co-locate responsibility for quality management of medical student placements and doctor in training posts and engage with evolving scholarship and educational innovation.

5. There is little evidence that the current system is in need of radical reform, evolutionary improvement and enhancement would seem a more appropriate approach. Nor is there evidence that a multi-professional approach is required. Inter-professional education to enhance team working once students have confidence in the unique requirements of their own profession is the way forward.
6. Clinical academic medicine is of vital importance to UK plc and is threatened by current proposals—higher fees will discourage intercalation; reduced NHS bursaries will limit widening access; the NHS Outcomes Framework requires no commitment to research and education; a focus on local issues will endanger the bigger picture—particularly with regard to smaller specialties. Without clinical academics innovation, efficiency and productivity will stall.

February 2011

Memorandum submitted by the Children’s Society (HS 49)

ABOUT THE CHILDREN’S SOCIETY

The Children’s Society, founded in 1881, is a leading children’s charity committed to improving the experience of childhood in the UK. Our national network of projects delivers specialist services for children who are disadvantaged in their daily lives. We support children in trouble with the law, young runaways at risk on the street, disabled children who face social exclusion and young refugees rebuilding their lives in the UK. We work with children who are often forgotten or whose needs are ignored: young carers, traveller children or children affected by parental substance misuse. Our approach is driven by the voices of children and young people, who are at the heart of all we do.

INTRODUCTION

The Bill proposes radical reform of the way in which the NHS is structured and how services are commissioned. It proposes reforms to the duties of NHS bodies and local authorities, accountability of NHS bodies and the role of patient involvement, and abolishes Primary Care Trusts and Strategic Health Authorities.

We believe that the current Bill may offer an opportunity to resolve some concerns around health care services for children and young people, particularly disabled children and young people and looked after children. Our concerns are focused around the provision of joint services for children and young people, strengthening the voice of children and young people about services they receive, and the commissioning of services for children and young people.

THE CHILDREN’S SOCIETY’S KEY CONCERNS

Joint working

The introduction of the local-authority led Health and Well-being Boards offers an opportunity to improve joint working across different sectors. But there are a number of concerns about how the proposed changes will impact on services for children and young people.

We are concerned that with the proposed loosening of requirements to cooperate, such as removing the duty on schools and colleges to co-operate with Children’s Trusts, removing the requirement for local authorities to set up Children’s Trusts Boards and revoking the statutory guidance on Children’s Trusts, the focus on issues that require joint working across different sectors to deliver specific services for children will be lost.

Children and young people very often access services in the community and in educational establishments. It is also in schools that some health related problems are picked up and identified. Therefore it is important that representatives from education, social care and other services for children participate in designing and providing services for children and young people. Most services are planned around adults’ needs and there is a danger that under the new Health and Well-being Boards children’s issues and needs will not get the desired focus.

Two examples of services requiring the involvement of Education, Health and Social services are speech and language therapy and mental health services. It has been highlighted in different reports that speech and language therapy services are often caught up in local “battles” between health and education, specifically whether services will be provided in respect of a child’s health needs or their education needs and, therefore, who should fund these services. As a result the quality and quantity of provision is different from one local authority to another and many children are not getting vital support that in the long-term would improve not just their education but their life chances as well.

Another example is Children and Adolescence Mental Health Services. The quantity and quality of the provision is different in different local authorities. The involvement of universal services such as education in identifying a mental health problem in a child is crucial. Provision of school based mental health services is often perceived by children to be less stigmatising.

Children’s Centres

Our work in Children’s Centres highlights the importance of integrated and multi-agency working and the importance of supporting families in the first years of a child’s life. We invest in building good relationship with other providers in the community. We work closely with early years providers, Local Authorities and Health. Health services are delivered from our centres and in
many of our centres services are co-located. We also work with voluntary and community groups. In this way they are able to have an understanding of our Children’s Centres and can refer families to us. Children’s Centres can play a critical role in early intervention and support and it is imperative that midwives, health visitors and family support workers are trained and supported to act quickly to help families when they first encounter problems.

We would like to see:

— Health, education, social services and all other relevant services need to have clear responsibility for meeting children’s health needs.
— The role and remit of Health and Well-being boards needs to be defined clearly and has to include specific responsibilities in relation to children and young people.
— Well-defined mechanisms for local authorities to monitor and influence the way different agencies co-operate in meeting the shared outcomes for children and young people.
— Health and Well-being boards should have clear responsibilities for community services including Children’s Centres and services for disabled children.
— Health and Well-being boards need mechanisms to involve service users directly, particularly those who are frequent users of services but do not have a strong voice, including disabled children and young people.
— Health and Well-being boards to have a champion for children’s services and a representative from education.

Strengthening the voice of children and young people

Under the proposed changes both the NHS commissioning board and local and national HealthWatch will have a role to play in patient involvement. The processes to ensure consistent and proactive involvement of disabled children and young people and their families must be in place and should build on successes achieved under the Aiming High for Disabled Children work.

For the proposals in the Bill for HealthWatch to work to the benefit of children and their families there must be well-identified mechanisms for children and young people to be involved on a long-term and strategic basis in service planning, development and delivery. It is particularly important to ensure that the voices of those who traditionally use health services more but have less of a say about the services they receive, like disabled children and their families, are represented in a non-tokenistic way.

In addition to shaping the look and feel of services, we would also like to see individual children having greater involvement in decision about their own care. However, the reality for many children is that they receive care but are rarely asked for their opinion about the care they receive. At the same time, as noted by an advocate working with disabled young people through The Children’s Society’s Advocacy project, “the more the young people the project supported understood and were involved in decisions, the less likely they were to say ‘no’ to treatments, tests etc”, (Evaluation of The Children’s Society’s “My Care, My Choice” project).

The Children’s Society and health advocacy for disabled children and young people

The Children’s Society’s Disability Advocacy project in London runs “My Care, My Choice” project focusing on health advocacy for children and young people. Some of the intended outcomes for this three-year project were similar to those identified in the NHS reforms—to empower children and young people to participate in decisions about their health care, to help health practitioners develop models of inclusion for disabled children and young people, and to ensure that children have access to independent advocacy.

The project has identified key barriers to involving children and young people in decisions about their health care, and they include a lack of time and skills, treating it as a tick box exercise and a lack of understanding as to why disabled children and young people should be involved in their health care or thinking that the young person really doesn’t have a choice of treatment so why should they be involved.

We would particularly like to voice our concerns about the needs of looked after children and particularly disabled children living away from home to participate in decisions about their health.

Disabled children and representation in health settings

There are around 13,300 disabled children in England living away from home in long-term residential placements, in educational, social care and health settings. They are more likely to be subject to a number of medical interventions, treatments and assessments and less likely to be involved in decisions about it. Our practitioners have raised a number of concerns about the lack of voice and representation these children have: “working with disabled children, some of whom have no formal use of communication, I have found on occasions that drugs prescribed by GPs, psychiatrists or psychologists are being used to control
challenging behaviour, without thought for the benefits of the child, the medication will often only benefit staff or support workers in working with the young person” (Practitioner, The Children’s Society’s Disability Advocacy Project).

Looked after children and health

Looked after children and young people share many of the same health risks and problems of their peers, but often to a greater degree. They can have greater challenges such as discord within their own families, frequent changes of home or school, and lack of access to the support and advice of trusted adults. Children often enter the care system with a worse level of health than their peers, in part due to the impact of poverty, poor parenting, chaotic lifestyles and abuse or neglect. Longer-term outcomes for looked after children remain worse than their peers.

A national survey undertaken by Meltzer and colleagues for the Office for National Statistics (ONS) confirmed the findings of earlier research about the high level of mental health need amongst looked after children, particularly those in residential care. 45% of looked after children were assessed as having a mental health disorder, rising to 72% of those in residential care. Among 5–10 year olds, 50% of boys and 33% of girls had an identifiable mental health disorder. Among 11–15 year olds, the rates were 55% for boys and 43% for girls. This compares to around 10% of the general population aged 5 to 15.

We would like to see:

— HealthWatch needs to be proactive in engaging all children and young people, and particularly disabled children and young people.
— All engagement methods should be accessible and age appropriate.
— Training around communication with children who need communication support should be offered to professionals.
— The core offer introduced under Aiming High for Disabled children set standards for local areas regarding the level of involvement of disabled children, young people and their families in decision making about the services they receive. Positive developments in this area particularly around parent involvement and standards for involvement should remain.
— We are concerned that medical professionals are not adequately trained or experienced in working with disabled children. In many cases communication channels are not established with young people to inform them about the side effects of treatment or medication or to ensure that they have a say in decisions based on how their medication makes them feel. Training for professionals on different means of communication and how to work with disabled children has to be developed.
— Where the young person requires support to participate in a decision about the care they receive, access to an independent advocate has to be ensured. Advocates can support young people to speak up for themselves, and can put across their views for them. It is particularly important in the case of children and young people living in health settings, especially where the child’s views differ from those of parents and professionals.

The Children’s Society’s advocacy for disabled children and young people

The Children’s Society provides advocates for disabled children, and produces resources and training to support the participation of children and young people in decision-making. The organisation has recently produced a resource pack including a DVD entitled “My Health, My Choice: Involving children and young people in decisions about their healthcare.” We provide a one-day training course to provide practical support for involving disabled young people in reviews and meetings. The organisation also provides training and support to local authorities and other agencies under the “Making it happen” initiative to improve the quality of shared decision-making and partnership working with disabled children and young people. This was achieved through the support of a local project worker, a Disabled Young People’s Champion, and an advisory group of disabled children and young people. In addition, we have designed the “I’ll go first” planning and review toolkits which enable children to communicate their wishes and feelings about the care and education they receive, which is used in over 60 local authorities.

Commissioning of services for children and young people

We believe that children and families need services that are holistic, easy to access and effectively integrated. In his review, Sir Ian Kennedy points out that services are often developed around the buildings and working practices of professionals when they need to be designed and delivered around the needs of young people. Commissioning a range of children’s services including secondary and public health services by GP consortia may remedy this situation, ensure continuity of services when a young person transits from children to adult services, and make it easier for children with complex needs and their families to access such services.
Crucial to the success of the reforms is the accuracy and efficacy of commissioning. We have concerns that many professionals do not have the training needed to ensure that the needs of children and young people are taken into account, nor is the data currently collected consistent or comprehensive enough to provide certainty around at a local level. Professional training and data collection must be improved to ensure that allocated commissioning budgets reflect local needs and that vulnerable groups of children do not fall through the gaps in service provision.

We would like to see:

— Data in many areas of health and health care for children and young people is poor or non-existent. This has been highlighted in many reports, including in the review by Sir Ian Kennedy. For effective commissioning and commissioning budgets that reflect the true needs of local communities, data collection about children and young people, longer-term conditions, and mental health and consequently Joint Strategic Needs Assessments must be improved.

— GP consortia should be subject to the public sector equality duty introduced under the Equality Act 2010, and required to conduct equality impact assessments of their commissioning frameworks across all equality streams including age.

— GP consortia should also be subject to the duty to cooperate to reduce child poverty in the local area, placed on Primary Care Trusts and Strategic Health Authorities under Part 2 of the Child Poverty Act 2010.

— Each GP consortia needs to have a children’s champion or someone with responsibility to ensure that the needs of the local child population are taken into account in the commissioning process.

— Interaction with community groups who represent the most vulnerable groups also has to be promoted. These can be voluntary organisations, parents groups etc.

— Better training is needed for GPs around children’s health issues, including early intervention and mental health, and in particular around the provision of universal services to disabled children.

— In the case of specialist services commissioned at the national level there needs to be a link to local information collection about services needed and simple referral routes for children and families who require these services.

— We are concerned about the commissioning of services for looked after children and also disabled children placed away from home in long-term health or social care placements. Nearly a third of looked after children are placed outside their local authority area, and over 10% experience three or more placement moves in a single year. With GP consortia commissioning it is not clear who will be responsible for commissioning and delivering services for these children. This needs to be specifically addressed and the duty currently placed on Primary Care Trusts and Strategic Health Authorities under the Children Act 1989, to comply with requests from their local authority to help them provide support and services to children in need, should be transferred to GP consortia.

February 2011

Memorandum submitted by the Medical Defence Union (HS 50)

INTRODUCTION

1. The Medical Defence Union is a mutual, non-profit making company owned by our members who are over 50% of the UK’s doctors, and 30% of dentists. Members have access to a wide range of benefits of membership including a £10 million indemnity policy for clinical negligence claims. We also provide advice and assistance with a range of medico-legal matters such as responding to complaints procedures including those that are referred to the Ombudsman.

2. Our memorandum covers two areas of importance to our members: the need for clarity about indemnity under the proposed commissioning arrangements, and the proposed extension of the Ombudsman’s powers to disclose reports.

SUMMARY

Clauses 9 and 10

3. We believe it is a failing that the Bill does not mention the subject of indemnity in clauses 9 or 10, and that in the many documents that have been published outlining the changes consideration has not been given to the arrangements that will be needed in place to ensure patients receive compensation. The changes proposed in the Bill need to be supported by clear arrangements for indemnity that will ensure certainty of compensation for patients who are negligently damaged. We believe the Bill should be amended to provide clarity about indemnity arrangements to protect patients.

105 Care Matters: Ministerial Stocktake report 2010.
Clause 185
4. We believe clause 185 should be amended to make it clear that the criteria that the Ombudsman needs to consider when making wider disclosures are not just the appropriateness of sharing the reports or statements, but that the Ombudsman may only send a report or statement to another person if the Ombudsman can demonstrate that is necessary to do so in the public interest and that the Ombudsman considers it reasonable to do so in the circumstances.

Clauses 9 and 10

The need for clarity about indemnity
5. The current position is that, outside the indemnity provided by the NHS, doctors and dentists have to make their own indemnity arrangements for clinical negligence claims. The MDU provides insured indemnity to individual and corporate medical and dental members working in the primary care and independent sectors in order to ensure that patients receive appropriate compensation if they are negligently damaged by our members. A number of our medical members, including doctors currently indemnified by the NHS for their NHS work, are already asking us what will happen to their indemnity if they change the way they practise or the services they provide to patients in future. Doctors who want to take part in the changes proposed in the Bill need to know they will be indemnified if they do.

6. Our concerns about the lack of clarity in the Bill about indemnity are twofold: first there is no mention of clinical negligence indemnity arrangements at all, and second it does not provide for guidance about the type of arrangements that will need to be in place to ensure that patients who are negligently harmed receive compensation.

7. The Bill is silent on how the arrangements for indemnity for clinical negligence will need to change, yet change they must to ensure they underpin any new arrangements for commissioning and provision of care. Clauses 9 and 10 of the Health & Social Care Bill 2011 set out the duties and powers of consortia to commission secondary care services on behalf of patients of consortia members and we would expect to see mention of indemnity in respect of these provisions. But the Bill does not specify that under the new arrangements clinical negligence claims arising from such services must be indemnified, or how patients receiving care commissioned from non-NHS providers can be certain they will be compensated.

8. We expect that under the new arrangements proposed in the Bill, responsibility for clinical negligence claims should lie with the providers and not the commissioning consortia. If this is the case, before entering into agreements with providers, GP consortia will need to be satisfied that the providers accept responsibility for compensating any patients who are negligently harmed by them. Commissioners will need to be satisfied that providers’ indemnity is adequate and appropriate to ensure patients will be properly compensated, whether through NHS indemnity or separate arrangements. If the indemnity is not provided by the NHS, commissioners will need contractual certainty that patients whose care they are commissioning will be compensated if they are negligently harmed.

9. From the point of view of providers, it must also be clear what services the NHS is prepared to indemnify, or whether doctors will need to make their own indemnity arrangements if they choose to offer services to the NHS as independent providers under the new arrangements.

10. Given the planned increase in the direct involvement of patients and representative organisations in commissioning decisions, Healthwatch England and others will almost certainly wish to be satisfied that clear and robust arrangements are in place to ensure that patients will be compensated if they are negligently damaged by the provider. We expect that GP consortia and patient and consumer representatives will need certainty about the amount and type of indemnity, and assurances that the organisation providing it, if it is not an NHS body, is a reputable insurer.

11. The standard NHS contracts and guidance refer only to appropriate insurance provided by a “reputable” insurer and we believe that the requirements should be more specific. While NHS indemnity may be relied upon, there will need to be greater clarity about the indemnity and the provider. It should no longer be possible for the Department of Health to say that an arrangement is acceptable on the grounds that it has worked in the past, not least because a widening of the market may see a range of new insurance providers wanting to provide indemnity insurance to doctors. In order to protect patients, who won’t themselves buy the clinical negligence insurance upon which they might need to rely, there needs to be a new set of ground rules that apply equally to all concerned, outside NHS indemnity. There will need to be clear criteria for the types of indemnity and for providers that will be considered adequate and appropriate to protect patients. For example, we would suggest at a minimum that any indemnity provider should be authorised and regulated by the FSA, or other appropriate EU regulator, to conduct this type of business.
PROPOSAL FOR AMENDMENT TO CLAUSES 9 AND 10

12. We believe it is a failing that the Bill does not mention the subject of indemnity, and that in the many documents that have been published outlining the changes consideration has not been given to the arrangements that will be need to in place to ensure patients receive compensation. The changes proposed in the Bill need to be supported by clear arrangements for indemnity that will ensure certainty of compensation for patients who are negligently damaged. We believe the Bill should be amended to provide clarity about indemnity arrangements to protect patients.

WIDENING OF THE HEALTH SERVICE COMMISSIONER’S POWERS

13. As drafted, clause 185 Disclosure of reports etc by the Health Service Commissioner says: “In section 14 of the Health Service Commissioners Act 1993 (reports etc by the Commissioner), after subsection (2H) insert—

‘(2I) Where the Commissioner is required by this section to send a report or statement of reasons to certain persons, the Commissioner may send the report or statement to such other persons as the Commissioner thinks appropriate’.”

14. The MDU supports the rationale behind the widening of the Ombudsman’s powers as proposed in clause 185. We believe the change is intended to enable the NHS to share learning from complaints as widely as possible so that lessons learned can feed back into practice and inform any necessary changes with the purpose of enhancing patient care and safety. In the first place it is important that such learning takes place within the body (or by the individual) that was the subject of the complaint. Even if the Ombudsman decides that it is not appropriate for her office to investigate a complaint, the body or individual who is its subject should be informed of the complaint.

15. There is also a wider interest in sharing information from complaints with other organisations that are in a position to learn from them, or that can encourage other bodies and individuals to take account of the points raised. We are sure that the intention of the Ombudsman is only to make such disclosures in circumstances where it is reasonable to do so in the public interest and in a way that respects the rights of the complainants as well as those of the subject body or individual. The clause at is stands does not, however, specify this and we believe it should because even if a report is anonymised, patients and doctors can often be identified from the case details. Patients have a right to confidentiality and equally individuals and organisations that are the subject of complaints have rights to fair procedures and to be treated fairly.

PROPOSAL FOR AMENDMENT TO CLAUSE 185

16. We believe clause 185 should be amended to make it clear that the criteria that the Ombudsman needs to consider when making wider disclosures are not just the appropriateness of sharing the reports or statements, but that the Ombudsman may only send a report or statement to another person if the Ombudsman considers it reasonable to do so in the circumstances.

February 2011

Memorandum submitted by Diabetes UK (HS 51)

SUMMARY

1. Diabetes UK is the leading charity for over 3.5 million people in the UK with diabetes, funding research, campaigning and helping people living with the condition. Our mission is to improve the lives of people with diabetes and work towards a future without diabetes.

2. Diabetes UK welcomes the Government’s aim for a patient centred NHS. Key to this is the delivery of integrated care, in which a person with diabetes has access to the multidisciplinary skills of generalists, specialists, allied health and other professionals in a timely and co-ordinated manner. Diabetes UK is concerned proposals within the Bill could undermine this.

3. We believe the Bill should be strengthened to ensure:

3.1 integrated working and service provision;

3.2 people with diabetes, and the multidisciplinary range of professionals with expertise in diabetes care, are involved in the commissioning of diabetes services;

3.3 there is increased accountability of commissioners, and in particular for integrated working;

3.4 people with diabetes have access to the range of skilled professionals they require for their care;

3.5 participation in national clinical audits are made mandatory; and

3.6 standards of quality are more strongly embedded within the Bill.
1. **Continuity of Diabetes Care and Risks of Fragmentation**

4. A person living with diabetes can be in contact with public health, primary and specialist care. For example, through a risk assessment that could lead to an intervention to diagnose Type 2 diabetes, being supported to manage the condition, having reviews and screening for complications and for some the management of these complications.

5. We have concerns that the proposed structural reform which will see different aspects of diabetes care commissioned by a range of commissioners could further fragment the way in which services are provided.

6. **Core principles of integration include:**

6.1 A joined up, seamless interaction of the person with the various professionals and parts of the system they are engaged with.

6.2 All relevant stakeholders including people with diabetes, carers, and the multidisciplinary range of professionals that work with them, are involved and inform the commissioning of an integrated model of care.

6.3 All professionals involved in the care of the person are working together, communicating effectively and aware of each others roles and responsibilities.

6.4 Local protocols and agreed referral pathways for the management of different aspects of diabetes care are implemented in accordance with national guidelines.

6.5 Effective IT systems that can support appropriate sharing of information between the different professionals supporting a person with diabetes are in place.

6.6 Involvement of the person with diabetes in their care through care planning to support individually tailored care; and enhanced communication with individuals through access to their health records and tools to support self management.

6.7 Effective clinical leadership, service user involvement and being innovative when planning services across organisational boundaries.

7. When diabetes services are not integrated we know this leads to problems with:

7.1 communication between providers;

7.2 duplication of efforts, for example repeating tests, which can delay care provision;

7.3 inconsistency in the advice and information provided to people with diabetes;

7.4 people with diabetes having to repeat the provision of information about themselves and their needs to different providers; and

7.5 People with diabetes not knowing which part of the system has responsibility for delivering a particular part of their care.

8. We know from surveys of people with diabetes that continuity of care, regular access to care, and better liaison between different providers, for example primary and specialist care providers, are key improvements they would like to see to their care.

9. While there are some requirements within the Bill for integrated and partnership working, and for consortia and the NHS Commissioning Board to seek appropriate advice from professionals, Diabetes UK questions the strength of these duties, and the degree of accountability within the new system to ensure this occurs.

10. Diabetes UK believes the duties to encourage partnership working placed on the NHS Commissioning Board and Health and Wellbeing Boards should be strengthened to duties to ensure this occurs. These bodies would then be held accountable for discharging this duty. As the ultimate goal of integrated working is the realisation of integrated services, this too should be recognised within these duties.

11. As commissioning consortia, local authorities and the NHS Commissioning Board will all have responsibility for commissioning services; each should have an explicit duty placed upon them to commission integrated services for people with conditions, like diabetes and those at risk of developing it, whose needs will span all three commissioners.

12. Diabetes UK believes a “duty to commission integrated services” would complement the duties on the NHS Commissioning Board and Health and Wellbeing Boards with regard to promoting partnership working to this end, creating further accountability for achieving this, within the system.

13. Integrated care and partnership working between all key stakeholders is crucial to ensure that diabetes services are commissioned in a way which means people with diabetes get the right care, from the right professional and at the right time.


14. Networks, such as diabetes networks bring together stakeholders with relevant expertise to inform the commissioning and design of diabetes services within a locality. These stakeholders include people with diabetes and their carers, representatives of third sector organisations, multidisciplinary diabetes specialists, primary care, pharmacy, ambulance services, public health, social care and education.

15. National recommendations recognise the benefits of networks in supporting the commissioning and delivery of integrated care. In particular at a time of structural upheaval they can be a force for stability and continuity.

16. Diabetes UK would like the “duties to seek advice” in Sections 19 clause 13 G and Section 22 clause 140 strengthened to become “duties to involve” multidisciplinary professionals and patients.

17. The duties should be further amended to require the involvement of both multidisciplinary professionals and patients with expertise in the condition being commissioned for, and the relevant networks.

18. Involvement should reflect all stages of a commissioning cycle, from the planning of commissioning arrangements through to the monitoring of the quality and effectiveness of the services commissioned.

19. Conflicts of interest have been identified within the legislation, for example between roles of commissioning and provision.

20. At present the Bill states that regulations, “may in particular, impose requirements relating to (b) the management of conflicts between the interests involved in the commissioning of services and the interests involved in providing them.”

21. Diabetes UK is concerned that these conflicts of interest will work to the detriment of partnership working and ensuring the integration of care as practitioners who are potential providers of services will also have the power to commission these services.

22. Furthermore the duties to promote competition raise concerns about the impact this will have on the delivery of integrated services, and on commissioners and their ability to work collaboratively with other colleagues in the design and commissioning of services.

23. This creates a possible risk that GP commissioners will not be in a position to work with specialist colleagues to design and deliver a comprehensive service. It also places significant challenges on organisations to work to retain business rather than working in the best interest of patients.

24. Integrated working with all relevant stakeholders is essential to ensuring services are commissioned in accordance with the needs of patients.

25. Diabetes UK recommends the Bill is strengthened in relation to these points, with explicit safeguards relating to patient safety, continuity of care, and the delivery of integrated, effective and high quality services.

26. The Bill makes some provision for the merger and dissolution of organisations.

27. Diabetes UK is seeking greater clarity regarding what safeguards are in place to mitigate against the potential for continual small scale reform and the impact this will have on integrated care, partnership working and continuity of care, if for example a consortia decides to split after a short period.

28. While some provisions within this Bill and prior legislation will enable a degree of assurance and monitoring of standards of care, Diabetes UK questions whether these go far enough in ensuring that high quality care will be available to all people with diabetes at a local level.

29. With an increasing availability of a range of service providers in the new system, it is vital safeguards are contained within the Bill to ensure people with diabetes can be assured of the competency of those providing their care. Diabetes UK questions whether CQC registration, and the duties placed on both the NHS Commissioning Board and the GP Consortia as to improvement in quality of services, will go far enough in ensuring people with diabetes have access to the full range of skills across diabetes care pathways, including specialist services.

30. Diabetes specialist teams have a key role within an integrated model of high quality diabetes care, not only in providing direct clinical care but also in providing training and support to generalists. Diabetes specialist teams should comprise of physician, nursing, podiatric, psychological, and dietetic diabetes specialists. Furthermore there will be liaison and potentially the delivery of joint clinics with specialists managing the complex co-morbidities of the condition. People with Type 1 diabetes, children and young people, pregnant women and those with long term complications are examples of individuals who are generally supported by diabetes specialist team members.


31. A key priority identified by people with diabetes is access to appropriately trained professionals to meet their needs:

“... by appropriately trained and competent staff who can prove they are up to date with all advances in their chosen field and have excellent communication skills.”

“Properly trained clinicians available who are regularly updated on latest treatments and care.”

32. Diabetes UK urges the government to strengthen the Bill to ensure that specialist services will be available to provide the services required of them.

33. While there are questions regarding whether the NICE Quality Standards will be comprehensive enough and cover the right areas, they have been given a prominent role within government plans.

34. Diabetes UK believes the role of the NICE Quality Standards should be strengthened within the legislation and that the strengthened duty is explicitly extended to commissioning consortia. If included as part of Section 22, clause 14 L, this would also ensure commissioning consortia must explicitly explain, as part of consortia plans, how they will discharge their duty with regard to the NICE Quality Standards (Section 22 14Y (page 34).

3. MANDATING NATIONAL CLINICAL AUDITS

35. In order to ensure accountability, particularly in light of proposed NHS structural reform, robust information regarding the quality of care is required to monitor services and improve them, and to provide patients with reliable information to support them both to make choices about their care and to hold services to account.

36. National Clinical Audits, such as the National Diabetes Audit (NDA) for adults and children and young people utilise thorough methodologies and are exemplars in quality data collection and analysis, leading to service improvement. The importance of national clinical audits and their extension has been acknowledged by the Government in the NHS White Paper.111

37. The NDA also provides an excellent foundation for the Government’s developing programme of work surrounding outcomes.

38. Diabetes UK recommends section 242 (clause 1 (a) (page 200) is amended to require the process of information collection and provision to be undertaken through a robust audit process such as those of national clinical audits.

4. INFORMATION ACCREDITATION

39. Diabetes UK is seeking clarity regarding the remit of the Information Accreditation scheme in Part 9 Chapter 2 247, and whether this will extend to providers of information for patients, such as the voluntary sector.

40. The voluntary sector is a critical source of patient information and if the Information Accreditation scheme is to apply to this role or sector, the Government must ensure the administrative, regulatory and financial burdens do not prohibit the sector from participating. Concerns about the current Information Standard scheme include the costs to information providers of being involved, the need for greater promotion of the scheme to healthcare information users, and the need for better integration with existing programmes such as NHS Choices and Information Prescriptions.

41. This is particularly important in an environment where patient choice is being extended and generalist organisations such as Local Healthwatch are expected to facilitate the role of information provision to support choice.

5. PATIENT INVOLVEMENT

42. “No decision about me without me” and increasing patient choice each anticipate that people with long term conditions will be involved in their own care.

43. For people with diabetes supported self management can help a person reduce their risk of developing the devastating long term complications of the condition including, heart disease, stroke, amputations and blindness.112

44. Diabetes UK believes support for self management such as care planning, information, education and emotional and psychological care and support, must all be available in order to support people with diabetes to self manage and participate in informed decision making around their care.112

45. This is supported by comments Diabetes UK received for its NHS White Paper consultations where the description of quality care or of what people would look for to inform their choice of service, included:

“Good quality of care is tailored to the individual.”

“... high quality care is supporting the patient and family to enable them to manage the condition efficiently and independently, so that their quality of life is as unaffected as possible and they are able through good diabetes management, to minimise the risks of developing complications of diabetes.”

“Good understanding and education is the key to good quality of life. Education is often talked about but ‘ignored’ and not tailored to the individual’s need and local communities.”

“Structured education to help manage own health condition.”

“What education can I access to improve that understanding; are the any self-help groups available to me; Are ALL types of treatment and medications available to me, so that I can, with information make my choice of what to use.”

46. We know from surveys of people with diabetes, and of diabetes care providers, there is great inconsistency in the availability of services to support self management. For example, only 36% of people with diabetes responding to our survey said they had attended a course to help them manage their diabetes since they were diagnosed.

47. Furthermore supported self management forms part of the current QIPP agenda for long term conditions, which recognises that supporting people with long term conditions to self manage demonstrates both high quality care and the potential for long term savings through better condition management.

48. Diabetes UK supports recommendations to define a patient’s involvement in their own treatment and care. We recognise there is an existing definition contained within The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Part 4 Section 17 2 (e), which aims to underpin the right for people to manage their own care.

49. While this provides a good foundation we believe this definition can be built upon and strengthened within this Bill, with the NHS Commissioning Board and Consortia required under their duties to “provide services to support people to self manage their long term conditions”.

LOCAL HEALTHWATCH

50. Local Healthwatch are to be tasked with providing advocacy, supporting people to make choices, reporting issues for investigation to Healthwatch England and promoting user involvement.

51. Diabetes UK continues to have concerns, raised in our submission to the White Paper, about the capacity and skills that will be required to deliver on all these functions and what safeguards will be in place to ensure these roles are undertaken effectively.

52. We also question how decisions will be reached as to what is referred up to Healthwatch England when problems are identified and reported to local Healthwatch.

53. People with diabetes have fed back their views on the need for local Healthwatch to engage with them: “... use expert patients. We live with our conditions and are aware of what’s important.”

“... ensure there is a good cross section of the population.”

54. Diabetes UK would like more clarity on the requirements which will be put in place to ensure that Local Healthwatch effectively work with and involve service users representing the needs and concerns of specific conditions.

February 2011

Memorandum submitted by the Health Professions Council (HS 52)

SUMMARY

1. The Health Professions Council (HPC) is pleased to make this submission to the Health and Social Care Bill Committee. In our submission to the Committee we have addressed issues surrounding the “Regulation of healthcare professions and health and social care workers”, which is Part 7 of the Bill. Our submission examines the implications of the relevant sections and how it will alter the current system of regulation. One of the main aspects of the Bill is the change in the regulation of social workers in England. We will continue to develop and maintain good working relationships with the General Social Care Council (GSACC) and the social care regulators in Scotland, Wales and Northern Ireland to ensure consistency in regulation across the UK.

2. The HPC is an independent UK-wide statutory regulator for 15 professions working in the NHS, education, the community and independent practice. Our focus is on the protection of the public and we do this by maintaining a register of professionals who meet established standards for training, professional skills, behaviour and health.

3. On the following pages we address Part 7 of the Bill comprising Clauses 193 to 215 by which the Health and Social Care Bill affects the HPC. We support the Bill and look forward to continuing to work closely with stakeholders across the UK during the process of implementation. Should the Committee wish for any further information we will be happy to provide it.

INTRODUCTION

4. The Department of Health’s (DH) July 2010 White Paper, Equity and Excellence: Liberating the NHS, was followed by the Report of the Arm’s-Length Bodies Review which detailed the intention to move the regulation of social workers in England from the General Social Care Council (GSCC) to the Health Professions Council (HPC). The overall objective is to make the regulation of social workers in England financially independent of government.

TRANSFER OF REGULATORY FUNCTIONS

5. The working timetable is to complete the transfer of the Register of Social Workers to the HPC by April 2012, as stated in the Report of the Arm’s-Length Bodies Review. The HPC is working closely with the GSCC on this process and the objective is to deliver a smooth transition which ensures the protection of the public.

OTHER PROFESSIONS

6. The HPC has a strong track record in working with professional and regulatory bodies in this regard. In September 2004 the HPC assumed responsibility for the regulation of Operating Department Practitioners after working closely with the College of Operating Department Practitioners. In July 2009 it commenced regulation of Practitioner Psychologists, transferring voluntary Registers held by the British Psychological Society and Association of Educational Psychologists to the HPC Register. Most recently in April 2010 the HPC assumed responsibility for the regulation of hearing aid dispensers after the abolition of the Hearing Aid Council. Prior to and during the transfer of responsibilities, the HPC and the above bodies established good working relationships; the HPC is committed to replicating the quality of these relationships with the social work profession, employers, education providers, user groups and other stakeholders, as well as the regulatory councils in Northern Ireland, Scotland and Wales.

ISSUES

Registration costs

7. The registration fee for the GSCC currently stands at £30 per annum, this would be much higher if the GSCC were to operate on a full-cost recovery basis as an independent regulatory body and higher than the £76 annual fee for HPC registrants. The Health and Social Care Bill 2011 Impact Assessment outlines the cost of registration for social workers if GSCC was fully funded by fees from its registrants and with no Government subsidy. Fees would have to rise by a cost of between £210 and £250 on top of the fees currently paid. Registering with the HPC will therefore be more economical than if the GSCC were to continue but without financial support from government; HPC also has one of the lowest regulatory registration fees.

8. Some registrants will qualify for a discount on fees. For example, newly qualified graduates receive a 50% reduction in the fee in their first two professional years. Fees for registrants who live and work in England will be tax-deductible.

STUDENT REGISTRATION

9. The HPC does not currently register students, unlike the GSCC. However, through its standards, guidance and approved education courses, students are regulated by HPC. HPC provides guidance on conduct and ethics for students and requires all education providers delivering relevant programmes to operate disciplinary processes for students aiming to enter the professions which it regulates.

10. The Health and Social Care Bill proposes regulatory powers for HPC to establish a voluntary register for students. HPC will carry out an impact assessment and a consultation with stakeholders later this year looking at the issue of student registration and specifically whether social work students should be registered. The Council will then make a formal decision on the issue.

114 E73. p 125, Health and Social Care Bill 2011 Impact Assessments Department of Health.
Setting Standards for the Profession

11. The HPC has formed a Working Group which is preparing draft standards of proficiency for social workers in England as well as the threshold level of qualification for entry to the Register. The group consists of 12 members including individuals from relevant social work stakeholder organisations as well as four HPC members. This work commenced on 14 January and will include a full consultation on the proposed standards.

New Name for the Health Professions Council

12. The Health and Social Care Bill proposes that the HPC be renamed the Health and Care Professions Council (HCPC) to reflect the expanded remit that is proposed. A strap line will be used to clearly communicate the range of professions that will be regulated: “Regulating health, psychological and social work professionals.”

13. There has been a positive response from stakeholders about the incorporation of the word “care” in the new name as it better reflects the range of professions that are regulated. In research conducted by Ipsos MORI and GfK NOP, 81% of the general public felt that “Health and Care Professions Council” would best reflect the role of a regulator of many different professions. 76% of the general public associated the term “care professional” with “social worker”. As a UK-wide regulator a Welsh translation of the name will be used in Wales.

UK Wide Registration

14. The registration of social workers in the UK is devolved and each of the four countries has its own regulator. These proposals only relate to regulation in England. The professions which the HPC currently regulates are UK-wide. The social work profession will be the only profession which the proposed HCPC will regulate in England alone.

15. HPC is experienced in working with the devolved administrations in regards to engaging with registrants and stakeholders. Clause 199 of the Health and Social Care Bill places a duty on HPC to cooperate with other Care Councils. HPC has begun working with the social work regulators in Wales, Northern Ireland and Scotland. HPC will continue to develop good communications to ensure consistency in decision making and to ensure public protection is provided across the UK.

16. HPC will enable social workers registered with Care Councils outside of England to practice in England on a temporary basis. Options regarding the temporary registration of social workers outside England are currently being examined.

Appeals

17. Fitness to practise appeals for social workers are currently heard by the Care Standards Tribunal but this will change with transfer of social work regulation. The Health Professions Order provides that appeals against decisions regarding fitness to practise are made to the High Court. This is consistent across all 15 HPC registered professions and the other healthcare regulators.

February 2011

Memorandum submitted by the Specialised Healthcare Alliance (HS 53)

1. The Specialised Healthcare Alliance is a coalition of 61 patient-related organisations supported by nine corporate members which campaigns on behalf of people with rare and complex conditions requiring specialised care. Examples are numerous but include certain cancers, cystic fibrosis, haemophilia, neurological conditions and a wide range of services for children. Accidents or complications of more common conditions can also trigger the need for specialised services such as burns, pain management and spinal injuries.

Executive Summary

2. There are four main issues which the Alliance wishes to draw to the attention of the Public Bill Committee:

(a) Direct commissioning functions of the NHS Commissioning Board.

The Alliance welcomes the provision that the Secretary of State may require the NHS Commissioning Board to commission services with regard to a range of criteria, including patient numbers and cost (clause 11). The accompanying Impact Assessment clarifies that these are expected to include national and regional specialised services, the latter as defined by the Specialised Services National Definitions Set. The Alliance agrees that commissioning by the Board holds out the prospect of improvements to specialised services in terms of access, funding and quality. We do, however, consider that the Board will require a sub-national
structure to deliver these benefits and the Bill is notably silent on that score, which might be sensibly addressed in clause 19 on exercise of (the Board’s) functions. This also needs to clarify what recourse individuals and organisations have outside the Board for services commissioned by the Board.

(b) Monitor and the designation of providers of specialised services.

The Alliance attaches great importance to designation of specialised providers, as set out in the Carter Report on specialised commissioning in 2006. This allows commissioners periodically to designate providers based on a nationally agreed set of patient-centred, clinical, service, quality and financial criteria. In particular, this ensures adequate patient volumes to sustain requisite levels of clinical expertise to deliver high quality, safe services; a key lesson of the Bristol Inquiry. The Alliance is concerned that Monitor’s role in promoting competition could conflict with the need to designate specialised providers. Monitor’s remit in the Bill needs to be amended to recognise the primacy of patient safety and allow for designation as defined in the Carter Report.

(c) Use of maximum tariffs.

The Impact Assessment envisages extension of the national tariff to specialised providers as one of the benefits of commissioning by the Board. The Alliance supports tariffs being developed for specialised care providing the data underpinning them is sufficiently robust and can accommodate often wide variations in cost per patient, depending on complexity. We are, however, concerned by reference in clause 103 and elsewhere to the tariff being used as a maximum price. The available evidence suggests that price competition in healthcare can easily be detrimental to standards. We would therefore welcome an amendment to the Bill deleting reference to the tariff being used as a maximum price or a clear and binding explanation as to the circumstances in which it could occur.

(d) Patient and public involvement.

The Alliance sees Healthwatch England as vital in collecting the views of people who use specialised services. However, the Alliance is concerned that this role may become swamped in Healthwatch England’s large portfolio. The Alliance is therefore calling for Healthwatch England to collect specific information on the views of people who use specialised services.

A. **DIRECT COMMISSIONING FUNCTIONS OF THE NHS COMMISSIONING BOARD**

Clause 11: Power to require Board to commission certain health services

Clause 19: The NHS Commissioning Board: further provision

3. The Alliance welcomes the provision that the Secretary of State may require the NHS Commissioning Board to commission services with regard to a range of criteria (clause 11, subsection (3)). The Department’s Impact Assessment makes clear that these are expected to include national and regional specialised services.

4. For the most part, the Alliance supports the Impact Assessment’s evaluation of the potential benefits of the Board commissioning specialised services, including streamlined decision-making, funding, planning and commissioning, and more transparent decision-making processes.

5. The Alliance also supports the defining of regional services, as referenced in the Impact Assessment, with regard to the Specialised Services National Definitions Set. This is a recently updated document which provides a clearly-defined reference point and would in particular aid the transfer of commissioning functions to the Board.

6. The Alliance recognises that the factors to which the Secretary of State must have regard when deciding which services he will require the Board to commission would allow for the inclusion of specialised services in the Board’s direct commissioning functions. However, it is not clear exactly how these criteria will be interpreted, or how they will be used in practice. The Alliance is therefore seeking clarification on how these criteria will be interpreted for the future.

7. The Alliance believes that the Secretary of State’s mandate to the Board (as set out in clause 19, 13A: Mandate to the Board) will go some way to ensuring that the Board is appropriately assessed with regard to its direct commissioning functions. However, the Alliance notes that the Board will only be assessed annually on the objectives set out in the Mandate. Therefore, the Alliance would like further information on what recourse individuals and organisations will have outside the Board for services commissioned by the Board.

8. The Bill gives no guidance on any sub-national structures of the Board, which will be vital in ensuring that the Board carries out its direct commissioning functions effectively. A sub-national structure would help integrate the Board’s work with that of GP commissioning consortia and providers. It would also enable the engagement and input of GP consortia, alongside the effective provision of those primary and community care services best commissioned at local level for people with specialised conditions. The Alliance is therefore seeking re-assurance that the Board will have a sufficient sub-national structure to fulfil its responsibilities effectively. This could be addressed at an appropriate point in clause 19.
B. Monitor and the Designation of Providers of Specialised Services

Clauses 51–55: Monitor

9. Clause 52 of the Bill sets out Monitor’s main duty as “promoting competition where appropriate.” Clauses 52 and 54 set out a large number of factors to which Monitor must have regard when exercising its functions, while clause 55 states that where Monitor considers that any of its general duties conflict with each other, it will be able to resolve the conflict “in the manner it considers best”.

10. The Carter Report on specialised services (2006) recommends the designation of providers of specialised services. Designation allows commissioners periodically to designate a certain number of providers for a particular service based on a nationally agreed set of patient-centred, clinical, service, quality and financial criteria. The Alliance supports the Carter Report’s view that designation of specialised providers helps to secure an appropriate concentration of clinical expertise and activity to safeguard patient access to high-quality, cost-effective services located to maximise geographical convenience.

11. The Alliance is concerned that Monitor’s new role in promoting competition might prove incompatible with the designation of providers of specialised services. Although the process of designation helps to ensure that many of the factors which Monitor must have regard to are met, in particular patient safety, it is clear that Monitor must balance a large number of considerations.

12. The Alliance is therefore calling for Monitor’s remit to be amended to protect the ability of the NHS Commissioning Board to designate providers of specialised services. We believe that this could be achieved by establishing the primacy of patient safety within those factors to which Monitor must have regard.

13. Please note that the designation of providers of specialised services should not be confused with the concept of essential designated services, as introduced in the Bill in clauses 69–73: Designated Services. However, the inclusion of these designated services in the Bill does set a precedent for the curtailment of Monitor’s powers with regard to competition where it is in the public interest to do so.

C. Use of Maximum Tariffs

Clauses 103–112: Pricing

14. The Department’s Impact Assessment envisages the extension of national tariffs for specialised services. The Alliance supports tariffs being developed for specialised care providing the data underpinning them is sufficiently robust and can accommodate often wide variations in cost per patient, depending on complexity.

15. However, the Alliance is concerned by references in clause 103 and elsewhere to a “maximum price” which would be set out in the national tariff.

16. The original intention of the tariff was to provide a robust approach to pricing which would free commissioners from negotiating prices at a local level, thus allowing for competition between providers based on quality rather than price.

17. The Alliance fears that the introduction of a “maximum price” would rapidly introduce competition on the basis of price rather than quality, resulting in a detrimental impact on the quality of services. As negotiation on price would still be required at local level it would also call into question the value of establishing national tariffs in the first place.

18. The Alliance is therefore calling for all references to the national tariff specifying a maximum price to be removed from the Bill or a clear and binding explanation as to the circumstances in which it could occur.

D. Patient and Public Involvement

Clause 166: Healthwatch England

19. The Alliance stresses the importance of Healthwatch England in collecting the views of patients with specialised conditions, since other Healthwatch organisations will be too locally focused.

20. However, the Alliance is concerned that the collection of the views of people who use specialised services could get overlooked given Healthwatch England’s large portfolio. The Alliance is therefore calling for clarification during discussion of clause 166, 45A (Functions to be exercised by Healthwatch England), that Healthwatch England will have a specific duty to collect the views of people who use specialised services.

February 2011

Memorandum submitted by the North West Scrutiny Support Officers’ Network (HS 54)

The North West Scrutiny Officers Network is led and attended by scrutiny officers from local authorities in the region. They share best practice and work together to prevent duplication of effort. They maximise their pooled knowledge and resources to support the development of their respective scrutiny functions. The submission in respect of the Health and Social Care Bill is from Officers who specialise in the health scrutiny function and have many years experience in facilitating democratic legitimacy in health and social care.
Our submission is brief and I would point out that the Network is largely supportive of the elements of the Bill that relate to the scrutiny functions of local authorities. There are however two areas of primary concern that we would like to bring to the attention of the Committee.

Firstly, Chapter 2 of the Bill titled “Local Government Scrutiny functions of local authorities”, Section 175, subsection 3 (a) which states “as to circumstances in which the authority may refer any of those matters to the Secretary of State, the regulator or the Board”.

Currently, a local authority health scrutiny committee has right of referral to the Secretary of State in relation to substantive service changes by NHS trusts. According to paragraph 5.41 of Liberating the NHS legislative framework and next steps (published December 2010), in future “the local authority will be able to refer decisions about significant changes to any designated services to the Secretary of State”. The Chapter of the Bill referred to above will allow the Secretary of State, via regulations, to make provision to allow the referral of only “designated” services in the future. Our understanding is that “designated” services will be those designated by the regulator as being essential services. Therefore, if this particular element becomes enacted, it will not be possible in the future to refer any services that have not been designated, thereby allowing an undeterminable number of still very important services to “slip through the net”, so to speak, in relation to the referral mechanism.

We would point out that since its inception under the Health and Social Act 2001, the power of referral to the Secretary of State has been used very sparingly across the country. Nevertheless, it is considered to have been a very useful mechanism of last resort in the arbitration of disagreements between NHS Trusts and the democratic health scrutiny function. We feel that if the referral mechanism were to apply only to designated services, it would be a retrograde step and would remove an important element of the democratic process that currently needs to be considered by Commissioners and Providers of services, when applying changes to services.

The second matter that we would like to draw your attention to also refers to Chapter 2 of the Bill titled “Local Government Scrutiny functions of local authorities”, Section 175, subsection 3 (a) which states “as to circumstances in which the authority may refer any of those matters to the Secretary of State, the regulator or the Board”. I again refer to Liberating the NHS legislative framework and next steps” (para 5.43) which states “To ensure that the health scrutiny model is consistent with other forms of scrutiny in local authorities, and as democratic as possible, we propose that any decision to refer a substantial service change proposal should be triggered by a meeting of the full council”.

Again, the Chapter of the Bill referred to above will obviously allow the Secretary of State, via regulations, to enact the provision whereby a referral to the Secretary of State can only be made following agreement by a meeting of full Council. We submit that this proposal is fundamentally flawed and should not be enacted. As we see it, there are two major problems. Firstly it is necessary to stress that on the rare occasions a referral to the Secretary of State is required, it is necessary to act quickly when often the closure of an important service provision is at stake. It would simply add an unworkable timescale element to the whole process if it was necessary to route a referral through full Council. This is because in a number of authorities, meetings of full Council take place on an infrequent basis, eg once every two months.

There is also the issue of whether in fact such a matter being considered by full Council will add anything of value to the democratic process. The stated rationale behind the proposal is to ensure consistency with other forms of scrutiny in local authorities and to be as democratic as possible. We submit that the proposal would not achieve any of these aims. Firstly, it is necessary to stress that on the rare occasions a referral to the Secretary of State is required, it is necessary to act quickly when often the closure of an important service provision is at stake. It would simply add an unworkable timescale element to the whole process if it was necessary to route a referral through full Council. This is because in a number of authorities, meetings of full Council take place on an infrequent basis, eg once every two months.

To conclude, we can see no reason to amend the current legislation around referrals of substantive service changes and the current route of referral.

February 2011

Memorandum submitted by Parkinson’s UK, the Motor Neurone Disease (MND) Association, the Multiple Sclerosis (MS) Society, Epilepsy Action, the PSP Association, Sue Ryder Care, the UK Acquired Brain Injury Forum (UKABIF) and the Neurological Alliance

1. BACKGROUND AND INTRODUCTION

1.1 Parkinson’s UK, the Motor Neurone Disease (MND) Association, the Multiple Sclerosis (MS) Society, Epilepsy Action, the PSP Association, Sue Ryder Care, the UK Acquired Brain Injury Forum (UKABIF) and the Neurological Alliance are charities working for people with neurological conditions. We share a number of concerns about how aspects of the Health and Social Care Bill could affect the people we represent. Therefore, for the convenience of the Bill Committee we are submitting a joint response.

The Neurological Alliance is the collective voice of 80 brain and spine charities, representing the eight million people in England with a neurological condition. The Alliance campaigns for access to high-quality, joined-up services and good information for every person diagnosed with a neurological condition, from their first symptoms, throughout their life. More information is available at www.neural.org.uk
1.2 The charity sector contributes a vast amount to health and social care. The work we do to support people with neurological conditions includes: contributing to local plans; providing advice, support and information; pump-priming specialist nurses and providing commissioning support through the work of Neurological Commissioning Support.\(^{116}\)

1.3 Many of these charities are members of National Voices. We fully support their submission to the Bill Committee \(^{117}\) Strengthening Patient and Public Involvement in Commissioning and the suggested amendments.\(^{117}\) These amendments are essential to ensure that the patient voice is at the heart of the NHS. Our previous submissions to consultations on the white papers leading up to this Bill emphasised the importance of strong accountability, patient and public involvement in commissioning and integrated care.

1.4 Rather than restate the points made in the National Voices submission, we would like to focus on additional issues of particular relevance for our organisations.

2. LOW VOLUME COMMISSIONING

2.1 The Bill as it stands (and indeed the white papers preceding it) do not stipulate clearly how GPs will commission for “low volume” services.

2.2 The term “low volume” has been used in the set of consultation documents Liberating the NHS and in the explanatory notes to the Health and Social Care Bill. However, no definition of the term has been provided. For example, neither the Bill nor the white papers preceding it give a definition of population size or what services could be classed as “low volume”. The coalition agreement did not include the term “low volume”, instead using the phrase “residual services”. It states: “The local PCT will act as a champion for patients and commission those residual services that are best undertaken at a wider level, rather than directly by GPs”.

2.2 Such a vague definition risks varied interpretation at a local level, which may lead to services falling through gaps, and deepening regional inequalities.

2.3 A huge number of patients use services which are termed “low volume”, and these services represent a significant proportion of NHS spend. A lot of neurological services need to be commissioned for a population size of 500,000 people. If a consortium only covers an area of 50,000, the number of people with neurological conditions will be too small to deliver a comprehensive service. Yet they are not rare enough to fall within specialised commissioning arrangements under the NHS Commissioning Board. This includes services such as a specialist neurological multidisciplinary team, comprising for example one or more specialist nurses, physiotherapists, speech and language therapists and occupational therapists.

2.4 A team of this kind, delivering high quality, cost-effective care could not be effectively commissioned by one small, locally focussed consortium. The Bill therefore needs to make adequate provision to ensure that consortia work together in order to deliver effective “low volume” commissioning.

2.5 We therefore propose the following amendments for the consideration of the Bill Committee.

3. AMENDMENTS

3.1 Duty to involve patients groups in deciding the appropriate level at which to commission services (Secretary of State).

Amendment one
Section 11 Clause (4)
Page 7 line 28
After section (a) insert—

(b) involve a range of groups representing patients and carers with expertise in the services to be affected/commissioned.

Explanation
As there is a lack of clarity about what constitutes “low volume” services we think the voice of patients should be at the heart of deciding at what level services are commissioned. This is particularly relevant as the explanatory notes state that some “low volume” services could be commissioned by the NHS Commissioning Board (Section 11 Clause 2).

3.2 Provision to publish guidance as to when consortia should commission jointly (Board).

\(^{116}\) Neurological Commissioning Support (NCS) is a joint initiative of the MND Association, the MS Society and Parkinson’s UK, offering consultancy advice on commissioning for services for the conditions represented. It currently works with some PCTs and intends to work with commissioners under the new system—such as GP consortia, including by helping them to involve patients in the commissioning process. More information is available at www.csupport.org.uk

\(^{117}\) This is also supported by Alzheimer’s Society, Asthma UK, Breakthrough Breast Cancer, Diabetes UK, National Voices, Rethink, and the Stroke Association.
Amendment two
Section 21 clause 14J
Page 29—line 9

After subsection (a) insert—

(b) collaboration between consortia, including neighbouring consortia, for the purposes of joint commissioning.

Explanation

This amendment would make provision for the NHS Commissioning Board to publish guidance to GP consortia on collaboration on commissioning for “low volume” services. GPs often have limited knowledge and experience of these services and the conditions they apply to. GPs typically have only one or two patients with MS or Parkinson’s and may see just one or two patients with MND during their whole career. They will see patients with conditions like ataxia or progressive supranuclear palsy (PSP) even less frequently.¹¹⁸ A report by the MS Society found that 30% of GPs reported a lack of confidence in identifying MS patients. Therefore the NHS Commissioning Board should support GP consortia in this important area and the Bill should be amended to reflect this.

3.3 Duty to issue guidance on joint commissioning, including for “low volume” services and to involve patients in this process (Board).

Duty to collaborate on “low volume” commissioning where advised to do so by the Board (consortia).

Amendment three
Section 22 clause 14Q (2)
Page 31 line 23

After section (1) insert—

(2) Arrangements must be made for two or more consortia to exercise commissioning functions jointly for “low volume” services, if the Board advises that these services cannot be effectively commissioned by a particular consortium or consortia, based on factors such as population size.

Explanation

This amendment would ensure that the NHS Commissioning Board retains oversight of how consortia commission “low volume” services, such as specialist neurological multidisciplinary teams. It could also advise consortia to commission jointly, where they do not, individually, cover a large enough population size to make commissioning for these services effective (see 2.3 and 2.4 above.) As the Bill stands, there is a danger that while some consortia may cover a large enough population to commission effectively, other consortia could be too small but have no lead from the NHS Commissioning Board as to how to work collectively. Having no national oversight therefore greatly increases the risk of regional inequality in the level of “low volume” services.

Amendments four to seven
Clause 22 Section 14V (1)
Add, subsection 1) a)

Such guidance must cover commissioning for “low volume services”.

Add, subsection 1) b)

The Board must involve a range of groups representing patients and carers with expertise in the services to be commissioned in the development of such guidance.

Clause 22 Section 14V (2)
Page 33, line 10—

Delete “must have regard to” and insert “has a duty to follow”

14V (2), subsection a)

Consortia must demonstrate to the Board that they have acted on their duty to follow such guidance as is published by the Board.

¹¹⁸ Some of the 80 charities within the Neurological Alliance represent people with rare conditions.
Explanation

Section 22 Clause 14V explains how the Board will issue guidance on commissioning functions. As GPs have limited experience in this field (see 3.1 above) consortia will need strong guidance on commissioning for low volume services, and there must be an imperative for them to follow this guidance. Further, since Liberating the NHS: Legislative framework and next steps makes clear that the Board will “hold consortia to account for the quality outcomes they achieve” (4.52, page 60), consortia should demonstrate that they have followed guidance from the Board relating to delivering quality services.

To place patients at the heart of these decisions they should be involved in this guidance from the outset.

3.4 Duty to include “low volume” commissioning in annual plans (consortia)

Amendment eight
Section 22 clause 14Y
Page 34 line 12

After section (2) insert—

(3) The plan must explain how the consortium proposes to ensure that commissioning for low volume services will be done.

Explanation

This amendment would encourage consortia to take a strategic view of “low volume” commissioning by ensuring this is covered in their yearly plan. It would also enable the Board to see from the beginning how the consortia plan to commissioning “low volume” services. This enables the Board to take an overview of “low volume” commissioning across the country.

February 2011

Memorandum submitted by Frances Crook (HS 56)

I am submitting this letter as written evidence to the Committee considering the Health and Social Care bill. I am a non-executive director on a Barnet primary care trust.

1. The plan to hand over the entire budget of the NHS to GPs, who will then commission services on behalf of individual patients is an up-ending of the system and a more radical overhaul than anything ever envisaged since the very foundation of the NHS. There has been no formal public discussion of the proposals through a green and white paper and the extent of the re-organisation, and commensurate cuts in budget, is only now leaking out. The proposals were not contained in the Conservative party manifesto or the Coalition agreement.

2. The NHS budget is £110 billion and there are around 30,000 GPs working in England and Wales. Currently the budget is divided up amongst the seven strategic health authorities who devolve it down to primary care trusts (PCTs), most of which are coterminous with local authorities. The strategic authorities do “what it says on the tin”, by setting strategy and holding the local delivery agents to account for national and local policy. The PCTs commission services from hospitals, GPs, opticians and primary services. Trusts increasingly have strong links with local authorities to provide social care to the elderly and people with disabilities or other health needs. This infrastructure would be demolished and the strategic health authorities will be abolished. The PCTs might survive but with reduced powers and with little or no authority over budgets or services; it is most likely that they might be simply employed by doctors as the administrative mechanism to purchase health services for individual patients.

3. The last major reorganisation of the NHS took place in 2002 and has therefore had less than a decade to settle. The PCTs are mid way through a restructuring that will separate the provider arm from the commissioners and no one seems to be clear whether this will be stalled or will proceed. There are undoubtedly bureaucratic tangles but these are not insurmountable.

4. The new vision for GP led commissioning envisages both sole practitioners and groups handling the entire budget and commissioning services for their patients from hospitals, local authorities, private companies and primary services. There are so many big questions concerning the detailed arrangements. How will single GPs delegate to a consortium of local doctors? Will GPs sub-contract the commissioning process to the big private companies involved in healthcare on the fringes and so bring privatisation to the heart of the NHS by stealth? Indeed, will GPs want to take on this responsibility?

5. It is not clear where public consultation and strategic decision making fit into the GP led model. The secretary of state may argue that as decisions are made about and with individual patients then this is inherently a form of public consultation and therefore unnecessary to conduct other forms of involvement. This is a fragmentation of public consultation as there would be no forum for leading discussion on, for
example, investing in new specialist trauma services at particular hospitals or reconfiguration of specialist stroke services. The strategic health authorities have been the lead agency in conducting public consultation but as they are to be abolished, it appears that public consultation will be abolished too.

6. It is unclear how strategic decision making will be conducted, if at all. Just as the schools system is being fragmented so that the strategic responsibilities of local authorities are being taken away, so it is with health. Devolution to the individual is the abolition of strategy.

7. Public health will be another casualty. It appears that the public health budget will be slashed from 7% of the total NHS budget to just 4%. Public health saves lives through the promotion of healthy life styles, public education and programmes like smoking cessation. It is one of the ways that we direct health services at the poor by directing services at inequalities.

8. Public statements have indicated that the NHS will not suffer the cuts that other departments are facing yet it is becoming clear that there are going to be significant budget cuts in health. PCTs are being told to cut 51% of their management and administrative costs. The effect of this is to hobble any attempt at strategic management.

9. Targets are being abandoned. Whilst there has been some unease at the rigidity of the target culture it is undeniable that imposing targets and holding everyone to account for specific time limits in accident and emergency units, seeing a consultant and the performance of operations has saved and improved the lives of millions of people.

10. Cities will be particularly hard hit. In London there are probably several hundred thousand people who are not registered with a GP and they will not be able to get access to any healthcare. Anyone who is not eligible for whatever reason to register with a GP will be denied medical and health services.

11. Since its foundation the NHS has been redistributive. It was designed, and has been functioning, to redistribute to the poor so that health inequalities are reduced. Its success has been patchy, but that explicit objective is embedded at all levels and in every service. As strategic planning is abolished and service purchasing is fragmented, the aim of reducing inequality is abandoned too.

12. With the abolition of PCTs the role of the non-executive director also disappears. There are no plans to include any NEDs on the GP consortia and so the voice of the public will disappear. In addition, NEDs provide senior links to other authorities by representing the health service on community safety boards, safeguarding boards, and may other bodies, and these links will disappear leaving health out of the loop.

*February 2011*

**Memorandum submitted by Dr Leonard Fagin (HS 57)**

I have recently retired as a Consultant Psychiatrist working for the NHS for over 35 years. I have observed with increasing concern the development of a market approach to health care over the past 10–15 years, with multiple re-organisations that have impacted on the standards of health care and on the morale of dedicated health providers. My commitment to the NHS was based on my belief that health care should be provided with best and most efficient use of often limited resources, with equal access irrespective of means, but despite serious limitations, especially in mental health care, there have also been important and useful developments. In my view the current proposals in the above Bill are very likely to scupper the achievements of the past 10 years, by opening up the parts of health care that can be cherry picked by willing providers with the only intention of financial gain, and with scant evidence of competence, only gaining contracts by undercutting other services. GPs are unwilling scapegoats in this process, having to decide where the axe must fall, rather than dedicating themselves to front line patient care. With all the will in the world, GPs are not ready, or frankly willing, to make overall public health decisions that affect large communities.

I recently participated in a local meeting discussing these issues, addressed by Lord Nicholas Rea and Dr Jonathan Tomlinson, a GP in Hackney. The meeting was very well attended, and the sense of outrage and militancy was palpable in the audience. I expect that the public will be prepared to make increasingly vociferous demands to kill this Bill, which in my view will lead to the death of the NHS.

*February 2011*
Memorandum submitted by the Royal College for Paediatrics and Child Health (HS 58)

INTRODUCTION

The Royal College of Paediatrics and Child Health is the leading authority on healthcare services for children and young people. We welcome the principles behind the Bill of clinician led commissioning, reducing inequalities, greater information about services and the focus on outcomes.

But we have concerns around the detail of the new structures and foresee care for infants, children and young people becoming fragmented. Child protection arrangements and responsibilities in the light of changes on commissioning are not clear. We are pressing for increased authority of health and wellbeing boards to ensure that commissioning of services for children reflects the interaction in their lives of both health and local council services.

The 11.78 million children in England comprise over 22% of the population and it is essential that the changes envisaged to the NHS and public health result in improvements to their health and wellbeing rather than worsening outcomes and increased complexity of provision.

Children and families must receive the right health care swiftly, linking effectively with other local services so all children get the best start in life.

We are pressing for changes and amendments to the Bill to strengthen its coverage and close loopholes to ensure that the vision of better healthcare and less bureaucracy can be realised for children and young people as well for as the adult population.

KEY MESSAGES

There are three core themes in the Bill where the College will press for greater consideration of the implications for children’s services.

Maintaining continuity and quality of care for children and young people with complex needs across health, education and social care

For those children with rare or complex needs, the proposals expose potential difficulties in maintaining continuity and integration of care, where a number of agencies and services are involved. Specifically:

— The removal of boundary restrictions for GPs and absence of a cotermnosity requirement between consortia and authorities is likely to result in complicated cross-charging arrangements for children requiring complex packages of care, with less opportunity for clinical, therapy and social care staff to build constructive professional teams around the child and family.

— Any delays in developing an alternative secure system of information sharing poses a risk to those children who have a range of professionals involved in their care, across several provider organisations. It is not clear where the “lead professional” oversight of the child’s package of care will lie; if it is with the GP we assert that patient information systems within individual practices may be insufficiently developed to deal with the complex contractual arrangements required to meet the health and social care needs of infants, children and young people.

— It is not yet clear how the outcomes and incentive arrangements will be implemented. We believe controls are needed to ensure that those whose condition does not fall into the 150 for which quality standards are being developed do not receive poorer care.

— We need stronger assurances that Health and Well Being Boards will work closely with GP Commissioning Consortia, specialist professionals and the wider local community, with a specific statutory remit to commission services together to raise standards of care for all children based on need and impact. Whilst recognising the strengthening of requirements on commissioning consortia to take account of the joint strategy, the governance remains underpowered with respect to commissioning across health/social care boundaries.

— We recommend establishing a mechanism for reporting on effective joint working and monitoring outcomes for all children across services (linking health, public health, education and social care), particularly in relation to incentive payments for commissioning.

— The market concept where any willing provider can be commissioned for specific services may improve service responsiveness in some areas, but will undoubtedly lead to a fragmentation of staff culture, competition between providers across a pathway of care, gaps in provision and information flows and a lack of integration and co-ordination of appointments. This will result in poorer quality of care and inequity of provision for children together with significant increase in bureaucracy to commission and performance manage effectively.

119 For example, children with Downs’ syndrome or cerebral palsy need input from a range of health services (such as paediatricians, physiotherapists, speech therapists, geneticists, and sometimes a children’s heart or glands specialist) which families usually receive from one health centre or hospital, as well as educational, social care and family support provided by public and third sector services.
— The Committee is urged to ensure that modelling takes place within the pathfinder consortia of pathways of care for disabled children and those with complex health and social care needs so that effective safeguarding can be designed without compromising the principles of the reforms.

— The impact of low-volume/high cost continuing care packages for children with the most complex needs could drain an individual commissioner’s budget and there should be a risk-pooling system to support these awards.

The changes may weaken child protection arrangements in a more fragmented and less experienced commissioning environment

— Professor Eileen Munro is reviewing the practice and behaviours of social work and acknowledges the importance of needs analysis and early intervention across partner agencies. The proposed changes however could significantly weaken the accountability and effectiveness of the multidisciplinary contribution and of healthcare’s contribution in particular to the safety of children.

— The crucial role of clinicians, in child protection, whether as the health visitor, the family GP or the paediatrician, together with the key roles of Named and Designated health professionals must be acknowledged in the Bill and subsequent regulations to ensure that the responsibilities transferred from PCTs are not diluted in the new structures, where expertise may be lacking or resources stretched.

— It is crucial that existing networks of experienced health child protection professionals are maintained and strengthened, to provide expertise, supervision and support to consortia and public health teams and their designated nurse and doctors.

— The links between health and with other agencies (Children’s social care, the police and the judiciary) needs much greater recognition and clarity over responsibilities during transition and once the new reforms are in place. Specifically the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy must include core sections on child protection arrangements across organisations and pathways of services, with contributions from expert designated clinicians.

— Overarching responsibility for child protection rightly lies with the Local Authority, with the LSCB bringing partners together to agree and monitor shared plans, training and knowledge. Already LSCBs find that the number of different representative organisations in “health” including acute trusts, mental health, community providers, PCT commissioners and CAMHs can be hard to marshal effectively and this apparent lack of cohesion must be addressed through clear duties on Commissioning Consortia, monitored effectively by the NHS Commissioning Board.

— Under the proposals, commissioning consortia may span more than one Authority, and there will probably be two or more consortia in each LSCB catchment area. Managing LSCB business with this plurality of health organisations, including implementing LSCB-wide procedures, delivering joint training and building strong and trusting relationships between GPs and the relevant social care teams will be an increased challenge, and there is a much greater potential for children at risk to be missed, or confusion over responsibility to occur. RCPCH is pressing for detailed modelling and practical exploration with Local Authorities and LSCBs as to what arrangements can mitigate this risk.

— Designated doctors and nurses currently provide an oversight and expert function within the PCT commissioner and to the (coterminous) LSCB Board, ensuring that provider-unit clinicians are properly supported in child protection practice, and that commissioning contracts, information sharing, training, supervision and learning properly protect children, young people and families using services. These clinicians contribute extensively in many areas to the work of LSCBs and sub committees, bringing a health perspective to local authority planning and training. Whilst the Bill states that the responsibilities will transfer to consortia, there is uncertainty as to whether the role will be supported and how links with the LSCB and authority will be maintained. There must be a clear duty on Commissioning Consortia to include advice from designated nurses and doctors within their commissioning plans.

— The Directors of Public Health have in their new remit responsibility for domestic violence, linking police education and social care services together. This remit does not mention child protection yet there is overwhelming evidence of the link between family violence and child abuse and responsibilities should be stronger. Consideration should be given to shifting commissioning of the designated nurse and doctor role to the Public Health department, and strengthening its jurisdiction so that commissioning consortia must take account of requirements. This could significantly fortify local arrangements, maintain authority-based team connections and trusting relationships and ensure that children within a local area have a consistent and effective framework of protection.
Responsibility for effective joint commissioning for the health and wellbeing of children who are looked after and/or placed away from home requires clarification within the new arrangements, as expertise within commissioning consortia is likely to be diluted in transition from PCT commissioners.

The implications of choice and keeping a national, networked service

Whilst welcoming the principles of choice and competition to drive up quality we seek additional security within the system to protect children's services. Market-based competition in health however without expert collaborative commissioning will undermine links between professionals, leach expertise, reduce service availability and increase waits and there must be safeguards in the Bill to ensure that services for children, which may not be lucrative enough for competitive market improvement, do not suffer.

Whilst provision of information and advice direct from providers in a plural system can improve choice and quality of care, navigation through the options for vulnerable patients and carers will require careful commissioner support, to ensure that children receive the care they need and appropriate safeguards are in place. There are examples within the current “Choose and Book” system of parents failing to make appointments for their children, or failing to attend with consequent deterioration of the child’s condition. Increased competition amongst provider services will require clear contractual safeguarding within commissioning to ensure children’s rights are protected.

Ensuring that children receive the best quality evidence based care requires the introduction or maintenance of clinical networks, for example for paediatric specialties. It is not clear in the Bill how these networks will be sustained in an open market to ensure appropriate investment in secondary and tertiary services, which may require co-located ancillary services. The College has published clear service standards for paediatric care and the bill requires strengthening to ensure that expert clinical advice is taken into account by the National Commissioning Board, Commissioning Consortia and Monitor.

Where services cannot be provided within the market system more clarity in needed on the process of “designated” services and how this process may affect children’s healthcare which may not be a lucrative investment for independent providers. Depending upon the strength of the designated service arrangements, there is a risk that assertive providers will convince commissioners they can “cherry pick” the most lucrative services. This could leave vulnerable families with more complex journeys, poorer levels of care and the consequent risk of children missing appointments and suffering poorer health outcomes.

We have concerns about the risk to availability and quality of medical training placements within small independent providers—this is already proving a concern within acute mental health and plastic surgery services.

Splitting the commissioning of the healthy start programme between consortia up to aged five years, and with local authorities through health and wellbeing boards once children have started school offers a potential risk to continuity and family support if health visiting and school nursing are insufficiently linked. There are no elements within the Bill that support mental health and emotional well-being interventions for young children and adolescents—two crucial points where input can demonstrably improve outcomes.

CONCLUSION

The Royal College of Paediatrics and Child Health has significant concerns over elements of the bill, and the speed and risk of implementation for children’s services. We seek reassurance and the opportunity to work closely with Ministers, parliamentarians and Public Bill team to develop arrangements which ensure that care for all infants, children and young people is of the highest quality, efficiently provided and tailored to their needs.

February 2011

Memorandum submitted by the Association of British Insurers (ABI) (HS 59)

1. The ABI is the voice of insurance, representing the general insurance, investment and long-term savings industry. It was formed in 1985 to represent the whole of the industry and today has over 300 members, accounting for some 90% of premiums in the UK.

2. The ABI is not opposed to the general principles of the Health and Social Care Bill. We do, however, wish to draw to the Bill Committee’s attention two issues on which we urge the Committee to seek clarification: the definition of social care and how the Government envisages the Bill will interact with existing initiatives on social care.
The Definition of Social Care

3. The Health and Social Care Bill, Commission on Funding of Care and Support and the Law Commission all use different definitions of social care. In the Bill, “adult social care” is defined as:

3.1 “Includes all forms of personal care and other practical assistance for individuals who by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances, are in need of such care or assistance”.

4. This definition is for adult social care. This use of the word adult implies that this definition is only for people of a certain age and, therefore, does not apply to children. We therefore ask what this means for children with social care needs?

5. The definition of social care outlined in the Bill is completely different to the Commission on Funding of Care and Support, whose definition of social care is:

5.1 “Care and support assists individuals with certain physical, cognitive or age-related conditions in carrying out personal care or domestic routines. It helps people sustain involvement in work, education, learning, leisure and other social support systems. It supports people in building social relationships and participating fully in society”.

6. The Law Commission defines social care as:

6.1 “…the responsibilities of local social services authorities towards adults who need extra support. This includes older people, people with learning disabilities, physically disabled people, people with mental health problems and carers.”

7. These Commissions’ work is vital to moving forward policy on funding care. We are concerned that these differing definitions of social care may be an issue when the commissions report to the Government on their findings.

Co-ordination with Other Social Care Initiatives

8. The Law Commission is currently at Stage two of its adult social care project, which is concerned with the law relating to the provision of adult social care in England and Wales to provide a clearer, modern and more cohesive framework for adult social care.

9. The Law Commission and Commission on Funding of Care and Support are doing important work on issues around social care. It is important that the Bill interacts with these and we would ask that this is considered during the Bill’s passage.

February 2011

Memorandum submitted by The Stroke Association (HS 60)

About The Stroke Association

The Stroke Association is the only UK wide charity solely concerned with combating stroke in people of all ages. We fund research into prevention, treatment and better methods of rehabilitation and help stroke survivors and their families directly through our website and national helpline.

We also provide a range of community services including support for people with communication difficulties as a result of stroke, family support, information services and welfare grants. In addition we campaign, educate and inform to increase knowledge of stroke and act as a voice for people affected by stroke.

Stroke Facts

Stroke is the third biggest killer and the largest single cause of severe adult disability in the UK. There are around 110,000 strokes and 20,000 Transient Ischaemic Attacks (TIA or “mini strokes”) in England a year and roughly 300,000 people are living with moderate to severe disability as a result of stroke.

Stroke is also one of the most expensive conditions, with direct care costs to the NHS of £3 billion every single year, within a wider economic cost of £8 billion.

The Health and Social Care Bill and Stroke—Summary

1. The Stroke Association welcomes the Health and Social Care Bill’s aims of developing clinically led commissioning, creating greater patient involvement, enhancing the role of local government in health and focusing on outcomes for patients.

1.1 We do, however, have concerns that some of the structures being proposed may, at least in the short term and during the transition period, cause the pace of improvement in stroke care to be slowed.

1.2 The Government must give assurances that adequate measures will be taken to ensure that the momentum generated in improving stroke care is not lost during any period of NHS reorganisation.
1.3 In particular The Stroke Association is calling for:

- a commitment from the Government that under a reformed NHS, stroke will remain a national, long-term priority;
- guarantees that the key elements of the National Stroke Strategy will be incorporated in any future guidance from the National Commissioning Board (NCB);
- a strengthening of the Bill to require both the NCB and GP consortia to involve and genuinely engage specialist health and social care professionals, patients and expert groups representing patients and carers in commissioning decision making;
- assurances that the recent advances in the commissioning of high quality stroke services are not lost, and that GP consortia will be supported to acquire these skills;
- continued existence and funding for coordinating organisations such as the NHS Stroke Improvement Programme and the stroke networks;
- alleviation of concerns that a lack of a strategic level of planning and commissioning under the proposed system may compromise the pace of future progress in stroke care;
- commitment to the continued funding of national auditing programmes for stroke;
- development of more outcome indicators covering the full stroke care pathway;
- consideration of an enhanced role for the voluntary sector in the proposed Health and Wellbeing Boards;
- enhancement of the health scrutiny functions to be exercised within local authorities as proposed in the Bill; and
- review by NICE of the Stroke Quality Standard to cover community based rehabilitation, longer term support and social care services for stroke.

RECENT PROGRESS IN IMPROVING STROKE CARE

2. Years of neglect left the UK with the unenviable reputation of having some of the worst outcomes for stroke patients in Western Europe.

2.1 This issue was addressed by the previous Government with the launch of the National Stroke Strategy for England in December 2007 backed up with a commitment of £105 million in central funding for three years (2008–11) to provide national support for its implementation.

2.3 By February 2010, the National Audit Office (NAO) in its report *Progress in improving stroke care* concluded that the actions taken to implement the Strategy had resulted in better outcomes including an increase in patients' survival and improving value for money in stroke care.

2.4 However, both the recent NAO and Public Accounts Committee (PAC) reports also highlight areas of remaining serious concern. In particular they conclude that the improvements in acute care are not universal, and are not yet being matched in post-hospital and longer term support.

NHS COMMISSIONING BOARD AND NATIONAL GUIDANCE FOR IMPROVING STROKE CARE (SECTION 19)

3. The National Stroke Strategy published in 2007 has played a fundamental role in providing national guidance and direction on improving the quality of stroke care along the whole of the stroke care pathway.

3.1 Under the current NHS system its successful implementation has been driven by strong strategic leadership and direction at the national and regional level.

3.2 Stroke was made a tier 1 national priority in the three year NHS Operating Framework (2008–11) ensuring that PCTs took action to implement the Stroke Strategy. Twenty-eight local Stroke Networks were developed, supported by the NHS Stroke Improvement Programme (SIP) at the national level, to coordinate the development of local services and promote good practice. Central funding of £105 million over three years 2008–09 to 2010–11 has supported implementation of the Strategy, primarily in the form of additional funding to Strategic Health Authorities and ring fenced-grants to Local Authorities.

3.3 We welcome the Government’s recognition that the Strategy is only just over three years into a 10 year programme and its commitment to further progress on its implementation including support for the Accelerated Stroke Improvement Programme.

3.4 We are, however, still unclear on how this will be achieved in the new NHS system as provided for in the Bill and how the mechanisms which have proved successful in the past few years will be replaced or enhanced.

3.5 We would like reassurances from the Government that under the proposals outlined in the Bill, stroke remains a national, long term priority and that it wishes to build on recent progress and see through the previous Government’s plans for the implementation of the National Stroke Strategy.

3.6 The proposed National Commissioning Board (NCB) will presumably have an important role in setting the direction for stroke services and must ensure that the key elements of the National Stroke Strategy are incorporated in any future guidance it issues on commissioning stroke services.
3.7 We would also recommend that the Bill should be strengthened so that the NCB is required to involve
and genuinely engage specialist health and social care professionals, patients, the public and expert groups
representing patients and carers in commissioning decision making.

GP COMMISSIONING CONSORTIA (SECTION 22)

4. We have concerns that some of the proposed GP consortia may have limited experience, understanding
and knowledge of stroke and hence may be unaware of the full needs that stroke survivors have across the
whole of the care pathway.

4.1 Although stroke is a common condition an individual GP may only see 2–3 new stroke patients a year.
In addition a survey by the NAO in 2006 showed that only 16% of GPs had a special interest in stroke
compared with 39% for Coronary Heart Disease.

4.2 The proposals to involve GPs more centrally in planning and commissioning stroke care could help
to address the gaps in knowledge in this area. However, we seek assurances that the recent advances in the
commissioning of high quality stroke services are not lost and that GP consortia, if introduced, will be
supported to acquire these skills.

4.3 There must also be a greater recognition of the role that a wide range of health and social care
professionals have in the delivery of stroke care and this should be reflected in a more multi disciplinary
approach to commissioning than is outlined in the Bill.

4.4 Commissioning for stroke may need to take place at different levels and not necessarily at the level
of individual GP consortia. It has been suggested that there could be as many as 500–600 GP consortia. If
these do not act cooperatively there is a danger that variation in standards of services will occur, increasing
the variations in services we already see. We must also ensure that any increased competition between
providers which may result from the Bill will not impede networking and integrated care.

4.5 Regional support for integrating, coordinating and improving stroke care including commissioning
for stroke has been greatly enhanced by the development of Stroke Networks, supported and partially
funded by the Department of Health’s NHS Stroke Improvement Programme.

4.6 The Networks and the Stroke Improvement Programme have been fundamental in recent
improvements working across organisational boundaries to spread best practice and bring together local
NHS organisations, Local Authorities, clinicians, patients and other groups involved with stroke.

4.7 The Stroke Networks are in an ideal position to facilitate cooperation between the proposed GP
consortia and help prevent inequalities in service provision developing. The greater the number of GP
consortia, the more important it is to have a body like the stroke network to bring them together and
encourage cooperation.

4.8 Whilst it is welcome that funding for the NHS Stroke Improvement Programme and the stroke
networks has been secured for 2011–12 the Bill gives no room for optimism that they will continue beyond
this point.

4.9 The refreshed Cancer Strategy (11 January) included the announcement that under a reorganised
NHS the National Cancer Action Team and cancer networks might best offer their support to providers and
commissioners through “a more flexible, social enterprise-based approach”.

4.10 Cancer charities have voiced concerns about the impact that the removal of cancer networks will
have on patient care and we would have similar concerns should the stroke networks cease to exist.

4.11 We would urge the Government to ensure that funding is allocated to the SIP and stroke networks
during the full duration of any transition period to GP consortia and that consideration is given to
maintaining SIP and the networks beyond this period.

4.12 As with the NCB we would also recommend that the Bill should be strengthened so that GP
consortia are required to involve and genuinely engage specialist health and social care professionals,
patients, the public and expert groups representing patients and carers in commissioning decision making.

ABOLITION OF STRATEGIC HEALTH AUTHORITIES AND PCTS (SECTION 28 AND 29)

5.1 Reconfiguration of stroke services may be necessary to create the optimum number and location of
hyper acute (offering access to 24/7 specialist stroke care) and acute services in any one geographical area,
as well as ensuring that the ambulance service is fully integrated.

5.2 Some systems for providing effective and efficient rehabilitation and support (for example Early
Supported Discharge, which provides more rehabilitation in the community rather than in hospital and is
known to achieve better results for people and cut pressure on hospital beds) may also require planning and
commissioning of services covering a relatively large population area.

5.3 The planning and execution of service change has so far been fulfilled by SHAs and supported by
PCTs and Stroke Networks. For example In London the recent reorganisation of stroke care spearheaded
by NHS London brought together all London PCTs to develop a more effective and efficient system of acute
stroke care which is now recording some of the best results in Europe.
5.4 With the proposed abolition of SHAs, the development of a more fragmented system based on a larger number of GP consortia and uncertainty around the future of organisations such as the stroke networks, we have concerns that a lack of a strategic level of planning and commissioning may compromise the pace of future progress in improving stroke care.

5.5 If SHA’s and PCTs are to be abolished we would like consideration to be given to the proposed National Commissioning Board hosting, either nationally or regionally, a commissioning network for stroke.

5.6 We would also urge the Government to consider the need for the continued existence of coordinating organisations such as the SIP and stroke networks under the new NHS system.

OUTCOME MEASURES AND MONITORING OF PROGRESS

6. We welcome the new focus on outcomes and the development of the new NHS Outcomes Framework. However, we believe there is a continuing need for some clinically relevant structure and process measures. This would allow for the monitoring of progress in implementation of key quality markers from the National Stroke Strategy while also encouraging the continued improvement in high quality care.

6.1 We would therefore like to see the continued collection and publication of the vital signs measures on stroke units and TIAs.

6.2 We also believe a commitment to the continued funding of national audits such as the Royal College of Physicians Stroke Sentinel Audit and the new SINAP (Stroke Improvement National Audit Programme) is vital to aid collection of outcome data, enable professionals and patients to identify areas where progress is required and allow for clarity of performance to be established.

6.3 We would also like to see more outcome indicators developed covering the full care pathway in particular covering the post hospital period and long term support.

INCREASING ACCESS TO BETTER POST-HOSPITAL AND LONGER TERM SUPPORT

7. Post-hospital and longer term support in the community has traditionally been the weakest element of care for many stroke survivors and access to long term support services for stroke survivors and carers remains a postcode lottery.

7.1 In January the Care Quality Commission (CQC) published a review of community stroke services in every PCT area in England which reveals large and unacceptable variations in level of support available. Services in around half of all PCT areas were rated as either in the “least well performing” or “fair” categories and in need of major improvements.

7.2 The integration of health and social care is crucial to ensure that individual stroke survivors and their families get the full range of services and support that they need when they leave hospital.

7.3 At present this is not always the case and the CQC review found that only 34% of PCT areas have a framework for joint reviews of people’s health and social care needs across most or all of the PCT area.

7.4 The CQC also find evidence that in some areas social care services have not been fully engaged in the process of developing local stroke pathways and supporting the implementation of the National Stroke Strategy.

7.5 We would recommend that either the CQC in its new form or the NCB continue to play a role in reviewing the quality of longer term stroke services at a national and local level.

INCREASING LOCAL AUTHORITY INVOLVEMENT IN HEALTH (SECTIONS 175–178)

8. We welcome the Bill’s aim of increasing the role of Local Authorities in health and support the introduction of statutory Health and Well Being Boards and the introduction of a duty for local authorities and GP consortia to prepare joint strategic needs assessments and strategies. We hope that these measures will help improve the integration of health and social care and lead to better care for stroke survivors.

8.1 Voluntary sector organisations at a local level are well placed to offer expertise and advice on the needs of those patient groups they represent and may also be involved in the delivery of services for the local population.

8.2 We would therefore like to see the consideration of an enhanced role for the voluntary sector in the proposed Health and Wellbeing Boards.

8.3 The Bill provides greater flexibility for local authorities to carry out scrutiny of the local health service and local overview and scrutiny committees will not be mandatory. Local scrutiny of commissioning plans is a crucial aspect of democratic legitimacy. We share the concerns of other patient groups that the lack of detail in the Bill regarding best practice around the scrutiny function could result in potentially less scrutiny than in the current system.

8.4 We therefore recommend that the Bill requires the scrutiny function to be exercised by an independent structure within the local authority, led by locally elected representatives.
NICE QUALITY STANDARDS FOR LONGER TERM STROKE CARE (SECTION 218)

9. We welcome the proposed role of NICE in developing Quality Standards and the widening of its remit to cover standards for social care as outlined in the Bill. Stroke was one of the first Quality Standards developed (published June 2010) but the main focus of this was on acute care and early rehabilitation.

9.1 NICE will need to review the Standard to cover community based rehabilitation, longer term support and social care services for stroke.

9.3 We would also like clarification of the status of Quality Standards, how they will relate to guidance contained in the National Stroke Strategy and how they will apply in practice to stroke services.

February 2011

Memorandum submitted by the Federation of Specialist Hospitals (HS 61)

The Federation of Specialist Hospitals has been formed to provide a voice for specialist hospitals in the UK. Twenty-four specialist hospitals carry out 250,000 procedures and 2.5 million outpatient appointments each year, mainly for patients with rare and complex conditions. As such, members are at the forefront of innovation and an important source of training for the NHS at large.

As a general remark, the Federation is pleased to see that the Bill formalises the Government’s intention to place commissioning of specialist services with the NHS Commissioning Board, using the criteria set out in Article 11 (d). Broadly speaking, we agree with the Impact Assessment’s statement (para A126) that this offers the potential to improve outcomes through improved quality, consistency and access.

The Bill also contains a range of important provisions about quality and innovation. These could, however, be undermined by major aspects of Monitor’s remit. In particular:

1. Designation—Article 69 of the Bill allows for the commissioner of a health service to apply to Monitor for the service to be designated where its loss would have a significant adverse impact on the health of relevant patients. The need for potential designation around market exit is clear. It also arises, however, in relation to market entry. In particular, the Carter Report on Commissioning Arrangements for Specialised Services in May 2006 introduced designation of specialised service providers to secure an appropriate concentration of clinical expertise and activity at designated centres, located to maximise geographical access. Designation safeguards patient access to high quality, cost effective services and prevents unsafe and/or unplanned proliferation of services. While this broader concept of designation needs to be actively managed by the NHSCB to avoid provider complacency, it reflects one of the most important lessons of the Bristol Inquiry and must not be prejudiced by Monitor’s role in promoting competition more generally.

2. Pricing—Chapter 5 of the Bill sets out detailed provisions in relation to future development of the national tariff (previously Payment by Results) by Monitor. The original rationale for Payment by Results was to develop robust nationwide prices for procedures so that commissioners would be freed to concentrate on quality as the main criterion for competition. Article 104 provides for Monitor to develop the national tariff as a maximum price below which commissioners and providers could negotiate a lower figure. In evidence to the Public Accounts Committee on 18 January this year, Sir David Nicholson urged extreme caution about price competition in healthcare, citing international evidence that it can adversely affect quality. The use of the tariff as a price cap would also seem to defeat the purpose of freeing individual commissioners and providers from the need to negotiate price.

3. Consultation on tariff proposals—Article 105 requires Monitor to consult on tariff proposals before publication. The Federation sees it as essential that earlier consultation should take place as the proposals are being developed, underpinned by strong, transparent clinical governance. This would be in keeping with the emphasis placed on clinical leadership in the wider healthcare reforms and reduce the risk of unforeseen consequences for good, innovative clinical practice. Similarly, Article 106 allows a prescribed percentage of commissioning consortia or licence holders to block publication of a tariff, unless it subsequently receives support from the Competition Commission. This is a welcome safeguard but the share of supply percentage for licence holders must reflect those undertaking procedures of comparable complexity for comparable patients if specialist providers are not to be put at a potentially harmful disadvantage.

SPECIALIST HOSPITALS
Alder Hey Children’s NHS Foundation Trust
Birmingham Children’s Hospital NHS Foundation Trust
Birmingham Women’s NHS Foundation Trust
Clatterbridge Centre for Oncology NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Trust
Liverpool Heart and Chest Hospital NHS Trust
Liverpool Women’s NHS Foundation Trust
Memorandum submitted by The Children’s Trust, Tadworth (HS 62)

1. ABOUT THE CHILDREN’S TRUST, TADWORTH
   1.1 The Children’s Trust, Tadworth is a national charity providing specialist care, education, therapy and rehabilitation to children with multiple disabilities, complex health needs and acquired brain injury.
   1.2 Our services include residential rehabilitation for children with acquired brain injury (ABI); community-based services for children and young people with ABI; a residential school for pupils with profound and multiple learning difficulties (PMLD) and complex health needs; residential and community-based short breaks (respite care); transitional care between hospital and home for technology-dependent children; palliative care and continuing residential care. All of these services are wholly or partly funded by Primary Care Trusts.
   1.3 Our combination of services gives us a unique perspective on the Health and Social Care Bill’s implications for severely disabled children and their families.

2. SUMMARY
   2.1 Children with low-incidence, high-cost needs will pose a significant challenge to the new health system. We are concerned that GP consortia may not have the expertise or purchasing power to commission specialist services for this population.
   2.2 The Bill must take account of this vulnerable group of children and ensure they do not miss out on the specialist services they need by giving commissioning responsibility to the NHS Commissioning Board.
   2.3 The involvement of education and other local authority providers in Health and Wellbeing Boards should be put on a firm statutory basis.

3. ABOUT THE CHILDREN WE WORK WITH
   3.1 The children and young people to whom we provide services are amongst the most severely disabled in the UK. Many of them have profound learning disabilities and need to be supported in every aspect of their daily living. They are mostly unable to walk or talk and many depend on technology to keep them alive, through gastrostomies, tracheostomies or artificial ventilation, requiring round-the-clock nursing care. Some have rare and complex genetic conditions like Rett Syndrome or Batten Disease. Most use a wheelchair and may also need other items of special equipment to help manage their posture and prevent deformity or aid mobility and communication. Others may appear “normal” and be physically able, but have subtle yet highly significant problems with their learning and behaviour as a result of a brain injury.
   3.2 Adequately meeting these children’s needs is unavoidably expensive and represents an enormous challenge to health, education and other statutory agencies. At the same time, improved medical interventions mean this population is growing.
4. THE ROLE OF GPs AND GP COMMISSIONING

4.1 We have deep concerns that GP consortia will not have the clinical or management expertise to adequately commission the specialist services required by children and young people with severe disabilities and complex health needs. These services are unavoidably expensive and even in the current system we have often faced great resistance by local PCTs to meeting such costs, particularly when decisions about services for a single child can distort the budget held by individual commissioners. We would expect these difficulties to be exacerbated under a system of GP commissioning. GP consortia will have even less commissioning expertise in complex cases than PCTs and will be even less able to cope with spikes in financial demand brought about by the incidence of very complex paediatric needs in their area. We fear this will not only lead to children being denied access to vital services, but also pose a threat to highly specialist, national services such as our ours.

4.2 Many of the children we see at The Children's Trust have very unusual conditions. Statistically the average GP is unlikely to see a child with one of these particular conditions in an entire career, so to put the commissioning of services for all these children into the hands of GP consortia would present them with quite unfamiliar challenges. Professor Sir Ian Kennedy's recent report has already criticised the lack of general paediatrics training that GPs receive. This is particularly true for disabled children, where GPs are sometimes not involved in care and treatment at all. A child with a serious disability will be in the hands of a community paediatrician or a paediatric neurologist and other specialists either from birth or from the moment they are discharged from hospital after acquiring a disability through an accident or illness.

4.3 There is a risk that these children will miss out on vital services unless the responsibility for commissioning these services is clearly and decisively put on a national or regional footing. Pooling resources and concentrating commissioning expertise is the most effective way of ensuring that lower-incidence, high-cost needs are met. The new NHS Commissioning Board (NHSCB) represents a powerful mechanism by which this can happen. While the Bill already places responsibility for commissioning the specialist services identified in the National Definitions Set on the NHSCB, the Bill must also make explicit provision for the NHSCB's powers to include specialist services for children with low-incidence, high-cost needs (Section 11, subsection 3B).

5. INTEGRATED WORKING

5.1 It is vital that statutory agencies adopt a holistic approach to disabled children and work closely together to meet their needs. The creation of Health and Wellbeing Boards is a welcome development with the potential to deliver better outcomes for children and families and in many cases deliver significant savings to the taxpayer. However the Bill in its current form only requires Health and Wellbeing Boards to “encourage” the involvement of providers of “health-related services” (Section 179, subsection 3). This is not enough. For disabled children in particular, the definition of “health-related” provision encompasses a broad group of agencies.

5.2 For example, children and young people with a “hidden” acquired brain injury are a group with much to gain from better integrated working that involves education. There are many children who appear to make a good physical recovery after suffering a brain injury and are discharged home with little follow-up support. Yet the ongoing, invisible deficits they experience in areas such as communication, behaviour and attention as a result of their brain injury can lead to poor outcomes in education, possibly exclusion and the risk of becoming involved in the justice system. Their needs cannot be easily categorised and can call on funds from many agencies, including education, health, mental health and youth justice. With the right support and a co-ordinated approach from statutory agencies, the difficulties these young people face can be significantly mitigated.

5.3 The need for an integrated approach is also illustrated by the difficulties we often experience in attempting to discharge children home from our residential services. We have frequently come across situations where child and family are ready to move home but are unable to do so because of inflexibility in the rules or other difficulties in arranging financial support for their housing. Arguments between local government departments about funding housing adaptations, which might cost a five figure sum, can cause the PCT's costs for keeping a child in residential care longer than necessary to mount up to six figures. Meanwhile a specialist bed is blocked until the child is able to move on. These delays, which can cause misery for families and waste public money, are an outrage.

5.4 In order to offer disabled children and young people a truly joined-up approach, the involvement of education, housing and other agencies cannot be left to the discretion of Health and Wellbeing Boards. The Bill should therefore mandate the involvement of these providers through amendments to Section 178, subsection 2 and/or Section 179, subsections 3–6.

February 2011

120 Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs, Professor Sir Ian Kennedy, Crown Copyright 2010.
Memorandum submitted by the National Autistic Society (HS 63)

The National Autistic Society (NAS) is the UK’s leading charity for people affected by autism. We have around 20,000 members and over 100 branches, who are at the heart of what we do. We provide a wide range of advice, information, support and specialist services to 100,000 people each year. A local charity with a national presence, we campaign for lasting positive change for people affected by autism, and empower local people to influence change they will experience at a local level.

Healthcare and Autism

Autism is a serious, lifelong disabling condition that affects the way a person communicates with, and relates to, other people. It is a spectrum disorder which affects each individual in different ways. Some people with autism are able to live independent lives with little support, whilst others need specialist support throughout their lives. Around 1 in 100 have autism—over 500,000 people in the UK.

People with autism routinely struggle to access the services they need; consequently outcomes for both children and adults with autism are poor:

(a) 71% of children with autism also have one or more mental health problems, and yet our research shows that CAMHS are failing to improve the mental health of two thirds of children who access their services.

(b) A third of adults with autism report that they have experienced severe mental health problems because of a lack of support.

(c) People with autism are also often disadvantaged in accessing health services as their needs are not properly recognised and understood by professionals. Indeed, in a recent survey 80% of GPs told the National Audit Office that they needed additional guidance and training to effectively manage patients with autism.

We have concerns about elements of the proposals in the Health and Social Care Bill, but also see them as an opportunity to address long standing inequalities. This brief highlights a number of the main areas of concern and proposes a number of solutions to ensure this opportunity can be maximised for people with autism and their families.

We also support Mencap’s and EDCM’s submissions, particularly where they concern tackling inequalities and improving cooperation between Health and Wellbeing Boards, “free-schools” and academies.

Summary

— The NAS is concerned that with the removal of Children’s and Young People’s Plan the needs of children with disabilities—and in particular those with autism—will not be accounted for when planning services locally.

— The NAS believes that, although Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies are valuable tools, this Bill needs to ensure Health and Wellbeing Boards recognise and plan for meeting the often complex needs of children and adults with disabilities.

— The Health and Social Care Bill proposes to amend the Adult Autism Act 2009 to include GP commissioning consortia. The NAS believes that the Adult Autism Act should also be amended to include Health and Wellbeing Boards.

— The NAS believes that this Bill needs to be much clearer on the commissioning of specialist services, such as specialist autism teams.

— The NAS would like the committee to raise a number of questions regarding “Any Willing Provider”, particularly regarding how it will affect other statutory services.

Membership of Health and Wellbeing Boards (HWB)

Education

Many children with autism have complex needs and require support from social services, education, health and other agencies. Where services are not co-ordinated, children may undergo tens of assessments, support can be delayed by the numerous referral routes they need to take, and greater strain is placed on parents who have to take on the burden of co-ordinating services themselves. By enhancing co-operation


123 This figure comes from our survey of over 1,400 people with autism and their parents/carers. See M Rosenblatt (2008) I Exist London: NAS.

and ensuring that local services are coming together to plan for the needs of their local population, 
bureaucracy can be reduced, services can be streamlined and support to meet children’s needs can be put in 
place quickly, potentially saving costs in the long term.

The original draft Autism Bill contained clauses to help planning at a local level for children with 
autism. During the passage of the Bill through Parliament, sponsored by the Rt Hon Cheryl Gillan MP with 
strong support from across all the main political parties, the Government committed to ensuring that the 
challenge of co-operation and local planning would be overcome through Children and Young People’s 
Plans.

The NAS was therefore very disappointed when in July, the Government announced plans to revoke the 
requirements to prepare and publish Children and Young People’s Plan and the associated regulations and 
guidance. The removal of duties on schools to co-operate and to have regard to the Children’s and Young 
People’s Plans currently in the Education Bill is also very worrying (clauses 30 and 31).

However, there is a real opportunity in this Bill to ensure that the new NHS landscape includes 
mechanisms for ensuring that the needs of children with complex needs, such as autism, are recognised and 
met at a local level. We strongly believe that requiring a senior person responsible for SEN and disability 
sit on Health and Wellbeing Boards would help to ensure that the needs of those disabled children will 
be met.

Currently, the Health and Social Care Bill states that:

Clause 178 Establishment of Health and Wellbeing Boards
(1) A local authority must establish a Health and Wellbeing Board for its area.
(2) The Health and Wellbeing Board is to consist of:
   (a) subject to subsection (4), at least one councilor of the local authority,
   (b) nominated in accordance with subsection (3),
   (c) the director of adult social services for the local authority,
   (d) the director of children’s services for the local authority,
   (e) the director of public health for the local authority, 
   (f) a representative of the Local Healthwatch Organisation for the area of
   (g) the local authority,
   (h) a representative of each relevant commissioning consortium, and
   (i) such other persons, or representatives of such other persons, as the local authority thinks 
      appropriate.

The NAS would like the committee to consider adding:
   (j) a senior official responsible for special education needs and disabilities as appointed by the local 
       authority.

This amendment would also ensure that the reforms soon to be taking place because of the SEN Green 
Paper are fed directly into the emerging NHS landscape and, as such, providing the much needed joining 
up of statutory services.

However, reforms to the education system mean that increasingly schools will become more independent 
of local authorities. Therefore, further consideration is needed about how these schools can input into local 
planning, particularly for those with complex needs. We support EDCM’s briefing on this issue and urge 
the Committee to consider their probing amendment.

**Autism Partnership Boards**

In passing the Autism Act 2009, parliamentarians recognised that there were significant challenges for 
adults with autism in accessing the support they need from health and social services.

Fulfilling and Rewarding Lives: the strategy for adults with autism in England that was published as a 
result of the Act recommended establishing local autism partnership boards. These boards are key to 
overseeing the planning and commissioning of local services for adults with autism and overcoming some 
of the structural barriers facing adults with autism, as they try to access services. There are a large number 
of boards set up across England already. Over 80% of local authorities in the South West for example have 
established such boards, the members of the Greater Manchester Autism Consortium have had autism 
partnership boards for over 10 years (called autism services development groups or ASDGs) and a vast 
number have been established across the rest of England. The experience of our regional teams is that local 
authorities in particular see the value in these Boards and good practice local authorities are keen to set them 
up where they are not already in place.

These Boards are also crucial for involving adults with autism and parents/carers in the planning of 
services, reflecting the Government’s agenda for ensuring “Nothing About Us, Without Us”.

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125 Which will be discussed in more detail below.
Therefore, a further addition to the above would be to add into clause 178 the below:

(k) a representative from an autism partnership board.

**ROBUST DATA**

Although the NAS welcomes the Bill’s focus on outcomes, our concern is that because very little information is collected on autism it is almost impossible for the outcomes of this vulnerable group to be judged on real tangible data. This, in turn, will impact the speed with which reform is needed and the practical day-to-day commissioning of services.

We are aware that the Government has recognised this potential problem:

“The Government is aware that current data and data collections cannot adequately identify certain groups at present, such as people with a disability, and particularly those with learning disabilities. Indeed, the NHS Outcomes Framework makes it clear that people with learning disabilities are a particular group for whom we need to be able to better measure outcomes, and compare these with the rest of the population. As the framework evolves over time, outcome indicators will be refined with a view to being able to more fully measure and record health outcomes for all groups wherever it makes sense to do so.”

Liberating the NHS: Legislative framework and next steps (15 December 2010)

We welcome the Government’s recognition of this, although we would argue that while data on people with a learning disability is poor, data on autism is even worse. Therefore, it is crucial that data collected as part of the outcomes frameworks can be broken down by multiple disabilities ie a child has autism, epilepsy and depression. As such, the NAS would like to support Mencap’s suggested amendment on this issue.

In addition, however, we would urge the committee to pay specific attention to Government’s plans regarding Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies.

**Joint Strategic Needs Assessments (JSNA)**

In order to plan effectively, local services need to know how many people there are with autism in their area and what their needs are. It is the Government’s vision that the key tool for assessing this at a local level is the “Joint Strategic Needs Assessment” (JSNA).

The substantial lack of data on autism means that local authorities and PCTs find it difficult to plan effectively. The NAS strongly supports a needs based approach to commissioning, however, at present there are no references to autism prevalence in any of the statistical sources included in the JSNA core dataset. Indeed, just 20% JSNAs even mention autism, let alone ensuring services are planned through this process.

**LEWISHAM: DATA COLLECTION AND LOCAL ASSESSMENT OF NEED**

Local and national campaigning, along with the authority’s adult social care modernisation programme, have been drivers for Lewisham to conduct a detailed needs analysis for people with autism, with a specific focus on those with high functioning autism and Asperger syndrome who may fall between learning disability and mental health services. Lewisham used a mixed method, in-depth approach in gathering quantitative and qualitative data, matching the methods to the individuals and using specialist input.

The quantitative analysis pulled together data from statutory and voluntary partners and compared this to the national prevalence estimate to establish local prevalence and profile the future adult population with high functioning autism. This was used alongside qualitative data to predict future service capacity and understand the kind of support resources needed. Face-to-face interviews with learning disability services, mental health teams and the voluntary sector also revealed the need for a clearer pathway to diagnosis, information and assessment for social care services.

The authority profiled the gender, age and ethnicity of those identified, 58% being of non-white ethnic origin, most being male between the ages of 25 and 35, which will inform a service response. The aim of the qualitative research was to explore the particular local impacts on this group of people within the social and economic context of Lewisham. A specialist conducted semi-structured in-depth interviews which encouraged people to speak freely on a range of topics using themes where they were appropriate to the participant. A thematic analysis identified key needs including practical life skills, social and emotional skills, education and employment, housing, and support for family and carers.

Lewisham’s final report was made public in spring 2009. This analysis then fed into the JSNA, the development of transition services, and other commissioning strategies such as Supporting People.

Currently, the Health and Social Care Bill states that:

Part 5—Public involvement and local government

Chapter—2 Local government

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126 The core dataset provides a list of indicators that can assist partners in preparing their JSNA with detailed information on each indicator.
127 Clark *et al* (2009). Supporting adults with autism through adulthood, the National Audit Office.
176 Joint strategic needs assessments

(6) After subsection (8) insert—

“(8A) In preparing an assessment under this section, the responsible local authority or a partner commissioning consortium may consult any person it thinks appropriate.

The NAS would like the committee to consider adding:

“(8D) must have regard for the needs of all disabled children and adults”

— Joint Health and Wellbeing Strategies (JHWS).

Clause 177 of the Bill imposes a duty on local authorities and commissioning consortia to produce a Joint Health and Wellbeing Strategy (JHWS). Given the complexity of planning and commissioning services for people with disabilities, who often require support from multiple agencies, it is essential that health bodies and local authorities use these strategies to ensure that they have a clear plan to meet complex needs and tackle health inequalities.

Furthermore, all NHS bodies and local authorities are required to comply with the Equality Act 2010, meaning that all NHS and social care organisations have a general duty to:

— to eliminate unlawful discrimination, harassment and victimisation;
— to advance equality of opportunity between different groups; and
— to foster good relations between different groups.

Amending the bill as outlined below has the potential to ensure that each area plans to meet these needs as well as their duties under the Equality Act.

Currently, the Health and Social Care Bill states that:

Part 5—Public Involvement and local government
Chapter 2—Local government
Clause 177 Joint health and wellbeing strategies

After section 116 of the Local Government and Public Involvement in Health Act 2007 insert—

“116A Health and social care: joint health and wellbeing strategies:

(1) This section applies where an assessment of relevant needs is prepared under section 116 by a responsible local authority and each of its partner commissioning consortia.

(2) The responsible local authority and each of its partner commissioning consortia must prepare a strategy for meeting the needs included in the assessment by the exercise of functions of the authority, the National Health Service Commissioning Board or the consortia ("a joint health and wellbeing strategy").

(3) In preparing a strategy under this section, the responsible local authority and each of its partner commissioning consortia must, in particular, consider the extent to which the needs could be met more effectively by the making of arrangements under section 75 of the National Health Service Act 2006 (rather than in any other way).

(4) In preparing a strategy under this section, the responsible local authority and each of its partner commissioning consortia must have regard to the mandate published by the Secretary of State under section 13A of the National Health Service Act 2006.

(5) The responsible local authority must publish each strategy prepared by it under this section.

(6) The responsible local authority and each of its partner commissioning consortia may include in the strategy a statement of their views on how arrangements for the provision of health-related services in the area of the local authority could be more closely integrated with arrangements for the provision of health services and social care services in that area.

(7) In this section and section 116B—

(a) “partner commissioning consortium”, in relation to a responsible local authority, has the same meaning as in section 116, and

(a) “health services”, “health-related services” and “social care services” have the same meanings as in section 179 of the Health and Social Care Act 2011.

The NAS would like the committee to consider adding:

(8) In preparing a strategy under this section, the responsible local authority and each of its partner commissioning consortia must consider the extent to which the needs of all disabled children and adults will be met.
Health and Social Care Bill

AUTISM ACT

The Autism Act 2009 puts two key duties on the Government. The first was to produce a strategy on services for adults with autism. This was published in March 2010 (www.autism.org.uk/dhstrategy). The second was that statutory guidance for local authorities and local health bodies had to be published by the Secretary of State for Health by the end of 2010. The Act stated that the aim of this guidance was to secure implementation of the strategy.

On 17 December 2010, the statutory guidance was published. This guidance sends a clear message that local authorities and the NHS must improve:

— training for their staff;
— identification and diagnosis of autism in adults;
— planning of services for people with autism, including the transition from child services to adult services; and
— local leadership.

As this guidance is statutory, local authorities and NHS bodies must follow the guidance when it is relevant to them and, unless a good reason can be given, can be challenged through the courts.

Currently, the Health and Social Care Bill states that:

Schedule 5—Part 1: amendments of other enactments

Autism Act 2009 (c 15)

Clause 72 In section 4 of the Autism Act 2009 (interpretation), in subsection (1), in the definition of “NHS body”—

(a) omit paragraph (a),
(b) omit paragraph (b), and
(c) before paragraph (d) insert—

“(ca) the National Health Service Commissioning Board;
(cba) a commissioning consortium;”.

The NAS warmly welcomes the amendments proposed to the Autism Act and on ensuring that GP commissioning consortia have a duty to implement the statutory guidance. We would also, however, suggest that Health and Wellbeing Boards are put under a similar duty:

(cc) health and wellbeing boards:”.

The NAS believe this is an essential amendment as it would place a requirement on Health and Wellbeing Boards to coordinate their actions with the autism lead and make sure that their work is joined-up.

Although most local authorities will ensure this happens, we think it is important to clarify this and make sure that the autism strategy and statutory guidance are being taken forward in every local authority.

Clearly, although these boards are not commissioners in the sense of the Autism Act 2009 they will have a vital strategic role in the planning of services and, as such, should be bound by the ambitions set out in the adult autism strategy as well as the statutory guidance.

Further to this, the statutory guidance states that each local area should put in place a pathway to diagnosis. To help secure this requirement, the statutory guidance also states that:

“Each local authority should appoint a lead professional to develop diagnostic and assessment services for adults with autism in their area. This should be done in conjunction with the Local Strategic Partnership.”

With the demise of Local Area Agreements and the creation of health and wellbeing boards, many Local Strategic Partnerships (LSPs) are reviewing how they work and if they will continue. In this context, it would seem logical that Health and Wellbeing Boards accept these responsibilities, not least because a diagnostic pathway will primarily consist of clinical staff.

COMMISSIONING SPECIALIST TEAMS

Research conducted by the National Audit Office into public spending on autism found alarming gaps in training, planning and provision across a range of services. One of the best ways to solve this is to establish a specialist autism team within every local authority area. The adult autism strategy, Fulfilling and rewarding lives, recognised that where things were working well in a local area this was often as a result of the development of such a team. It recommended that local services look at the models of teams that have been developed and consider developing one locally.

Furthermore, the NAO found that if such teams are established there is a potential to save money. They estimated that if local services identified and supported just 4% of adults with High Functioning Autism and Asperger Syndrome the outlay would become cost neutral over time. In addition, they found that if they did

128 Clark et al (2009), ibid.
the same for just 8% they could save the Government £67 million per year. The Liverpool Asperger Team, which is the longest-standing specialist Asperger service, reports identification rates of 14%. 4% therefore seems a very achievable figure for newly established autism teams, thus achieving a cost-neutral level of service is an entirely realistic prospect.

Although an initial cost with identification will be placed on the NHS—estimated to be around £28 million for an 8% identification rate—the saving for local authorities would potentially be around £105 million. With health and social care being more closely integrated—because of the NHS reforms—this amounts to real savings for the NHS in the medium to long term.

There is a concern, however, about how such teams will be commissioned and funded in the future. Currently the Bill sets out two methods by which these services would be commissioned, either by Health and Wellbeing Boards or by the NHS Commissioning Board and its regional arms.

So on the one hand, Health and Wellbeing Boards have a duty to promote integrated working and, as such, would lead on commissioning specialist services such as this locally. However, the White Paper also set out the intention for the NHS Commissioning Board to take responsibility for commissioning specialised services at both the national and regional level as informed by the Specialised Services National Definitions Set (SSNDS). The SSNDS contains definitions on 34 services. Definition 22, Specialised Mental Health Services (all ages), includes specialised services for Asperger syndrome and autism spectrum disorder.

It is, therefore, unclear how specialist autism teams will be commissioned in the future.

Further to this, each of the above commissioning scenarios is not without its problems. First, if 80% of the commissioning budget sits with consortia but the Health and Wellbeing Boards are responsible for commissioning of joint services, there is a worry that the major budget holders—the GPs—may not commission services whose primary benefit in the short to medium term will be to local authorities. This commissioning problem could also potentially become more complicated when a Health and Wellbeing Board has a number of consortia in an area. In theory, the incentive for GP consortia will be “free ride” and not contribute to joint projects. Secondly, these specialist teams are more often than not commissioned jointly by local authorities and PCTs and therefore work across health and social care very effectively. By changing the funding mechanism and shifting these teams to a regional level, it may make it more difficult for these teams to integrate themselves into each local authority they serve and, therefore, limit the transformation effect these services can have.

Clearly, the Bill is not silent of ensuring Health and Wellbeing Boards and the NHS Commissioning Board cooperate, with clause 181 allowing for Health and Wellbeing Boards to request the NHS Commissioning Board appoint a representative to join the board. The NAS, however, are unsure this clause alone will solve the problem.

The NAS would, therefore, like the committee to consider tabling two probing amendments. The first to strengthen the role Health and Wellbeing Boards have in commissioning these services and the second for the Secretary of State to ensure there is continuous improvement of access to these specialist services.

(1) The Health and Social Care Bill currently reads:

Part 5—Public involvement and local government
Health and Wellbeing Boards: functions
Clause 179 Duty to encourage integrated working

(1) A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

We would like the committee to consider adding:

. . . and lead on establishing joint health and social care budgets for the commissioning of specialist services as defined by the Specialised Services National Definitions Set (SSNDS).

(2) The Health and Social Care Bill currently reads:

Part 1—The health service in England
Clause 2 The Secretary of State’s duty as to improvement in quality of services
After section 1 of the National Health Service Act 2006 insert—

“1A Duty as to improvement in quality of services

(1) The Secretary of State must exercise the functions of the Secretary of State in relation to the health services with a view to securing continuous improvement in the quality of services provided to individuals for or in connections with—

(a) the prevention, diagnosis or treatment of illness, or

(b) the protection or improvement of public health.

Clark et al (2009). Supporting adults with autism through adulthood, the National Audit Office.
We would like the committee to consider adding:

(c) ensuring access to specialist services as defined by the Specialised Services National Definitions Set (SSNDS)

Diagnosis and “Any Willing Provider” (AWP)

A central part of the Government’s vision for adults with autism is that they can get a diagnosis and access support it needed.\(^{130}\) The case studies below demonstrate the costly implications of late/misdiagnosis for the individual and local service providers. The consequences of a failure to provide support at an early stage include increased expenditure over time, due to a significant waste of resources on the provision of ineffectual treatments.

**CASE STUDY: THE FAILURE TO MAKE A TIMELY DIAGNOSIS**

“I spent my late teens and twenties involved with the mental health system, receiving diagnoses of anxiety and depression, self injury and anorexia and ‘personality disorder (unspecified)’. From early on I said from time to time to different psychiatrists, nurses and therapists that I thought I was autistic (I’d read about spectrum conditions when working voluntarily with disabled children from when I was 16 years old), but they said I was too able for such a diagnosis to be useful.” (Person with autism)

“12 years of misery, inappropriate therapies and inpatient settings. Twelve years of self harm, leaving scars for life. Many inappropriate medications and a GP facilitated valium addiction. Unfortunately only having other people with mental health problems as friends for most of that time, meaning a confirmed cycle of negativity.” (Person with autism)

There is a real shortage of diagnostic services at a local level. Searching our own database of services (which is by not exhaustive, but is the most comprehensive database of this type) we found only 15 NHS teams or individuals who actually diagnose autism in adults in England.\(^{131}\) There are, however, 28 private sector services and two voluntary sector services.

As a result, adults with autism and carers tell us that they have had to fight to get a diagnosis in adulthood. The adult autism strategy echoes this and rightly identifies the challenges facing adults with suspected autism as they try to access diagnosis. It goes on to stress the importance of ensuring that diagnosis is easily accessible in every area with the aim that there is a pathway to diagnosis in each local area by 2013.

Currently, due to the limited number of diagnostic services and the long waiting lists, we are aware of many individuals who have received a private diagnosis of autism—and in particular Asperger syndrome—only for local authorities to reject this diagnosis during an individual’s community care assessment because it did not come from the NHS. Although, clearly local authorities should not be rejecting these diagnoses out of hand anyway, the NAS believes that a potential side benefit of AWP is that other statutory services—and in particular social services—will no longer be able to disregard private diagnoses. It should also mean that local authorities and GP commissioning consortia will have plenty of options when designing their pathway to diagnosis.

The NAS, therefore, cautiously welcome the Government’s move towards AWP but believes more detail is needed about how this would work in practice, particularly how the move towards AWP will affect other services such as community care assessments.

**KEY QUESTIONS**

1. When will guidance regarding AWP be published?
2. What is the legal status of diagnoses commissioned by private providers and how will these affect other statutory services?
3. Is it the Government’s vision that the pathway to diagnosis set out in the adult autism strategy can be provided by AWP?

*February 2011*

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**Memorandum submitted by Breast Cancer Campaign (HS 64)**

1. This submission to the Health and Social Care Bill Committee by Breast Cancer Campaign considers some of the key issues in the proposed reforms affecting breast cancer services and proposes a number of amendments to the Health and Social Care Bill 2011.

1.1 Breast Cancer Campaign welcomes the Government’s intention to improve outcomes in the NHS, empower patients and reduce inequalities. However, this briefing highlights key issues where clarification of the Bill’s proposals would be of benefit to those affected by breast cancer.

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These are in relation to:

— How cancer commissioning will improve under the new system.
— Deciding which services should be specialised services.
— How inequalities can be further tackled to improve outcomes for breast cancer.

1.2 This briefing also sets out some suggested amendments to the Bill to:

— Increase the involvement of patients, clinicians and researchers to ensure good quality care and commissioning.
— Ensure that the NHS continues to promote research and uses the outcomes from that research.
— Ensure that inequalities continue to be tackled.

2. Breast Cancer and Breast Cancer Campaign: Key Facts

— Around 48,000 people are diagnosed with breast cancer in the UK every year.
— Breast cancer is the most common cancer.
— Every year around 12,000 women and 90 men die from breast cancer in the UK.\textsuperscript{132}
— Five year breast cancer survival rates in England are improving—in the early 1970s they were at 52% but now around 82% of women diagnosed with breast cancer this year will be alive in five years time.\textsuperscript{133}
— In recent years this improvement in survival rates in England has continued from 77.5% for patients diagnosed 1996–99, to 82% for those diagnosed in 2001–06.
— Despite this improvement, English breast cancer survival rates lag behind the European average. If breast cancer survival rates are to be amongst the best in Europe then the NHS must continue to support research, adopt the latest treatments, increase uptake of screening, tackle inequalities and improve early diagnosis.
— Breast Cancer Campaign specialises in funding innovative world-class research to understand how breast cancer develops, leading to improved diagnosis, treatment, prevention and cure.
— Breast Cancer Campaign only funds research into breast cancer and will support research at any centre of excellence in the UK and Ireland.
— The charity currently supports around 80 projects, worth around £16 million.

3. Commissioning of Cancer Services and Cancer Networks

3.1 Implications of the Bill’s proposals:

— Abolishing Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) giving most of their commissioning responsibilities to GP consortia.
— PCTs and SHAs previously supported cancer networks, which since 2000 have brought together the experts in cancer care—providers, commissioners, local authorities and the charity sector to help commissioners drive improvements in cancer care.
— However, the Government has to date only committed to funding Cancer Networks during the transition period. Their future after 2011–12 is uncertain, although it has been suggested that they may become social enterprises.

3.2 What this means for breast cancer:

— Cancer Networks play an important role in co-ordinating services and helping to provide information on local cancer incidence and outcomes to help improve the quality of cancer treatment, and promote the prevention and early detection of cancer.
— GPs will need specialist advice if they are to successfully commission complex breast cancer services and ensure that breast cancer outcomes continue to improve.

3.3 Key Questions regarding the Bill’s proposals:

— Will the Government commit to ensuring the expertise of Cancer Networks is not lost beyond the transition period, so that GP consortia are supported to commission complex cancer services effectively?
— How will the Government ensure that GP consortia are given the support they need to commission complex cancer services and continue to drive improvements in breast cancer care and survival rates?

\textsuperscript{132} Office of National Statistics, Scottish Cancer Registry, Northern Ireland Cancer Registry.
\textsuperscript{133} CRUK breast cancer survival statistics.
4. INEQUALITIES

4.1 What the Bill proposes:

— Placing duties on the Secretary of State, NHS Commissioning Board and GP consortia to reduce health inequalities.

— A duty will be placed on the Secretary of State to protect public health, which will include the NHS Breast Screening Programme.

4.2 What this means for breast cancer:

— There are significant inequalities in breast cancer. Research has shown that older patients are less likely to receive a range of diagnostic tests and treatments compared with younger patients and evidence suggests that this is based on their age rather than the type of tumour.\(^{134}\)

— We also know that there is significant variation in uptake of screening—from 56 to 84.8% in different regions, and variation between different ethnic groups.\(^{135}\)

— A Department of Health study suggests that if England is to achieve breast cancer survival rates equal to the best in Europe, then breast cancer must be diagnosed earlier. A cost-benefit analysis of improving breast awareness and uptake of breast screening to 100% showed an average cost per life saved of £2,329. This shows that earlier diagnosis of breast cancer would be very cost-effective.\(^{136}\)

— Breast Cancer Campaign funded research has shown that South Asian women are less likely to visit their GP with breast symptoms than other groups and is also investigating the psychosocial impact of diagnosis amongst Black and Minority Ethnic (BME) women.\(^{137}\)

— BME women have a lower survival rate than white women—a three year survival rate for black women aged 15–64 of 85% compared to 91.4% for white women of the same age.\(^{138}\)

4.3 Key Questions regarding the Bill’s proposals:

— How will these provisions work in practice to ensure that with local variation in services there is not a growth of unacceptable variations in inequalities?

— Will the duties to tackle inequality also include tackling inequalities in uptake of services?

— Will the Secretary of State ensure that inequalities in the uptake of breast screening continue to be addressed?

5. DESIGNATING WHICH SERVICES ARE SPECIALISED: CASE STUDY—RADIOThERAPY

5.1 What the Bill proposes:

— The Secretary of State has the power to require that certain specialised services are commissioned by the NHS Commissioning Board where appropriate.

— Other secondary health services will be commissioned by GP consortia.

— It is not yet clear if radiotherapy will be defined as a “specialised service” and therefore commissioned by the NHS Commissioning Board or by GP consortia.

5.2 What this means for breast cancer:

— Radiotherapy contributes to the cure of 40% of cancer patients.\(^{139}\)

— Radiotherapy has been estimated to add a 3% gain to breast cancer overall survival.\(^{140}\)

— Radiotherapy makes up 5% of the cancer budget (18% is spent on drugs).\(^{141}\)

— Radiotherapy services have suffered from a lack of progress on increasing access rates.

— The Government’s new Cancer Strategy notes that 52% of cancer patients should receive radiotherapy, but in 2007 only 37% of cancer patients had access to radiotherapy.\(^{142}\)

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136 *The likely impact of earlier diagnosis of cancer on costs and benefits to the NHS*, Department of Health.


— Access also varies greatly between regions: in the south and south-east access rates are estimated to be 49%; in the north-east, north-west, Yorkshire and Humber the rate is only 25–35%.143

— If cancer outcomes in England are to be among the best in Europe, access to radiotherapy will have to improve.

— Good commissioning will be vital to improve radiotherapy capacity and to address these regional inequalities.

— Radiotherapy needs a large patient population to plan services, and planning radiotherapy services also has capital cost considerations—it should be commissioned at a national level by the NHS Commissioning Board.

— Uptake of the latest radiotherapy techniques in England has also been slow. Campaign funded research has shown that a new form of radiotherapy, Intensity Modulated Radiation Therapy (IMRT), leads to reduced cosmetic side effects for women with breast cancer (reducing the costs of treating them) and lowers the risk of patients developing telangiectasia which is an indicator of developing heart disease many years after treatment.144

— IMRT is only available in around half of radiotherapy centres in England, despite its widespread use in Europe and the USA.

5.3 Key questions regarding the Bill’s proposals:

— Will the Secretary of State commit to giving the NHS Commissioning Board the power to commission radiotherapy, ensuring that this essential treatment is planned at an appropriate level?

— If GP consortia are to commission a low volume service such as radiotherapy how can sufficient regional co-ordination be secured?

— If GP consortia are to commission radiotherapy how will they be able to plan for the capital costs of new radiotherapy machines if needed?

— Will the Board review and ensure the implementation of the latest radiotherapy techniques such as IMRT across England?

6. SUGGESTED AMENDMENTS TO THE HEALTH AND SOCIAL CARE BILL 2011

Breast Cancer Campaign has identified a number of key areas where improvements could be made to the Bill as present.

These amendments are to:

— Increase the involvement of patients, clinicians and researchers to ensure good quality care and commissioning.

— Ensure that the NHS continues to promote research and uses the outcomes from research.

— Ensure that inequalities continue to be tackled.

7. INCREASING THE INVOLVEMENT OF PATIENTS AND CLINICIANS ENSURING GOOD QUALITY CARE AND COMMISSIONING

7.1 Clause 11, page 7, line 29, at end insert—

“(c) hold a period of public consultation”

Impact of amendment: Clause 11 gives the Secretary of State the power to make regulations to require the NHS Commissioning Board to commission certain services as part of the health service. When deciding to make regulations under this section, the Secretary of State must obtain appropriate advice and consult with the Board. This amendment would also require the Secretary of State to hold a public consultation before deciding to make regulations under this section.

Purpose of amendment: to require the Secretary of State to consult with the public when making regulations as to what services the Board should commission. This would ensure there is a formal opportunity for NHS staff, representative bodies, patient groups and the public to contribute their views to the important decision of which services should be commissioned by the Board and which will be commissioned by GP consortia.

Effect of amendment for breast cancer: as the Bill stands, formal opportunities are limited for the public and clinicians outside primary care to contribute their knowledge and expertise to assist with deciding at what level services are commissioned. This consultation would give them such an opportunity. One example of a breast cancer service that should be commissioned at a national level is radiotherapy which requires a large planning population to be effectively commissioned.


144 Cambridge Breast Intensity Modulated Radiotherapy Trial, Coles et al.
7.2 Clause 19, page 15, line 42, at end insert—

“(c) hold a period of public consultation”

**Impact of amendment:** this clause requires the Secretary of State to lay before Parliament every year “the mandate”—a document that would set out the totality of what the Government expects from the NHS Commissioning Board. Before specifying the objectives or requirements in the mandate, it is currently proposed that the Secretary of State must consult the Board and such other persons as the Secretary of State considers appropriate. This amendment would also require the Secretary of State to hold a public consultation before specifying the objectives or requirements in the mandate.

**Purpose of amendment:** to require the Secretary of State to consult with the public when preparing the mandate. This would ensure there is a formal opportunity for NHS staff, representative bodies, patient groups, researchers and the public to contribute their views to the development of this important document.

**Effect of amendment for breast cancer:** as the Bill stands, formal opportunities are limited for the public, researchers and clinicians outside of primary care to contribute their knowledge and expertise to assist with deciding priorities for the NHS. This consultation would give them an opportunity.

7.3 Clause 22, page 33, line 11, at end insert—

“(3) When the Board prepares guidance under this section the Board must have regard to Quality Standards issued by NICE”

**Impact of amendment:** this clause requires the NHS Commissioning Board to publish guidance for GP consortia to assist them with their commissioning functions. This amendment would require the Board to consider the Quality Standards that will be produced by NICE before issuing guidance.

**Purpose of amendment:** NICE will publish Quality Standards setting out what good quality care and services should look like based on an assessment of evidence including clinical practice and research. NICE has begun the development of a Quality Standard for breast cancer, as well as standards for other conditions. Having regard to Quality Standards when preparing commissioning guidance will help to ensure that consortia have regard to clinical best practice.

**Effect of amendment for breast cancer:** breast cancer patients in all areas of the country should have access to best practice care and services, this amendment would help ensure this is achieved.

8. ENSURING THAT THE NHS CONTINUES TO PROMOTE RESEARCH AND USES THE OUTCOMES FROM THAT RESEARCH

8.1 Clause 8, page 5, line 25, at end insert—

“(h) supporting research into the prevention, diagnosis or treatment of illness”

**Impact of amendment:** clause 8 (3) lists some of the steps to improve public health that local authorities and the Secretary of State would be able to take. This amendment would explicitly add research to that list.

**Purpose of amendment:** the explanatory notes relating to this clause states that subsection (3) of this clause includes “carrying out research into health improvement”. However, subsection (3) does not specifically mention research. This is a probing amendment to clarify whether research is indeed covered under the current wording of Clause 8(3).

**Effect of amendment for breast cancer:** we know that lifestyle factors such as being overweight, exercise, diet and alcohol have all been identified as risk factors for breast cancer. Research into both the lifestyle factors which contribute to disease and the necessary action to encourage a reduction of exposure to these risk factors is important to make progress on improving public health and lowering the risk of developing breast cancer.

8.2 Clause 218, page 189, line 35, after “preparing” insert “or revising” a quality standard.

**Impact of amendment:** Clause 218 sets out the functions of Quality Standards that will be produced by NICE and the requirements that NICE must fulfil when preparing the Quality Standards.

**Purpose of amendment:** NICE will want to review Quality Standards periodically to ensure that they represent an up to date picture of best practice care and outcomes. As current it is not clear whether NICE will be required to consult the public when revising Quality Standards and this amendment will ensure that their views are taken into account when updating Quality Standards.

**Effect of amendment for breast cancer:** this will ensure that the views of breast cancer patients, clinicians, researchers and organisations are taken into account when NICE revises Quality Standards to ensure that they do reflect current best practice care.
9. Ensuring that inequalities continue to be tackled

9.1 Clause 2, page 2, line 34, after “effectiveness” insert “and uptake” of the service.

Impact of amendment: when the Secretary of State acts to improve the outcomes that are achieved from the provision of services, the outcomes relevant for this purpose would include considering uptake of a service.

Purpose of amendment: probing amendment to define further the meaning of Clause 2 (3)(a) the effectiveness of the service. The explanatory notes explain that this clause is covered by any service that is associated with both public health and the NHS and cites screening as an example.

Effect of amendment for breast cancer: the effectiveness of some services relies not only on their performance but also ensuring sufficient uptake. The NHS Breast Screening Programme is one example of those services. Information from the Breast Screening Programme shows that there is significant regional variation in the uptake of Breast Screening—from 56 to 84.8% between different regions. A Department of Health study suggests that if England is to achieve breast cancer survival rates equal to the best in Europe, then breast cancer must be diagnosed earlier. A cost-benefit analysis of improving breast awareness and uptake of breast screening showed an average cost per life saved of £2,329.

9.2 Clause 3, page 3, line 5, leave out “must have regard to the need to reduce” and insert “must, so far as it is in the interests of the health service, act with a view to securing a reduction in”.

Impact of amendment: clause 3 imposes a new duty on the Secretary of State to consider the need to reduce inequalities in respect of the benefits that may be obtained from the health service. This amendment would strengthen the responsibility of the Secretary of State in relation to this duty.

Purpose of amendment: it is proposed that the Secretary of State “must have regard to the need to reduce inequalities”. This amendment would strengthen the responsibility of the Secretary of State in this regard.

Effect of amendment for breast cancer: we know that inequalities exist in breast cancer services and outcomes and these need to be tackled to improve breast survival rates. Despite age being the most significant risk factor for breast cancer, research has shown that older patients are less likely to receive a range of diagnostic tests and treatments compared with younger patients. Evidence suggests that this is based on their age rather than the type of tumour.

There is also evidence that Black and Minority Ethnic communities and those from lower income households have lower awareness of breast cancer. Breast Cancer Campaign funded research has shown that South Asian women are less likely to visit their GP with breast symptoms than other groups. This can lead to later diagnosis and data suggests that Asian and black women have lower survival rates than white women; black women aged 15–64 have significantly poorer survival from breast cancer at both one and three years than white women of the same age (85% compared with 91% at three years).

9.3 Clause 19, page 20, line 10, after “13D” insert “13I, 13F”.

Impact of amendment: the annual report that the Board is required to publish after the end of each financial year has to contain certain information, including how effectively it discharged its duties under sections 13D (duty as to improvement in quality of services) and 13L (public involvement and consultation by the Board). This would add 13I (Duty in respect of research) and 13F (Duty as to reducing inequalities, promoting patient involvement etc) to that list.

Purpose of amendment: this would require the annual report from the Board to include an assessment of how effectively it has met its duties in respect of research and to reduce inequalities and promote patient involvement. It is not clear why the current proposals do not expect the Board to report back on how effectively it has discharged all its duties.

Effect of amendment for breast cancer: along with earlier diagnosis and screening, research has contributed to the improvement in breast cancer survival from 52% in the early 1970s to 82% today. It is important that the NHS continues to support research to ensure that outcomes for breast cancer patients continue to improve. Reporting on work to tackle inequalities will also help to ensure that progress continues to be made in tackling inequalities in breast cancer services.

February 2011

149 CRUK breast cancer survival statistics.
Memorandum submitted by the Royal College of Speech and Language Therapists (HS 65)

1. **About the RCSLT**

   1.1 The Royal College of Speech and Language Therapists (RCSLT) is the professional body for speech and language therapists, students and support workers working in the UK. The RCSLT has almost 15,000 members, including nearly 95% of the speech and language therapists working in the UK.

   1.2 Speech and language therapists are allied health professionals (AHPs) who work within multidisciplinary teams alongside other clinicians and allied health professionals.

   1.3 There are just over 100,000 doctors and just under 100,000 allied health professionals. AHPs work autonomously with patients, they are not support staff. Their involvement and input is crucial to all commissioning decisions.

   1.4 The RCSLT seeks urgent reassurance regarding the provision of speech and language therapy services in the new commissioning and public health arrangements.

2. **Summary of Evidence**

   2.1 Successful commissioning will depend on the involvement of all healthcare professionals. Allied health professionals must be represented in all key decision making structures at national, regional and local levels.

   2.2 The RCSLT believes that allied health professionals must be represented on:

   — National Health Service Commissioning Board.

   — Commissioning consortia.

   — Health and Wellbeing Boards.

   2.3 Allied health professionals should be named as a partner to developing the joint strategic needs assessment and the health and wellbeing strategy.

3. **National Health Service Commissioning Board**

   **Membership**

   3.1 Successful commissioning will depend on the involvement of healthcare professionals. Allied health professionals must be represented in all key decision making structures at national, regional and local levels. The knowledge and expertise of allied health professionals will be crucial to the decisions of the NHS Commissioning Board.

   3.2 The NHS Commissioning Board will be a strategic body and should consist of the appropriate clinicians.

   3.3 AHPs are already represented at a strategic level across Northern Ireland and Scotland. In Northern Ireland the commissioning structure for health and social care services includes AHPs. The Health and Social Care Board operates through five commissioning groups and each has representation from allied health professionals. In Scotland community health partnerships and community health and care partnerships include representation from allied health professionals at Board level. The RCSLT fully endorses the representation of allied health professionals at a strategic level and recommends that this is adopted into the English health and social care system without delay.

   3.4 Schedule 1 lists the proposed membership of the NHS Board which fails to include representation of allied health professions. We recommend that to the list of membership as specified on page 221 Schedule 1 line 17 an allied health professional is added.

   3.5 It is essential that the NHS Commissioning Board obtain clinical advice and expertise from allied health professionals in order to effectively discharge their functions. We recommend that on page 221 Schedule 1 after line 24 add (4) the NHS commissioning board must obtain appropriate clinical advice and expertise from allied health professionals in order to effectively discharge their functions.

   **Patient involvement**

   3.6 If a child, young person or adult has speech, language and communication needs they will require additional support to exercise their choice. It should also be recognised that people with communication needs, with the right support, are perfectly capable of exercising choice and making decisions. Appropriate support will be critical to ensure people with communication needs have access to the information they need to make informed choices regarding their future care.

   3.7 The NHS Commissioning Board will be responsible for securing the involvement of patients to enable them to make choices about the provision of health services. It is essential that patients with speech, language and communication needs are supported to be able to make choices. Appropriate support from speech and language therapists will ensure equitable representation across all care groups, universal and specialist services. On page 18 clause 13L (2) after line 33 add (d) by supporting those with speech, language and communication needs.
4. COMMISSIONING CONSORTIA

4.1 The RCSLT is concerned that the variability in the structure of commissioning consortia may lead to health inequalities in decisions made and services offered due to the variation in clinical input. GP consortia must include input from a range of health and social care professionals including allied health professionals. Allied health professionals are best placed to understand their patients’ needs and shape services to meet those needs. They work across health, education, social care with adults and children and in acute and primary care hence represent a wide proportion of patients.

4.2 The RCSLT seeks assurances that any changes to the structure of commissioning honour the Secretary of State’s assertion in Parliament that a range of health professionals, including AHPs will be involved in planning and decision making. We would welcome reassurances that GP consortia would be under a duty to work with a range of health professionals and the mechanisms to ensure that this happens locally. The government should set out clear expectations that all commissioning consortia should be under a duty to work with allied health professionals.

Duty as to reducing inequalities and promoting patient involvement

4.3 Commissioning consortia will be required to reduce inequalities and promote patient involvement. In the exercise of this function, commissioning consortia must consider the speech, language and communication needs of patients when involving patients to enable them to make choices about the provision of health services. On page 30 after 14N (1) line 29 add (e) by supporting those with speech language and communication needs or communication disability.

Duty to obtain appropriate advice

4.4 The duty on commissioning consortia to obtain appropriate advice on page 30 clause 14O needs to be strengthened in order to embed this approach into the system. The definition of physical and mental health is too narrow and should make provision for those who have communication impairment either accompanying or separate to a physical or mental impairment. Commissioning consortia should be under a duty to work with health professionals and seek their expert advice. On page 30 remove lines 33 to 36 and replace it with “Each commissioning consortium must make arrangements with a view to securing that it obtains advice appropriate for enabling it effectively to discharge its functions from persons with professional expertise, including allied health professionals, relating to the physical or mental health or communication ability of individuals.”

Reports by commissioning consortia

4.5 On page 34 after 14Z (2) line 44 add the report must also explain how the commissioning consortium has discharged its duty under section 116B of the Local Government and Public Involvement in Health Act 2007.

4.6 Clause 177 of the Health and Social Care Bill on page 150 (section 116B) would amend section 116 of the Local Government and Public Involvement in Health Act 2007 setting out the duty of a consortium to have regard to the most recent joint strategic needs assessments and joint health and wellbeing strategy. This amendment aims to ensure that commissioning consortia must report on how it has exercised that duty. This ensures that all the strategies are joined up in exercise and functioning.

5. JOINT STRATEGIC NEEDS ASSESSMENT

5.1 On page 149 clause 176 local authorities have to work with commissioning consortia within their boundaries to prepare a joint strategic needs assessment to identify the current and future health and wellbeing needs of the local population. Failure to accurately capture the needs of the local population will result in a substandard assessment and in turn will have a detrimental affect upon the consequential health and wellbeing strategy.

5.2 Experience suggests that joint strategic needs assessments are haphazard in operation. We would like to know what incentives or mechanism will be introduced to ensure that commissioning consortia will be required to follow the joint strategic needs assessment and be held accountable.

5.3 On page 149 clause 176 allied health professionals should be named as a key partner to developing the joint strategic needs assessment. As it stands, the legislation does little to encourage local authorities or a partner commissioning consortia to consult with appropriate persons. Given the importance of ensuring integrated working, particularly with regard to services for children or vulnerable adults, there should be a duty to consult with appropriate health professionals, including allied health professionals who may work across sectors such as education and justice and have expertise with regard to children and vulnerable adults.

Reference:

150
5.4 On page 149 change clause 176 (6) remove lines 24 to 26 and replace with:

“(8A) In preparing an assessment under this section, the responsible local authority or a partner commissioning consortium must consult persons with experience of delivering relevant services, giving particular regard to health professionals, including allied health professionals, working with:

(a) children; and

(b) vulnerable adults”

6. JOINT HEALTH AND WELLBEING STRATEGIES

6.1 Page 149 clause 177 imposes a duty on local authorities and commissioning consortia to produce a joint health and well-being strategy to address and meet the needs identified in the joint strategic needs assessment and to have regard to it when carrying out their commissioning functions. Joint health and wellbeing strategies will provide the overarching framework for NHS, social care and public health commissioning plans.

6.2 In clause 177, after section 116A(2) of the Local Government and Public Involvement in Health Act 2007 line 10 insert local authorities and partner commissioning consortia should work with local allied health professionals.

6.3 The Health and Social Care Bill presents an opportunity to correct the historic fragmentation of commissioning of speech and language therapy, in order to safeguard services for children and vulnerable adults. This is especially pertinent to services such as speech and language therapy, which often use pooled budgets as set out in section 75 of the National Health Service Act 2006.

6.4 Given the lack of a robust, established commissioning framework for speech and language therapy services (in the same way as for example, cancer or cardiac networks), transformation could further destabilise the fragile arrangements that persist in some areas. Services are currently delivered through a set of commissioning and funding arrangements particular to each locality (often isolated or led by one agency) and lack integration into mainstream service provision. The majority of speech and language therapists are commissioned by the NHS and local authorities, whilst others are funded independently by schools, early years centres, further education institutions and prison services.

6.5 In clause 177, after 116A(3) of the Local Government and Public Involvement in Health Act 2007 remove lines 11 to 15 and replace with (3) to “in preparing a strategy under this section, the responsible local authority and each of its partner commissioning consortia must, in particular, consider the extent to which the needs could be met more effectively by the making of arrangements under section 75 of the National Health Service Act 2006 (rather than in any other way), with particular regard to services for:

(a) Children; and

(b) Vulnerable adults”

7. ESTABLISHMENT OF HEALTH AND WELLBEING BOARDS

7.1 The RCSLT hopes that the Health and Wellbeing Boards (Clause 178) will encourage local authorities to take a strategic approach and promote integration across health, social care, children’s services and education including safeguarding for vulnerable children and adults.

7.2 Health and Wellbeing Boards remit will encourage integrated working across health and social care which we wish to be explicitly extended to cover children’s services and education.

7.3 Whilst Boards will have a duty to promote health and social care integration there is no equivalent duty on GP consortia. This failure will jeopardise local relationships and an equal requirement should be placed on the consortia to promote health and social care integration.

Membership

7.4 We do not believe that health and well-being boards will automatically strengthen local democratic legitimacy. While this will depend in part on local relationships and approach, it is important that the right structure is created for the board to operate optimally in the local environment.

7.5 The listed membership of the Health and Wellbeing Boards in clause 178(2) is too limited and fails to consider frontline health professionals and allied health professionals. To be effective health and well being boards need to have an inclusive picture of local health need, this requires the involvement of local professionals with knowledge and understanding of the needs of the community where the board operates.

7.6 It is essential that allied health professionals are represented on Health and Wellbeing Boards. Health and Wellbeing Boards should be required to work with allied health professionals who can bring their expertise and knowledge across a range of pathways and settings spanning social care, public health, health and children’s services. On page 151 clause 178(2) after line 18 add (h) allied health professionals.
Functions

7.7 Page 153 clause 180(3) alone is insufficient to ensure local authorities are accountable to their respective Health and Wellbeing Boards. On page 153 clause 180 remove lines 14 to 16 and replace with (3) a Health and Wellbeing Board must give the local authority that established it its opinion on whether the authority is discharging its duty under section 116B of the 2007 Act. This opinion must be made public. As with the amendment to Clause 22, above, this amendment would ensure that local authorities are required to report on how they have had regard to the most recent joint strategic needs assessments and joint health and wellbeing strategy.

7.8 On page 153 after clause 180(2) line 13 add (3) A local authority must report annually to the health and wellbeing board and NHS commissioning board on discharging its duty under section 116B of the 2007 Act, and this report should be made public.

February 2011

Memorandum submitted by Ruth Marsden (HS 66)

Ruth Marsden: heavily involved in ppi for 10 years. Currently member of Hull LINk (Local Involvement Network), Lead Group member for East Riding of Yorkshire LINk, regional representative for Yorkshire and Humberside for National Association of LINks (NALM), also NALM Steering Group member and Vice Chair of NALM, and currently member of Advisory Board for Healthwatch with CQC/D of H.

1. Experience over LINks’ lifetime has shown that for a significant number of LINks, the local authority has not been a “safe pair of hands”. LAs’ Contract Managers, often more used to bridges and roads, have had contracting for and management of LINk hosts organisations left to them.

2. Even over the last three years of relative plenty, LAs have withheld LINks’ budget allocations to the tune of over £3 million. Now that the local authorities’ own budgets have been squeezed, even more is being withheld, current information showing cuts for 2011–12 of 20% to over 60%. Monitoring of social care commissioned and provided by councils is impossible when councils hold the purse strings of the monitors.

3. Andrew Lansley, at the Conservative Party Summit on Patient and Public Engagement in October 2006 said, “On the important issue of independence, local involvement networks (LINks) would struggle to be credible as long as they are funded through local government.”

How right he was.

4. It is now proposed that Healthwatch be funded through the same local-government route. This leaves HW money open to being appropriated by the local authorities and risks the current flow becoming a haemorrhage.

5. The proposals leave the local authority tanks on the Healthwatch lawn! Funding for Healthwatch must come through Healthwatch England.

February 2011

Memorandum submitted by East Riding of Yorkshire Local Involvement Network (HS 67)

Healthwatch

East Riding of Yorkshire LINk (Local Involvement Network) was set up under the Local Government and Public Involvement in Health Act 2007. It is proposed under the current bill that the LINk becomes Local Healthwatch.

Summary—For independence, credibility and capacity, Local Healthwatch must not be funded through local authorities

1. Funding: the current funding stream comes from the D of H to the local authority. To date, this has been an identifiable sum, dedicated (though not ring-fenced) for the purpose of supporting/enabling the Local Involvement Network (LINk) and paid through the Area Based Grant. This system comes to an end in March this year, 2011.

2. Even without the current funding squeeze on local authorities, the LINk has never received the full sum allocated for it. Every year, 2008–09, 2009–10, 2010–11, the East Riding of Yorks LINk (ERYLINK) has had about £50k diverted by the LA to other purposes. To date, nearly £3 million of LINks’ monies has been siphoned off by English LAs.

3. This year, we are told by the LA that they are cutting our funding by 20%, that 20% to be used by them for other purposes. Already, neighbouring LINks have suffered swinging cuts—Hull LINk budget cut by 69%, North Yorks LINk budget cut by 50%.
4. The lesson is stark. LAs are poor custodians of LINks' funding. Healthwatch will have wider and more responsibilities (advocacy etc) and will under current proposals be similarly reliant on the LAs for its funding.

5. Independence: the independence of LINks/Healthwatch is seriously compromised. Being reliant upon the LA for funds, Healthwatch cannot freely monitor social care services as the LA is itself the provider. The LA hold the purse strings, a financial choke-chain against independent monitoring, and have shown themselves very ready to tighten this chain, even before the current extreme financial situation.

6. Local Healthwatch must be funded through Healthwatch England.

*February 2011*

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**Memorandum submitted by Wendy Savage MBCh FRCOG MSc (Public Health) Hon DSc (HS 68)**

NCB CLAUSE 5 AND SCHEDULE A1(2) AND(3).

We think that all members of the NHS Commissioning Board should be appointed after open advertisement. The job description should describe their duties and the competencies required. They should be appointed by an independent panel or by the Health Select Committee of the House of Commons.

We do not accept that the Secretary of State has already appointed the first Chair of this Committee before the Bill has been debated fully in Parliament and think this shows gross contempt for the parliamentary process.

Commissioning Consortia Schedule 2 3(2) replace may by must before include provision for nine. The accountable officer must be someone with relevant experience—this is too vague

15(b) Dispose of property—Mr Lansley told me personally that the NHS would not dispose of any assets.

223L(1) we do not think that consortia need to be paid bonuses for doing their job well.

Somewhere there is a line saying that two people can start a consortium—this should be removed as it is ludicrous to think that two GPs could run a consortium.

Under public involvement it says that consortia may consult by providing information, consulting or other ways which included being on committees. It is not sufficient to just provide information or include in tone of the meaningless consultations which people are bombarded with. They must have representation on the Consortium Board and relevant Committees to feed into decision making.

*March 2011*

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**Memorandum submitted by Julie Lord (HS 69)**

I am a community commissioning matron and work for a PCT in the North West, one that I hasten to add, is well managed and in financial balance.

I have worked for the NHS for 30 years.

I came into this commissioning role in June last year after a career in nursing, predominantly as a ward sister and later managing community services. I am one of those people that this Government refer to as a PCT pen pusher despite my own and many other PCT staffs background in frontline clinical services.

I have worked through an endless succession of NHS reorganisations.

I wish to comment on the health and social care bill and I will articulate my views from my perspective as nurse, manager and commissioner.

You may find some of my comments to be a little bit emotive, I make no apologies for that, there are many logical arguments for and against this bill but I speak as someone who cares passionately about the NHS, who believes in the founding principles of the NHS and know that this bill will destroy all that is good about the NHS.

Firstly, despite the fact that this bill is only on its second reading PCT’s are already being instructed to make staff redundant in readiness for the implementation of this bill, is this a done deal? Despite the fact that the bill is not yet law? We are supposed to have a democratic form of government; the way this is being handled does not represent a democratic process. In addition these changes are having a significant effect already on the functioning of commissioning as well as on staff performance.

Secondly, NHS staff at the frontline of care delivery and commissioning have had no say in this bill no one has consulted with NHS staff with regards to the best way forward.

Thirdly, the current Government lied about NHS reorganisation and Andrew Lansley must have been developing this bill for some time but failed to make his intentions explicit that constitutes deception towards the general public and NHS staff.
This bill is hailed as one that puts Doctors and nurses in the frontline of decision making.

There is nowhere in this bill that gives nurses any say in commissioning decisions or a place on commissioning boards, and these words are pure rhetoric.

The long term effect of this bill will almost certainly mean that the Government will shed its responsibility as an employer of NHS staff with the scrapping of PCT’s and the creation of foundation trusts who will be able to set their own employment terms and conditions and the increased participation of private providers.

Nurses are currently subject to AFC terms and conditions.

Nurse have in the past been poorly paid, AFC represents a decent pay structure that is fair and offers opportunity to progress within a fair pay system, even so, nursing is acknowledged to be a stressful job, both physically and emotionally demanding. Remove the pay structure and terms and conditions of employment and the Government runs the risk of ensuring that nursing becomes a less attractive career option.

This bill could therefore contribute to a future nursing workforce shortage. Combine that with the number of experienced senior nurses who will be made redundant or who are in their fifties and will be retiring soon and I predict a shortage of nurses in the years to come.

This bill proposes scrapping PCT’s and these organisations have been much maligned by the Government in the past few months, these could easily be retained and re-organised and merged.

This would save money, maintain safe services and systems and would prevent disruption to NHS provider services for this not to be even considered and dismissed as an option does not make good common sense, therefore, this plan to scrap PCT’s must surely be the result of extreme right wing ideological thinking.

The bill proposes the use of any willing provider, I see at first hand, in the area that I work, the variation in standards between private providers, often the governance arrangements are very poor in comparison to NHS standards, qualified nurse staffing ratios are often poor, examples are one trained nurse to 50 patients, and that will remain poor with providers who aim to make profits from healthcare.

We will end up with a patchwork system of providers and it will be a nightmare to police standards and to achieve joined up seamless services.

Over the years I have seen deterioration in standards and an increase in costs and administration with the introduction of the internal market and NHS trusts with increased costs and salaries payable to chief execs and trust boards and the introduction of general management, where nurse management roles were displaced to make way for non-clinical managers.

This latest health and social care bill and the proposed change in how the NHS is administered will not improve matters. It is the 2010 version of the emperor’s new clothes and a prime example of politicians believing that they know how to fix the NHS, that, as most of us who have worked in the NHS for many years know, is just an illusion.

March 2011

Memorandum submitted by Target Ovarian Cancer (HS 70)

1. About Target Ovarian Cancer

Target Ovarian Cancer is a registered charity (no 1125038) dedicated to achieving a long and good life for every woman with ovarian cancer in the UK. After breast, lung and bowel cancer, ovarian cancer is the fourth biggest cancer killer in women. There are approximately 6,800 cases each year, with 4,400 deaths—more than four times the number of women who lose their life to cervical cancer each year.

2. Target Ovarian Cancer works in the areas of research, education and advocacy. Through the Target Ovarian Cancer Pathfinder Study (2009 and ongoing) the charity maps the challenges and opportunities to improve quality of life and survival for women with ovarian cancer, and works to develop initiatives to deliver progress, through collaboration with women, health professionals and other organisations. Target Ovarian Cancer has invested funding in a feasibility study for international benchmarking, which fed in to the International Cancer Benchmarking Partnership Study, in support services (courses and resources) for women, training women to raise awareness in their local communities, and in the development of a CPD module for GPs, which won an Excellence in Oncology Award. In 2010 it launched the Six Simple Steps campaign, encouraging MPs to consider taking action on at least one of the steps identified, to help save the lives of at least 400 women a year. This is the number of women who are currently dying unnecessarily from ovarian cancer, because our survival rates lag behind the average European rates. Target Ovarian Cancer acts as the secretariat to the newly formed All Party Parliamentary Group on Ovarian Cancer. Target Ovarian Cancer has recently been accredited by the Information Standard.
3. **Summary of Evidence**

Target Ovarian Cancer recognises the opportunities to improve outcomes for cancer patients, but would urge the Bill Committee to include amendments and additions to ensure that the opportunities which presented themselves through the White Paper are included and reinforced in the Health and Social Care Bill, in order to ensure that deliverable outcomes are achievable in this most fundamental reorganisation of services. Specifically our concerns relate to the lack of global rather than just three site specific cancer outcome measures for breast, lung and bowel cancer; the potential conflict of interest between GP as both provider and commissioner together with the lack of specialist expertise in commissioning; the need for mandated care pathways in less common, life threatening conditions; and the appropriate role to enable meaningful engagement for patient involvement and the voluntary sector.

4. Much of what we say is also applicable to other less common cancers and other life threatening conditions. We believe there are some inherent conflicts within the Bill, and that the Committee have the opportunity to reduce these conflicts to good effect.

5. **In More Detail—Outcome Measures**

The White Paper highlighted one and five-year cancer survival (in general) as an improvement area, and proposed these survival figures as outcome indicators in order to prevent premature death which is amenable to healthcare. One-year survival rates are seen as a proxy measure for late diagnosis. Low one-year survival rates, it should be noted, also impact on five-year survival rates. It is important for both to be considered when trying to deliver and measure improvements. We welcomed this as a way for commissioners to think across the board about early cancer diagnosis. However, the Bill has focused only on outcome measures for three specific cancers—breast, lung and bowel. We would prefer to see measures for cancer as a whole, ie a commitment to global cancer measures (for one and five year survival), something which we know is also being called for by the Rarer Cancers Foundation in their recent report Primary Cause?¹⁵¹ Failing that, we would want to ensure ovarian cancer is included as a site specific measure. After all, it will be one of the first NICE Quality Standards to be developed (along with bowel and lung cancer) and one and five-year survival rates have already been verified through the International Cancer Benchmarking Partnership Study.¹⁵² Ovarian cancer is after all, the fourth most common cause of cancer death in women, with 4,500 deaths each year.

6. This focus on three cancers means that some 60% of people who die from cancer will not be protected by the outcome indicator, representing the proportion of cancer patients who die from cancers other than breast, lung and bowel. We believe this will inadvertently result in Commissioners focusing only on the “big three” cancers. We have already seen that this results in the exclusion of other cancers. For example the new investment (£10.5 million) in awareness initiatives is concentrating on breast, lung and bowel cancer, excluding ovarian cancer, despite compelling evidence that late diagnosis is a key issue that must be tackled. The Bill places a duty “as to the improvement of quality of services, with a view to continuous improvement in quality of services including prevention, diagnosis or treatment of illness” (section 2). We believe however that the adoption of just three site specific cancer measures will not only lead to a widening of inequality between cancer types in terms of diagnosis and survival, but there is also a very real risk that survival rates for the majority of cancers not covered will fall, affecting the overall cancer survival rates negatively.

7. We are therefore asking for a generic cancer measure for one and five-year survival rates to be reinstated in the Bill. Failing that we believe that ovarian cancer, as a minimum should be included as an outcome measure. This is because of the following compelling evidence:

- The International Cancer Benchmarking Partnership Study as previously cited showed that one-year survival rates for ovarian cancer are the lowest in comparison to the other countries in the study. This is a proxy for late diagnosis.

- The Eurocare 4 study showed that more than 400 lives of women could be saved in the UK each year, if we matched the average European survival rate for ovarian cancer.¹⁵³

- The Target Ovarian Cancer Pathfinder Study (2009)¹⁵⁴ showed that over a third of women wait six months or more from first visiting their GP to getting a correct diagnosis of ovarian cancer.

- The Pathfinder Study also showed (using the National Awareness and Early Diagnosis Initiative validated ovarian cancer awareness measure) that just 4% of women are very confident about recognising a symptom of ovarian cancer. Hence awareness amongst women is key to ensuring women visit their GP promptly.

151 Primary Cause? An audit of the experience in primary care of rarer cancer patients, February 2011 by the Rarer Cancers Foundation www.rarercancers.org.uk


153 EUROCare-4. Survival of cancer patients diagnosed in 1995–99. Results and Commentary. Sant Mp; Allemani C; Santsjaguana M; Knijn A; Marchesi F; Capocaccia R; the EUROCare Working Group, European Journal of Cancer 2009, 45: 931–991.

154 www.targetovarian.org.uk/Pathfinder
— The National Cancer Intelligence Network routes to diagnosis study showed that only 26% of women with ovarian cancer were referred through the urgent two-week referral, and some 29% were diagnosed as a result of an emergency presentation.155

— Data to be released from the GP Audit will show that after pancreatic cancer, ovarian cancer has the second highest rates of diagnosis at a late stage.

— The NICE clinical guidance on the recognition of ovarian cancer clearly lays out the key symptoms and importance of frequency and persistency triggering investigation.156

8. Stark differences already exist between services (including diagnostics) for more and less common cancers, as this example from a woman shows:

9. “It took several months for my ovarian cancer to be diagnosed. It was like being on a dirt track with several no entry signs along the way, and a two miles per hour speed limit. At the point where my gynaecologist decided I probably had ovarian cancer, I was told I would have to wait six weeks for surgery. However, when six months later, my oncologist suspected I may have breast cancer it was a completely different story. In less than a week I was at a one-stop clinic, where they were going to do a mammogram, ultrasound, and biopsy, and tell me the results the next day. I felt I was getting red carpet treatment.”157

10. **I N S U M M A R Y:**

   Given the very strong evidence on late diagnosis, and lack of awareness, we call upon the Committee to reinstate the generic one and five year cancer survival measures, or failing that, to include more site specific measures, including ovarian cancer. This is to ensure the less common cancers do not become even less of a priority in the eyes of the commissioners, causing survival rates to fall.

   11. As a patient organisation who has worked to present robust evidence on diagnosis, access to tests and survival, we understand the urgency of taking action to improve our poor rates of late diagnosis, and have presented the opportunities that exist at a parliamentary, policy and ministerial level, even to the extent of offering joint funding for programmes. As such, we will continue to track one and five year survival in ovarian cancer nationally, and assess the impact of the reforms accordingly, holding the Government to account if as we fear, we fail to see improvements, or even more concern, see a worsening in relation to late diagnosis.


   For less common conditions, such as ovarian cancer, there is an inherent conflict in the GP as commissioner, and GP as provider, resulting in services that are not in the best interest of women with ovarian cancer, or people with other less common conditions. In particular we have concerns over:

   13. There is a strong possibility that the identified, necessary uptake of increased access to diagnostic tests, to ensure more women are investigated for ovarian cancer and diagnosed quickly will not take place because cost and not clinical decision-making will be the key driver. Currently one in seven GPs cites difficulty of access to such tests as the reason for delays in women’s diagnosis of ovarian cancer.158 This is why we have welcomed the decision to ensure all GPs have access to diagnostic scans for ovarian cancer. However, with GPs as both budget holders and service providers, we have concerns they will be reluctant to increase investigations, with cost, not clinical decision making driving their desire for investigations. This goes against the need to lower the threshold for diagnostic testing, in order to promote earlier cancer diagnosis, as highlighted in *Improving Outcomes—A Strategy for Cancer*. Already there is evidence published in *Pulse* on 24 February 2011 that new primary care gateways are rejecting GP referrals in order to drive down cost.159 For women, it is in their best interests to be investigated as soon as possible to rule out a condition like ovarian cancer, in order to reduce the significant delays that contribute to the late diagnosis of women in the UK.

   14. For those women who are investigated, we also have concerns that cost rather than quality will affect decision-making. Recently a Primary Cancer Cancer Lead (GP) told us of how his PCT buys in diagnostic services for transvaginal ultrasound, one of the key investigations for women with ovarian cancer. The decision was based on cost, and on timeliness of access. However he finds that the reports that are returned can be non-committal, in contrast to those from his local NHS provider. It has resulted in a number of women having to be referred on for second investigations. This has a number of potential outcomes including a) additional delay for those with ovarian cancer, b) additional anxiety for those healthy women undergoing repeat testing, or c) where the GP decides not to refer for a second test, the potential for false reassurance, ultimately risking the woman presenting as an emergency case at A&E, which is associated with worse outcomes. The GP’s PCT have not yet chosen to alter their service provider, in common with others—in a point that is noted in the first Health Select Report on Commissioning in paragraph 68.159

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159 [http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/268/26807.htm#a13](http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/268/26807.htm#a13)
15. A GP only sees a case of ovarian cancer once every five years. Recent progress in five-year survival rates has been achieved through the organisation of specialised services.\(^{160}\) We are concerned that GPs are not best placed to commission services right along the patient pathway, in the best interests of women who have ovarian cancer. We would like the Committee to consider the role of specialist involvement in the commissioning process, so that the appropriate expertise is utilised. We believe the effort should be placed into strengthening the coordination and communication between specialist expertise, rather than driving back the decision making process to a general practitioner.

16. **MORE DETAIL—MANDATED INTEGRATED CARE PATHWAYS**

We would also urge the Committee to consider the inclusion of mandated care pathways in the Bill for those with less common, but life threatening conditions such as ovarian cancer. Localised decision making risks the swift exacerbation of post code lotteries. Women clearly want to know that they are being given appropriate care, no matter where they live in the UK. This should include access to and similar services offered by Clinical Nurse Specialists, who have been identified as the most important source of support for women with ovarian cancer.\(^{161}\) Similarly they want equity of access to current and newly developed drugs which may extend their life, and to clinical trials. At a time when they are extremely unwell, and have just been given a diagnosis of ovarian cancer, which carries such a poor prognosis, they are not in a position to be able to investigate standard models of care, effectively being asked to carry out quality control. Without mandated integrated care pathways we are extremely concerned that power is being handed to commissioners “in good faith” but without redress, and that this has the potential, at best, to lead to considerable variation in services, and at worst, a significant decline in outcomes. We welcome the forthcoming NICE Quality Standard on Ovarian Cancer, but unless this type of guidance is integrated and mandated, it will have no significant effect.

17. **MORE DETAIL—HYPERLOCALISM AND THE EFFECT ON PATIENT INVOLVEMENT**

We welcomed the mantra of “No decision about me, without me”, in the White Paper, but have been far less convinced, in the content of the Bill, that the wishes and priorities of women with ovarian cancer will be met under the current plans for patient and public engagement.

18. As a less common disease, and one which carries a very poor prognosis, the incidence of the disease, and typical patient pathway need to be considered in creating appropriate structures for patient involvement. We know from our work with women at Target Ovarian Cancer that they are very keen to share their thoughts as to their priorities, and standards of care. They have been able to help us, through the Target Ovarian Cancer Pathfinder Study, build a clear picture of what care looks like along the patient pathway. Similarly they can be very informative at a regional level (on services offered by a regional specialist centre). However, if an average GP consortia will have approximately 13 women with ovarian cancer a year, and given the vast range of conditions consortia will be dealing with, patient involvement at this level can be nothing other than tokenistic. We would like the Committee to ensure that different levels of patient and public involvement are defined appropriately, and that patients can play an important and meaningful (not tokenistic) part in reviewing specialist services, advising the National Commissioning Board, in developing the NICE Quality Standards, and working through voluntary sector organisations such as Target Ovarian Cancer and groups such as Cancer Networks.

19. **MORE DETAIL—THE MEANINGFUL ROLE OF PUBLIC, PATIENT AND VOLUNTARY SECTOR ENGAGEMENT**

There is currently much discussion about the role of the voluntary sector, and the “Big Society”. Yet this Bill misses an important opportunity to build on the invaluable knowledge of patient pathways, patient experience and links to specialist expertise around the UK that exists through organisations such as Target Ovarian Cancer. Organisations such as ours not only actively feed into consultations, but have a much greater capacity to work with Commissioners, NICE, Commissioning Boards, and Health and Wellbeing Groups in terms of supporting their decision making process, and developing new opportunities. We already have a track record of mobilising communities of ovarian cancer patients, in raising awareness. However, there is an issue of capacity. Many organisations are small, and as such do not have the capacity to build separate relationships with all commissioners. We would suggest, much as the Department of Health is currently accrediting organisations to give health information to patients (The Information Standard, which Target Ovarian Cancer holds), could it not also accredit organisations to give information to commissioners.

20. Our initial optimism over the potential role of organisations such as ours and volunteers in the Big Society has diminished. We have found it practically impossible to engage at a meaningful level in terms of delivering programmes to improve outcomes, even when we have brought significant money to the table—such as for International Benchmarking, and awareness campaigns. Based on our experience to date, we are not optimistic that women with ovarian cancer, at a local level, will be able to attempt likewise either.

*March 2011*


\(^{161}\) [www.targetovarian.org.uk/Pathfinder](http://www.targetovarian.org.uk/Pathfinder)
Memorandum submitted by Dr Rachel Wood (HS 71)

I am writing as I am very concerned about the far reaching changes proposed in the new NHS Bill. Whilst I acknowledge that there are challenges to running and keeping efficient such a vast organisation as the NHS I do not feel that the changes proposed by the Bill are likely to improve services and make them more effective. I am worried that the Bill will fundamentally undermine the principles of the NHS and we could end up a huge variation in services commissioned by GP consortiums and less transparency and accountability of a publically funded service. The concerns I have include:

There is currently no evidence base that GPs are best placed to hold the NHS budget and make commissioning decisions. Many GPs and other doctors are also concerned about this and do not think they should have this role. I think evidence for such an approach is needed before rolling it out on such a vast scale.

I am also concerned about such huge organisation change at a time when the NHS is facing huge cuts and cost efficiency savings. I am worried about the amount of money that will have to directed to making such changes rather than running what is already an excellent and mostly efficient organisation.

If services can be provided by “any willing provider” I am concerned that this will lead to privately run companies only taking on “profitable” parts of the NHS and leaving other parts for traditional NHS services to run (with reduced budgets, cuts to services etc). I am also worried that such cherry picking will lead to the NHS services being compared negatively to private providers. Working for the NHS in mental health I am all too aware of the inadequacy of attempts to measure outcomes—as part of a multidisciplinary service we are measured solely on patient contacts which takes no account of the amount of consultation, liaison, supervision etc which makes up a huge part of our work. We work with a hugely complex group of people and often with those who are the most vulnerable in society and I am worried that some money for this group of service users is being re-directed into primary care.

I feel that bringing “the business model” to the NHS will not lead to increased efficiency but money being spent on branding, marketing etc—at a time when huge cuts to services are already being made. We do not want to become like the US where health care providers spend huge amounts on advertising, marketing etc pushing up the cost of those who can afford it’s health insurance.

I am also worried that “any willing provider” being able to provide NHS services will lead to the loss of a shared sense of values and direction (if all these organisations are competing with each other) and lead to problems with sharing information, good practice and knowledge (I have already heard of examples where staff in one NHS trust have been told not to share information in staff in another because they are the competition). Surely one of the strengths of the NHS is the huge amount of shared knowledge, experience and resources.

Finally as a member of NHS staff I am worried about my own and my colleagues future careers, job stability and terms and conditions of employment. Morale is low in the NHS as there is so much uncertainty about jobs and because Trusts such as the one I work for are slimming down to make them more “competitive”, services (that are needed) and jobs are under threat. At present I am concerned we are moving away from an NHS with patient need at the heart (despite all the rhetoric about this). I also trained to work in the NHS (that is free for all and where any profit made goes back into providing services) and would very much like to continue working for it. I am worried that if these changes occur this may be under threat.

Please, please listen to the concerns of people like me, ordinary people who believe that the NHS should be not be radically changed, especially at a time of huge savings. Once these changes are made it will be very difficult to go back on them.

March 2011

Memorandum submitted by The Hepatitis C Trust (HS 72)

BACKGROUND: HEPATITIS C

— Hepatitis C is a blood borne, cancer-causing infectious virus that primarily attacks the liver and can lead cirrhosis, severe and potentially fatal liver disease and cancer. It can be asymptomatic or symptoms may be generic and are frequently misdiagnosed by GPs. Therefore the majority of people currently infected with hepatitis C are undiagnosed at present and may be passing on the virus to others.

— The Health Protection Agency estimates that there are around 250,000 people living with hepatitis C in the UK, most of which are undiagnosed, and of those diagnosed less than half have received treatment.162 Some estimates put the prevalence of hepatitis C as high as 466,000 people in the UK.163

— Around 100,000 hepatitis C patients have been diagnosed in the UK to date.\textsuperscript{164}

— There are an estimated 12,000 new hepatitis C infections per year.\textsuperscript{165}

— Hepatitis C is preventable and curable. The virus can be successfully treated and cured in around half of patients, preventing premature death and complicated and costly health interventions. Treating all hepatitis C patients according to NICE guidance would cost the NHS approximately £1.6 billion. The estimated cost to the NHS alone of failing to diagnose and treat existing patients could be between £4 billion and £8 billion over the next 10 years.\textsuperscript{166}

**BACKGROUND: THE HEPATITIS C TRUST**

The Hepatitis C Trust is the national UK charity for hepatitis C. It is a patient-led and patient-run organisation: almost all of its patrons, trustees, staff and volunteers either have hepatitis C or have had it and have cleared it after treatment. It provides information, support and representation for all those affected by the disease.

**SUMMARY: KEY OPPORTUNITIES AND THREATS FOR HEPATITIS C WITH THE BILL’S HEALTHCARE REFORMS**

— Hepatitis C could be virtually eradicated in the next generation if the NHS, GP Consortia and local Health and Wellbeing Boards focus on diagnosing, treating and supporting hepatitis C patients as a priority.

— Over 100,000 hepatitis C patients in England are undiagnosed—the new GP Commissioning arrangements present an opportunity to address this but only if GP awareness is significantly improved through training and incentives.

— The patient voice should be central to health services but there is a danger that this will be lost unless specifically protected by legislation.

— As hepatitis C disproportionately affects disadvantaged, vulnerable and socially excluded people, The Hepatitis C Trust welcomes the duty on the NHS Commissioning Board to tackle health inequalities.

— Local Joint Health and Wellbeing Strategies could be an excellent way of joining up public health commissioning across local areas. However, unless GP consortia are legally bound to comply with them, they may well become meaningless.

**Part 1, clauses 9–10: GP commissioning and poor GP awareness**

Low awareness of hepatitis C amongst GPs has traditionally been the greatest barrier to hepatitis C diagnosis and treatment. Hepatitis C was only discovered in 1989. When most of today’s heads of GP consortia were training, hepatitis C was not on the syllabus. Hepatitis C is often asymptomatic until a very late stage by which time it has already progressed to cirrhosis and/or liver cancer.

A lack of awareness of the risk factors is a significant factor in lack of diagnosis. Hepatitis C is transmitted through blood-to-blood contact and therefore the main risk factors are sharing any drug taking equipment, medical treatment abroad where equipment is not sterilised, tattoos or piercings in unsterilised circumstances and NHS blood transfusions and blood products before 1991; yet few GPs test people with these risk factors.

Under the new arrangements, GPs will be responsible for commissioning services for hepatitis C patients. This is very concerning in a disease area where GP awareness is so low.

Please seek reassurances that steps will be taken to ensure that GP awareness and understanding of hepatitis C will be addressed through improved training and the introduction of case-finding incentives.

**Part 1, clause 19 (schedule 1, chapter A1): NHS Commissioning Board and the Patient Voice**

— A key statutory duty of the NHS Commissioning Board, as set out in Clause 19 (schedule 1 chapter A1) of the Health and Social Care Bill is to “promote the involvement of patients and their carers in decisions about the provision of health services to them”. However, the NHS commissioning board, responsible for commissioning services including specialist services and primary care services, has no patient representation, making it less likely that it will be able to fulfil its remit.

— The Hepatitis C Trust recommends that a member of the board should be designated a “patient champion”. This person, ideally a patient themselves, would be a link between patient organisations and the board, meeting with and receiving representations from patient organisations which could then be fed into the decision-making process of the board.

\textsuperscript{164} Hepatitis C in the UK: 2009 report, HPA, 2009.


\textsuperscript{166} Losing the fight against hepatitis C. London: The Hepatitis C Trust and the University of Southampton, 2005.
**Part 1, Clause 19 (schedule 1, chapter A1): Health inequalities**

— Another key statutory function of the NHS Commissioning Board, as set out in Clause 19 of the health and social care bill, is to “reduce inequalities between patients with respect to their ability to access health services” and “to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services”.

— Targeting the health of disadvantaged groups is crucial to reducing health inequalities and therefore The Hepatitis C Trust hopes the NHS commissioning Board will consider hepatitis C a key area of concern.

— Hepatitis C disproportionately affects disadvantaged, vulnerable and socially excluded people, particularly homeless people, prisoners and injecting drug users. For example, research conducted to inform the Scottish Hepatitis C Action Plan found that 75% of hepatitis C patients are from the two lowest socio-economic quintiles. Further, there is a relatively high prevalence of hepatitis C in the first generation South Asian migrant community. Levers should be created to ensure commissioners consider disease areas which disproportionately affect lower social-economic groups, such as hepatitis C.

— Information and levers should be available to commissioners to encourage approaches to addressing hepatitis C which reduce health inequalities. For instance, treating current hepatitis C infected injecting drug users (IDUs) has been shown to be as effective as treating non-IDUs, and will reduce the pool of infection in a person at high risk of transmitting the virus. However few hepatitis C infected IDUs are treated each year.

— The Hepatitis C Trust urges the NHS Commissioning Board to create levers to ensure hepatitis C is considered in GP consortia commissioning decisions, as part of its statutory duty to reduce inequalities.

**Part 5, Chapter 2 clause 177: Local Health and Wellbeing Boards—Lack of strength in holding GP consortia to account**

— The patient voice is to be incorporated into the system at a local commissioning level through the Joint Strategic Needs Assessment and Joint health and Wellbeing Strategy created by local Health and Wellbeing Boards, of which both local HealthWatch and local GP consortia will be part. However, the legislation provides that GP consortia must “have regard” to these arrangements (Clause 116B to be inserted after section 116 of the Local Government and Public Involvement in Health Act); they will not be bound by them.

— The Hepatitis C Trust recommends that a stronger measure be put in place to ensure that GP consortia are legally bound to comply with the Joint Health and Wellbeing Strategy. If this does not happen, GP consortia will not be properly accountable in their commissioning decisions and the patient voice within the system provided by local HealthWatch’s place on the local Health and Wellbeing Board will be meaningless.

**Suggested Amendments**

— Patient champion on the NHS commissioning board:

Schedule A1, paragraph 3, after (4) insert:

(5) One non-executive member on the Board is to be tasked with representing patient organisations in carrying out their functions on the Board.

— Strengthening of Joint Health and Wellbeing Strategy:

Clause 177: A responsible local authority and each of its partner commissioning consortia must, in exercising any relevant functions, have regard to—

Replace “must” with “is legally bound”

Replace “have regard to” with “to uphold”

*March 2011*

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Memorandum submitted by Adam D G Macleod (HS 73)

ABOLITION OF STRATEGIC HEALTH AUTHORITIES AND PRIMARY CARE TRUSTS—PART 1 SECTIONS 28 AND 29 OF THE HEALTH AND SOCIAL CARE BILL

If the Bill receives Royal Assent and SHAs and PCTs are all abolished before the NHS Commissioning Board and Commissioning Consortia are fully established, an impossible situation will arise with no one having effective oversight of the NHS and its £100 billion plus budget.

I therefore strongly recommend that Sections 28 and 29 be amended to read:

“are to be abolished on a date to be decided by the Secretary of State.”

February 2011

Memorandum submitted by Tina Read (HS 74)

My name is Tina Read. I have an inherited bone condition called Hereditary Multiple Exostoses (HME). I have been a member of the Human Genetics Commission Consultative Panel since 2007. I was very concerned about passing on my condition to my children. There is a treatment called Preimplantation Genetic Diagnosis (PGD) in which a cell from an embryo created by IVF is tested genetically and only embryos which do not have the inherited condition are implanted into the mother. Unfortunately PGD for HME was not available on the NHS until 2009, since I am 50 this year, this treatment was not available for me. I did go ahead and have children and I have felt very guilty that my son has needed an operation for a bone growth on his leg which appears to be growing back.

Although it was too late for me, I raised the issue of PGD many times on the consultative panel of the Human Genetics Commission. I am saddened at how variable treatment availability is around the UK. PGD is not commissioned nationally and no comprehensive study has ever been conducted into the possible savings to the NHS if people with inherited conditions were allowed to avoid passing on their conditions to their children. The availability of PGD varies widely around the country when decisions have sometimes been made at PCT level, often by people who don’t understand the treatment. I worry that the decision makers at GP Consortia level will be even less likely to make informed decisions about PGD.

I am concerned that GP consortia will not have enough information to make good decisions whether that is about treating genetic conditions, cancer or other diseases or ordering supplies. There needs to be a system to provide advice on treatments and supplies. GP consortia will not be able to be properly informed about the vast array of information they need to make fair decisions without expert advice. GP consortia need to provide a good account to their patients for why they would go against this expert advice.

The purchasing power of the NHS will be broken up by the competitive format of Foundation Trusts and GP consortia. Money which should be being spent on NHS patients will be going towards making private companies and GPs rich. Patients will not trust that their GPs are well enough informed or motivated by the financial system to give them the best care.

March 2011

Memorandum submitted by L A Gilbert (HS 75)

1. The Health and Social Care Bill requires that commissioning is done on a competitive basis, open to providers outside the NHS. There appears to be nothing in the Bill to prevent such providers from undercutting their NHS competitors, on temporarily uneconomic bases, in deliberate attempts to force the NHS providers out of operation. “Loss leading” to such end is accepted business practice.

2. The Government has made clear that an NHS provider will not be bailed out if it goes over budget in order to fight off competition.

3. It would be most unfortunate if as a result some of our finest NHS hospitals were forced to close down.

March 2011

Memorandum submitted by Jane Schofield (HS 76)

RE: CONCERNS ABOUT THE HEALTH AND SOCIAL CARE BILL.

— Forcing commissioners to tender contracts to any willing provider will destabilise local health economies and fragment care for patients. Commissioning should work with hospital and community care colleagues and patients to develop the care pathways that provide the best care for their patients, without challenge from Monitor.
David Bennett talking about Tesco style healthcare is ludicrous and shows a fundamental misunderstanding of clinical care priorities and the evidence of how to improve quality. Competition is not proven to raise standards of care unless the patients’ can afford to pay the costs—evidence shows that price competition leads to a reduction in care quality overall. My experience is that now privatised utilities and transport cost more and provide a worse service.

The NHS has the highest approval rating ever. Mr Lansley’s claims about poor outcomes are discredited. NHS rates are improving fast for cancer and heart disease.

These major, untested reforms are a massive gamble based on little evidence. The Bill will have a significant negative impact on the future of NHS services, its workforce, and public health. There is no going back.

Andrew Lansley gave a pre-election pledge that there would be no major re-organisation

I will not be able to trust my doctor—I know that funding holding saving and of payments have gone into doctors pockets. Will I not get tested because they are saving money or is it really because I don’t need it? Will I get sent to the service my GP owns, regardless of whether it is the best so he can get the kick back or the profits?

Mr Lansley is forcing England towards an American style healthcare system. The World Health Organisation has ranked the US healthcare system as the highest in cost, 37th in overall performance and 72nd by overall level of health amongst the 191 member nations surveyed.

Please do not let bill pass.

March 2011

Memorandum submitted by Susan Ackroyd and Tess Harris (HS 77)

SUMMARY

We submit that the Bill needs to be strengthened by clarification of terminology and that thorough legislation is necessary to provide an integrated GP consortia-based framework. Legal protection of patients and GP is required. Consortia should involve specialist commissioning planners, who may be GPs, but who will take responsibility for commissioning. The Commissioning Board should approve providers and commissioning should be a separate subsequent step.

INTRODUCTION

1. We, as individuals, offer our views because there is now an opportunity for fully considering what is needed to implement the proposed NHS changes. Pitfalls should be avoided by planning ahead in detail to avoid problems and recriminations later but so far little detail has been made available to the public. We are concerned that the consequences of proceeding without full planning would negate the potential benefits of the concepts of GP involvement in commissioning and of patient involvement. In return for patients being more proactive, they should have positive safeguards.

2. We believe that previous attempts to improve the NHS have suffered because they have involved too little communication between the different levels of the structure and the remote anonymity of the people within the PCTs, going through all the levels from the patient to the Department of Health. However, it cannot simply be solved by GP involvement alone and other important steps need to be taken as well. The NHS seems to have become loose and unwieldy and in fact we feel it should be tightened up rather than cast adrift.

3. There are two main strands to this: the law and the system which is set up according to the law. Also the consortia should be regulated by a binding central code of practice. We call for safeguards to be introduced for patients and GPs to ensure that unforeseen scenarios are avoided. We ask that imprecise terms such as “any willing provider” in the Health Bill are defined and that statutory Rules are brought in to govern the changes plus a central code for all consortia so that they are subject to a set of core principles. We believe that localisation should not mean that central government does not oversee what happens locally and that the system should be set up to make this evident to the public.

4. We firstly refer to an article “Safe and sound” from lawyers Browne Jacobson LLP (Annex 1) see http://www.brownejacobson.com/resources/legal_updates/healthcare_update_-_issue_21/safe_and_sound.aspx. This outlines potential legal risks arising from the draft Health Bill. Such risks could destabilise the new NHS quite quickly and so we urge that steps to reduce the risks are introduced by examining the relevant issues and finding solutions urgently.
In particular, we suggest:

**Structure of Commissioning Framework Should Have Hierarchy and Network**

5. It is completely clear to us that, to ensure a joined up professional framework, there should be substantive forethought. We believe that a complete hierarchical structure, controlled by the Commissioning Board, of which little has been said, which must address all functions of the entities of the structure, including planning and performance as well as financial management, is necessary. This must be created and put into practice before the new NHS can be said to be fully up and running, so that the different entities know what their obligations are and from the outset produce the best possible communication and coordination.

6. It should include networks for communication between all related entities in the NHS. Obligatory standards should be set for the operation of all entities so each entity, whether for example a commissioner, provider or council, should be subject to performance standards and regular assessment by an official body, the Secretary of State for Health being ultimately responsible. Each entity should be obliged to meet best practice. Each entity should be regularly inspected by an officially responsible inspector as regards its performance and the inspector should report upwardly to the appropriate body. Local accountability should also be used as a check. GPs, hospital clinicians and patients should be involved at every level. Each and every entity should involve an official responsible for best practice, so that a network of such persons exists, which will produce feedback.

7. We are concerned that GP consortia will need to include specialists from other fields when it comes to running hospitals and little has been said publicly about this. GPs are generalists and it is the most newly qualified who will know most about hospitals currently since they will have worked in them. We believe it is essential that hospital clinicians are also statutorily required to be included in the consortia.

**Commissioners**

8. We now refer to the very recent report by Health Ombudsman Ann Abraham entitled Poor treatment of older people in the NHS is an attitude problem http://www.ombudsman.org.uk/improving-public-service/reports-and-consultations/reports/health/home and also the very recent report from Patient Opinion entitled In their words: what patients think about our NHS (Annex 2) http://www.patientopinion.org.uk/info/report. As everyone will acknowledge these documents are evidence that there are serious defects at present and that much drastic improvement is required. But such improvement must be planned not merely wished for. The Health Ombudsman and Patient Opinion have an important function after the event but they do not obviate the need for suitable people to hold responsibility. There could be identifiable professional commissioner planners, (whether they are GPs or other NHS expert, whose role should include bringing the required increase in standards into effect. It is not enough to have a Health Ombudsman if those that are responsible for the failings she has identified are not brought to book. The buck has to be traceable for decisions and the line of authority trackable back to wherever it stops. Thus, the legislation should be drafted to set up the system in advance with specified roles and obligations for commissioning bodies and those who work in them. Consideration should be given as to creating a new profession of Chartered Commissioners.

**Approval of Providers**

9. There should be approval of providers as being potentially suitable as a preliminary and essential stage. This should be done by the Commissioning Board to filter out unsuitable providers. It should be separate from commissioning itself. Thus, providers with suitable codes of ethics and additionally conforming to other principles and requirements can be approved as a protective measure.

10. The term “any willing provider“ needs to be more tightly defined in the Bill. Willing providers should be approved before the act of commissioning and the law should say so; this is crucial where the provider is itself answerable to others besides the NHS ie where there may be divided loyalties eg to private owners/sharholders. There should be an initial presumption of using NHS providers but ability to go to a private provider if they are better, not merely cheaper.

**Internal and External Checking Mechanisms**

11. There should be an internal mechanism within the NHS for continuous assessment and for redress of poor or questionable performance of entities and of those who are responsible for the carrying out the functions of the different levels of the system. There should be an external mechanism for the public to question the performance of a service provider or GP consortium to avoid first having to go to court. Both mechanisms should have a specified form and the proceedings of both should be reported to the public. The finances of consortia and providers should be open to public inspection.

**No Decisions Other than According to Patient Need**

12. At the frontline GPs should be unfettered in their clinical role. It should be positively stipulated in law that they should not take decisions as to WHAT is needed, especially as to treatment and medicine but also other healthcare and social care, other than according to patient need. Also the commissioning GPs should use their frontline knowledge and skill to commission without pressure of day-to-day patient contact so that commissioning is informed by their frontline knowledge but not biased by it.

14. He says “And if someone comes to see me, in the new world, and they need an endoscopy to see if they’ve got a gastric ulcer or cancer, instead of meeting that patient’s needs immediately, I’ll be thinking, hold on, in this practice we’ve sent 22 people this month for endoscopies, and my consortium is telling me that last month we had too many endoscopies, so I will think twice. I will think twice about giving this man what he needs and that will affect my clinical care. If I fail to send him for an endoscopy and that man gets cancer, I will have been guilty of giving that man bad care.”

15. Steps must be provided in the legislation to taken to stop that happening.

**CONFLICTS OF INTEREST**

16. GMC Guidance exists for GPs but we believe there should be provisions in the new law to stipulate protection of patients and GPs and other consortia members. Guidance includes http://www.gmc-uk.org/guidance/news_consultation/ethical_update.asp as below. Presumably this will be updated to take the changes into account but there should possibly be criminal sanctions against improper conduct, certainly if financial.

17. Furthermore, it will be difficult to be certain that GPs on the frontline and GPs in consortia are not influenced by business involvement if that exists but safeguards should be introduced to protect GPs and above all patients, likewise anyone else involved with patients.

18. **FROM THE GMC GUIDANCE:**

“In our core guidance for doctors, Good Medical Practice we advise that:

1. You must be honest and open in any financial arrangements with patients. In particular:
   (a) You must inform patients about your fees and charges, wherever possible before asking for their consent to treatment.
   (b) You must not exploit patients’ vulnerability or lack of medical knowledge when making charges for treatment or services.
   (c) You must not encourage patients to give, lend or bequeath money or gifts that will directly or indirectly benefit you.
   (d) You must not put pressure on patients or their families to make donations to other people or organisations.
   (e) You must not put pressure on patients to accept private treatment.
   (f) If you charge fees, you must tell patients if any part of the fee goes to another healthcare professional.

73. You must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals. In particular:
   (a) Before taking part in discussions about buying or selling goods or services, you must declare any relevant financial or commercial interest that you or your family might have in the transaction.
   (b) If you manage finances, you must make sure the funds are used for the purpose for which they were intended and are kept in a separate account from your personal finances.

74. You must act in your patients’ best interests when making referrals and when providing or arranging treatment or care. You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe for, treat, or refer patients. You must not offer such inducements to colleagues.

75. If you have financial or commercial interests in organisations providing healthcare or in pharmaceutical or other biomedical companies, these interests must not affect the way you prescribe for, treat or refer patients.

76. If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the healthcare purchaser.

2. **Good Medical Practice** makes it clear that trust between you and your patients is essential to successful professional relationships. Trust may be damaged by situations in which your financial or other personal interests affect, or are seen to affect, your professional judgement. Such conflicts of interest may arise in a variety of circumstances.
3. The guidance that follows identifies some such areas additional to those covered in *Good Medical Practice* where conflicts of interest may arise, but it is not intended to be exhaustive. You should always review new arrangements and use your professional judgement to determine if there is a conflict of interest and how best to address it. If you are not sure what to do, contact your defence body, a professional organisation or the GMC Standards and Ethics team for advice.

4. Some doctors or members of their immediate family own or have financial interests in care homes, nursing homes or other institutions providing care or treatment. Where this is the case, you should avoid conflicts of interest that may arise, or where this is not possible, ensure that such conflicts do not adversely affect your clinical judgement. You may wish to note on the patient’s record when an unavoidable conflicts of interest arises.

5. If you have a financial interest in an institution and are working under an NHS or employers’ policy, you should satisfy yourself, or seek assurances from your employing or contracting body, that systems are in place to ensure transparency and to avoid, or minimise the effects of, conflicts of interest. You must follow the procedures governing the schemes.

6. If you have a financial or commercial interest in a business case being considered by your Primary Care Trust under Practice Based Commissioning arrangements, you should declare your interest and exclude yourself from related decisions in accordance with the Department of Health and your PCT’s guidance.

7. If you work outside a formal scheme run by an employing or contracting body you should avoid conflicts of interest, where possible. For example, if you are a general practitioner with financial interests in a residential or nursing home, you should not usually provide primary care services to patients in that home. Exceptions may arise, for example, if a patient asks you to continue acting as their general practitioner, or there is no alternative. If you accept a patient in these circumstances you must be prepared to justify your decision.

8. In all cases you must make sure that your patients and anyone funding their treatment is made aware of your financial interest.”

And “Recommending services outside healthcare

14. Accepting or offering fees for referring patients to particular services is likely to undermine patients’ trust that the referral has been made solely on the basis of what is best for them. It would be an abuse of that trust to put pressure on patients to use a specific product or service which will be to your financial advantage.

15. The same principles apply if you are offered fees for recommending that your patients access services provided by firms or organisations outside healthcare, including insurance companies, solicitors and others. These schemes often involve making payment according to the number of customers referred.

16. Generally doctors will not have professional expertise in these areas on which to base their recommendation of a particular firm, and their chief interest in such schemes is a financial one. For these reasons you should not accept fees for referring patients to, or recommending patients to use the services of, particular organisations, companies or individuals, whether or not the services are health-related.”

**Separation of Frontline GPs from Commissioning GPs**

19. The need for a legislated separation is unequivocal when considering the obligations and responsibilities of GPs in caring for patients and ensuring the need to protect patients is likewise unequivocal. Such separation is likely to be necessary in our view from a liability and indemnity point of view. The term “patient choice” is should be more correctly referred to as “choice of provider”.

20. GMC guidance specifies in detail what is expected of GPs but certain provisions give GPs a degree of power over the patient in that they do not have to provide treatment requested by the patient if they consider it not to be of overall benefit to the patient. For instance, see http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance/partnership as, the GMC Guidance on good practice/list of ethical guidance/consent guidance/Part 1: Principle/Partnership, which says:

“5. If patients have capacity to make decisions for themselves, a basic model applies:

(a) The doctor and patient make an assessment of the patient’s condition, taking into account the patient’s medical history, views, experience and knowledge.

(b) The doctor uses specialist knowledge and experience and clinical judgement, and the patient’s views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.
(c) The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one. They also have the right to accept or refuse an option for a reason that may seem irrational to the doctor, or for no reason at all.

(d) If the patient asks for a treatment that the doctor considers would not be of overall benefit to them, the doctor should discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment would not be of overall benefit to the patient, they do not have to provide the treatment. But they should explain their reasons to the patient, and explain any other options that are available, including the option to seek a second opinion.

And see http://www.gmc-uk.org/guidance/ethical_guidance/6879.asp, the GMC Guidance on good practice/list of ethical guidance/End of Life care/Decision-making models/Patients who have capacity to decide, it says

“14 If a patient has capacity to make a decision for themselves, this is the decision making model that applies:

(a) The doctor and patient make an assessment of the patient’s condition, taking into account the patient’s medical history, views, experience and knowledge.

(b) The doctor uses specialist knowledge and experience and clinical judgement, and the patient’s views and understanding of their condition, to identify which investigations or treatments are clinically appropriate and likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, burdens and risks of each option. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.

(c) The patient weighs up the potential benefits, burdens and risks of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which. They also have the right to accept or refuse an option for a reason that may seem irrational to the doctor or for no reason at all.

(d) If the patient asks for a treatment that the doctor considers would not be clinically appropriate for them, the doctor should discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment would not be clinically appropriate to the patient, they do not have to provide the treatment. They should explain their reasons to the patient and explain any other options that are available, including the option to seek a second opinion or access legal representation.”

21. The patient is therefore not necessarily able to have choice as to treatment. Such clinical decision-making responsibility should be legally separated in the forthcoming legislation for ethical purposes from commissioning responsibility. A doctor considering the pros and cons of commissioning services and medicines in general may be adversely affected by that when having to weigh up certain treatment or medicine to a terminally ill patient. It does not work this way round.

22. Not all GPs are as far-seeing and conscientious as Dr Macgregor above and we believe GPs like him should be able to enhance their practice but less enlightened GPs should be prevented positively from making mistakes which will harm patients. Hence, this formal separation would at least protect both the public and those GPs participating in consortia.

23. Ways of doing this would include formally seconding GPs to the consortia from GP practices or separately employing them in the consortia for the time they are acting in the consortia, so that their role is clear and defined. The GPs or commissioners of services in the consortia should seek information from GPs on the frontline.

SUMMING UP

24. From the above it is clear that expanding the role of GPs into the business side is complex and has to be done in a way which is not only correct but can be seen to be correct. Legislation should cover this separately from GMC Guidance.

25. We find ourselves very surprised by the great haste of the huge proposed changes and we seek greater care as to how they go forward. Let us not forget the many sick, elderly and vulnerable people who deserve the best that can be afforded to them. It is not an exaggeration that the risks of not planning ahead fully are grave and enormous for the public in England. It should be remembered that it is of course also ourselves who will be affected by these changes as we will be old and ill in due course. Please make sure the legislation gives them strong protection and then put it into practice so that the good ideas behind the changes will be achieved.
26. Flexibility for evolution of the new system can still be built in. Without thorough checks and balances of practice the new system is likely to be much too weak and viability of the NHS will be uncertain.

March 2011

Memorandum submitted by Janet Porthouse (HS 78)

I wish to submit the question as to where NHS Continuing Healthcare sits within the context of the changes currently suggested in the Health and Social Care Bill.

This area of funding ongoing care needs for individuals with a Primary need for Healthcare is little understood in the communities by professionals or the public. It is a very costly process, though necessary, to ensure clients do not fund their healthcare.

Are GP’s realistically aware as to the financial risks in this area which is considered using a National Framework? If they are willing to accept this into their remit and the consortia, will they be expected to abide by the Framework which is guidance rather than legislation? The process relies on fairness and equity of consideration and provision of care, but I have as yet not been able to find anything within the witness statements or the Bill itself.

Have the committee considered this area of healthcare?

March 2011

Memorandum submitted by David Feather (HS 79)

Summary

1. The case for such a drastic change in the NHS in such a short time has not been put forward with sufficient reference to all available research information. An amendment to the proposed Clause 2A (2) is submitted.

Justification for my Submission

2. In The Guardian newspaper of 5 February 2011, Ben Goldacre cited various research sources that throw the Secretary of State’s assertions of benefit of GP management into doubt.

2.1 Kay in 2002 found it was introduced and abolished without any evidence of its effects. Presumably there was a lot of wasted expenditure involved.

2.2 Greener and Mannion in 2006 found a mix of good and bad, but no evidence that it improved patient care.

2.3 Coulter in 1995 found nothing but gaps in the evidence and no sign of any improvement in efficiency, responsiveness or quality.

2.4 Petchley found there was insufficient data to make any judgement.

3. The results of the voluntary scheme in Cumbria will not necessarily be achieved with a compulsory scheme. My long experience in work and leisure has shown this very clearly.

Proposed Amendment to the Bill

4. In proposed Clause 1A (2) add “and demonstrate that this improvement will be achieved by showing that sufficient research supports any action proposed and carrying out appropriate Impact Assessments.”.

March 2011

Memorandum submitted by United Kingdom Council for Psychotherapy (UKCP) (HS 80)

Summary

Details the concerns of the United Kingdom Council for Psychotherapy (UKCP) over the powers granted to statutory regulators to establish their own voluntary registers. UKCP believes this would be unhelpful, anomalous and confusing to the public. The proposal is for the draft bill to be amended so as to restrict the power of statutory regulators to establish voluntary registers only to those professional and occupational groups that do not have existing voluntary regulators.
1. **Brief Introduction to UKCP**

UKCP is the leading professional body for psychotherapists and psychotherapeutic counsellors in the UK and holds a register containing over 7,500 members. It has developed the most stringent professional entry standards for psychotherapy. Our members have undertaken four year training programmes to masters level or above. We approve 75 such trainings throughout the UK. UKCP is a founding member of the European Association of Psychotherapists and a member of the World Council for Psychotherapy. For further information please visit www.ukcp.org.uk.

2. **UKCP Evidence**

2.1 We welcome the concept of assured voluntary registration. If there are no changes to the sections of the Bill that grant the renamed Council for Healthcare Regulatory Excellence the powers to accredit voluntary registers, UKCP would in all likelihood apply to CHRE for such accreditation.

2.2 However we have major concerns about the powers proposed to be granted to statutory regulators to establish their own voluntary registers (s 212). As the Bill is currently drafted, this new power enables a statutory regulator to establish a voluntary register in competition with existing professional voluntary registers.

2.3 We think this constitutes an improper encroachment by an agency of the state into the existing professional voluntary regulatory field. It will be divisive and confusing, and will lead to competition of a kind that we cannot believe the Department of Health envisaged in the drafting of this Bill.

2.4 We urge that the draft Bill be amended to make clear that the statutory regulators would have a power to set up voluntary registers only in those circumstances when there are no recognised voluntary registers in existence.

2.5 This proposal would leave the Health Professions Council free to establish a voluntary register for social care workers, who are not registered voluntarily at present. But the fields of psychotherapy and counselling already work under a system of voluntary regulation that the Department is well aware of. Hence, we submit, they should not fall under a statutory regulator for the purpose of voluntary regulation.

March 2011

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**Memorandum submitted by The Foundation Trust Governors’ Association (HS 81)**

**Introduction**

1. The Foundation Trust Governors’ Association (FTGA) is the only national organisation representing Foundation Trust Governors. Currently we have 87 member Foundation Trusts (FT), representing approximately 3,000 governors across England. The FTGA was involved in drafting the legislation for the Health and Social Care Bill 2010–11.

2. We have confined our comments to areas that directly affect governors. Items are listed in the order in which they appear in the Bill, except for the first two items, which are presented as additions to the current wording.

**Comments**

**Board of Directors’ meetings**

3. The FTGA believes that FTs should hold Board meetings in public. We understand that there are issues of confidentiality or commercial sensitivity that need to be discussed in closed session and so would accept a Part I and Part II arrangement. However, it is important for the probity and local accountability of the FT that the Part I of the meeting is clearly the discussion and decision-making forum for the Board of Directors.

4. The contents of Part II should be carefully assessed to ensure their appropriateness. Each FT that operates a split Board meeting should establish a process for reassuring its governors that items in Part II really do need to be there, giving an outline of why they are in Part II and when they are expected in Part I for decision. This may be done through the Lead Governor.

5. If FTs are to fulfil their remit of being accountable to their communities rather than Whitehall, public scrutiny of the Board of Directors’ meeting is essential. There is clear precedent for this in the Local Government Act of 1972, clause 100, for example:

   “A meeting of a principal council shall be open to the public except to the extent that they are excluded (whether during the whole or part of the proceedings) under subsection (2) below or by resolution under subsection (4) below.”

6. The majority of our c 3,000 governor members agree with this and feel that without access to their Directors’ meetings, they cannot discharge their duties properly.
The Composition of Health and Wellbeing Boards

8. There are already some provisions in legislation for who should sit on Health and Wellbeing Boards, but their overall size and shape is for local discretion. At the moment, there is no prescribed provider presence, which we think is an oversight. We would like to propose that providers are given a place on all Health and Wellbeing Boards and that this be done through a governor.

9. If it was felt inappropriate for providers themselves to sit on this Board, governors are in the position of having knowledge of the sector without being directly responsible for it and of having a wider responsibility to the community as a whole. The overall strategic co-ordination function of the Board sits well with the Governor remit. And as consortiums will be represented by one person, it seems reasonable to mirror that with some level of provider input.

10. The FTGA view expressed here is supported by the Foundation Trust Network.

11. Clause 136 Governors

(3) Appointed Governors

The FTGA welcomes the increased flexibility surrounding partnership organisations and appointed governors but is concerned that this flexibility must not be used as a way of introducing “expert” governors by the back door. We think it is vital that governors remain either elected or appointed from organisations that have a clear interest in healthcare and the local community rather than for any particular professional expertise they may possess. Governors are not there to replicate the non-executive role.

12. Currently partner governors may sit on more than one Council of Governors, whereas elected governors may only sit on one. We think the position of partner governors is anomalous in this regard and should only be allowed to sit on one Council at a time.

13. Clause 136 Governors

(5) Equipping Governors with the skills required

The FTGA welcomes the inclusion of a requirement on FTs to train and adequately equip their governors to carry out their duties effectively. However, as it stands, this is as far as it goes. We think it is important that the legislation also specifies how this legal requirement be enforced and what sanctions are available if FTs fall short.

14. The key to enforcing this will be establishing how the effectiveness of governors might be assessed on an ongoing basis. The FTGA believes there is a role here for the Care Quality Commission (CQC). We feel that ensuring governors are inducted and trained by their FT to be effective is a mark of an FT’s overall approach to quality and governance and, as such, could be included in the assessment carried out by the CQC. This could be in the form of a submission set against a benchmarked set of criteria. This would be analogous to the assessment of the effectiveness of school governing bodies carried out by Ofsted as part of a school inspection.

15. Clause 137 Directors

(4) 18D (1) and (2) Agendas and Minutes of Board of Directors’ Meetings

The FTGA welcomes the openness and transparency this measure brings as it is a crucial part of governors being able to fulfil their role effectively. However, we are unclear how this information will be shared with governors if Board of Directors’ meetings are held in private as in many trusts this sort of information is not shared on the grounds of confidentiality. There would need to be a clear undertaking in the legislation that all agendas and minutes be shared with governors to make this work.

16. Clause 147 Panel for Advising Governors

The FTGA welcomes Monitor’s power to appoint a panel to advise governors on questions of dispute with their Trust. However, we would like the following points considered further:

(i) Given that the dispute may well be with the Chair of the Trust, will the Council of Governors feel able to vote publicly to refer a question to the panel in front of their Chair (they must do this in order to act as a full Council, which is the only body with the power to take this decision)?

(ii) Staff governors should at least be allowed a secret ballot in this instance.

(iii) Who will take the lead in communicating with Monitor? The FTGA thinks this should fall to the Lead Governor unless the Council deems otherwise.

(iv) The advice of the panel is not binding on the Trust. However, we feel that Trusts should be required to record in their Annual Report any instances of their Governors referring to the panel, detailing the question, the response of the panel and the Trust’s actions as a result.

(v) How will Monitor assure itself of the consistency of decision making from the panel when it will hopefully only be convened rarely? What provision will be made for retaining experienced members, evaluating performance and allowing for feedback from Trusts and their Governors?

(vi) Is the committee assured that this panel will be taken seriously by Trusts?

March 2011
Memorandum submitted by Weight Watchers UK Limited (HS 82)

SUMMARY

— Tackling obesity is the number one public health priority—yet omitted from the Health and Social Care Bill.
— Responsibility for commissioning of weight management services for the public remains unclear.
— How will weight management services for the public be commissioned?
— GP consortia will need training and support in commissioning weight management services.
— Danger that GPs will only commission services for the severely obese—when earlier intervention at lower BMIs more likely to be effective.
— No evidence that NHS reforms will solve the current inequalities in patient access to effective, evidence-based weight management services.
— Will the Health and Social Care Bill level the playing field between NHS and non NHS providers of weight management services to focus on outcomes?
— Weight Watchers welcomes judgement of services based on outcomes.
— Payment by results may affect equity of access to services.
— Weight Watchers recommends an approved providers list of weight management services.
— Weight Watchers is proven to deliver effective and cost-effective interventions.

1. TACKLING OBESITY IS THE NUMBER ONE PUBLIC HEALTH PRIORITY

Being a healthy weight is central to good health. Being overweight or obese has a severe impact on a person’s health—both are associated with an increasing risk of diabetes, cancer and heart and liver disease amongst others, and the risks get worse the more overweight people become. These illnesses put pressure on families, the NHS and society more broadly, with overall costs to society forecast to reach £50 billion per year by 2050 (Foresight 2007). The Foresight team described obesity as the “climate change of public health”. For all these reasons, helping the 26 million people who are currently overweight or obese to achieve and maintain a healthy weight should be central to any healthcare proposals and Weight Watchers is worried that the current proposals lack any emphasis on what should be the number one public health priority.

2. RESPONSIBILITY FOR COMMISSIONING OF WEIGHT MANAGEMENT SERVICES FOR THE PUBLIC REMAINS UNCLEAR

The Health and Social Care Bill seeks to dismantle Primary Care Trusts (PCTs), which have been the main commissioners of weight management services for overweight and obese patients. The vast majority of commissioning responsibilities will be transferred to new GP commissioning consortia. It is still not clear from the proposals within the Health and Social Care Bill and Public Health White Paper whether the new GP commissioning consortia will procure weight management services (eg NHS referral to group support programmes such as Weight Watchers) or whether the contracting process will be the responsibility of public health directors, who will sit within local authorities and lead on wellbeing services, or the NHS Commissioning Board, or be divided between them. This key question needs to be answered clearly and explicitly.

3. HOW WILL WEIGHT MANAGEMENT SERVICES FOR THE PUBLIC BE COMMISSIONED?

There is also a lack of clarity on how weight management services for individuals will be best commissioned. Specifically, more detail is needed on:
— Who will set criteria for “good results” from weight management interventions.
— How GP consortia will ensure that there will be equal, fair and transparent competition between NHS and non NHS providers of weight management services, all the time focused on outcomes.
— How local “need” for weight management services will be quantified and thus strategies and funding aligned to meet those needs.
— Who will take responsibility for making the type, range and volume of effective weight management services available which local populations deserve?

4. GP CONSORTIA WILL NEED TRAINING AND SUPPORT IN COMMISSIONING WEIGHT MANAGEMENT SERVICES

Over the last six years around two thirds of Primary Care Organisations (PCOs) have procured services from Weight Watchers. As a result the company has experience in NHS tendering and detailed its frustrations in evidence to the Health Select Committee’s recent inquiry into commissioning. It described an over-regulated, inflexible and insensitive process often driven by NHS commissioners with little apparent knowledge of the obesity literature and a seemingly poor understanding of the realities of weight management. Whilst GP involvement is likely to bring greater clinical expertise, most GPs are not trained in the skills and knowledge needed for effective commissioning of weight management services.
5. **Danger that GPs will only Commission Services for the Severely Obese—When Earlier Intervention at Lower BMIs More Likely to be Effective**

To date over 65,000 patients from 102 PCOs have been referred to Weight Watchers, by around 1,437 GP practices across the country. Most of these patients were severely obese (median weight approaching 15 stone and median BMI 35.1 kg/m²) suggesting that primary care practitioners don’t tend to intervene until patients have complex health problems. However, most obesity care pathways recommend earlier intervention with behavioural change programmes (such as Weight Watchers) to help overweight people (at BMI 25 kg/m² upwards) to change their eating and physical activity habits before the situation becomes too acute. Because GPs are trained to “treat for weight loss” rather than “prevent weight gain”, weight management services will continue to be offered only to the severely obese.

Lifestyle interventions such as Weight Watchers which seek to inculcate healthy eating and physical activity habits are effective in:
- Preventing healthy-weight people putting on weight with age.
- Preventing overweight people (ie BMI 25–30 kg/m²) becoming obese.
- Treating overweight people and obese people to achieve and maintain a healthy weight.

Thus Weight Watchers offers interventions for both prevention and treatment.

6. **No Evidence that NHS Reforms Will Solve the Current Inequalities in Patient Access to Effective and Evidence-based Weight Management Services**

Even though over two thirds of PCOs in England have bought Weight Watchers referral services for their patients, there is a huge variation in patient access to these services between PCOs. Over 75% of PCOs have purchased Weight Watchers in minute amounts (for less than 200 of their patients). This equates to referral to Weight Watchers becoming available to approximately 1 in 250 of the overweight/obese in sparsely populated PCOs. In more densely populated PCOs, around 1 in 3,300 overweight/obese patients would be offered Weight Watchers meetings paid for by the NHS. In reality Weight Watchers is only available to the select few who seek help through their GP practice. It is likely that this picture is indicative of patient access to other choices of weight management services.

7. **Will the Health and Social Care Bill Level the Playing Field between NHS and Non-NHS Providers of Weight Management Services to Focus on Outcomes?**

Despite NICE guidance recommending that “healthcare agencies should recommend to patients, or consider endorsing, self-help, commercial and community weight management programmes if they follow best practice”, over the last six years Weight Watchers has fought for acceptance as an effective referral route for overweight and obese NHS patients. The previous Government’s obesity strategy, “Healthy Weight: Healthy Lives”, promoted commercial partnerships as an essential element to solve the “obesity epidemic”. Yet this rhetoric seldom became a reality. For example, there was limited recognition of providers such as Weight Watchers within the Department of Health, or inclusion within local obesity care pathways drawn up by PCOs. Historically Weight Watchers has encountered commercial prejudices (ie not being perceived as offering as high a quality service as NHS providers) within NHS commissioning circles. It is hoped that proposals within the Health and Social Care Bill will promote a sea change in attitudes within the NHS to providers who have good quality data underpinning the effectiveness of the services they offer and who meet NICE best practice standards.

8. **Weight Watchers welcomes Judgement of Services Based on Outcomes**

Weight Watchers has invested heavily in research and evaluation. From this, the company knows what results it can achieve—particularly amongst the patients who are routinely referred by GP practices. These patients tend to be obese (average BMI 35 kg/m²) and have complex health problems. Over one third of all referrals lose 5% or more of their initial weight (Ahern et al, 2010) at 12 weeks and this results in a significant reduction in the risk of type 2 diabetes (Diabetes Prevention Programme Research Group 2002). Every kg lost results in a 16% reduction in risk of type 2 diabetes (Hamman et al, 2006). Typically someone completing a 12 week course of Weight Watchers will lose around 5–6 kg. Very few weight management interventions from NHS or non NHS providers possess similar evaluative data and many public health commissioners have contracted weight management services with unknown results. Weight Watchers welcomes the proposals within the Health and Social Care Bill which will encourage commissioners to buy services with proven outcomes.

9. **Payment by Results May Affect Equity of Access to Weight Management Services**

Weight Watchers applauds the overall emphasis in the Health and Social Care Bill that it will be outcomes that matter, not targets or activity alone, with government pledging an end to the production line approach to delivering services. As such, providers will be paid according to their performance. However, this principle needs careful application to weight management services. Helping people lose weight is complex, often requiring behavioural intervention, backed up by regular and lifelong support and review. Losing weight requires great effort and patients often describe the weight loss journey as “an endless battle” (DH 2010).
Research suggests that high relapse and dropout rates are common in weight loss treatment studies—ranging from 10–80% (Inelman et al, 2005). For example, in the Counterweight study where weight management interventions were mediated by practice nurses (2004) retention was 22.5% at 12 months. There is a danger that if payment by results is insensitively applied to weight management service providers, then only patients with lower BMIs (25–30 kg/m$^2$) and less complex health and socioeconomic needs will be accepted for referral and this will cause inequalities of patient access to weight management services. Payment by results in the weight management arena will discriminate against larger patients with complex health problems. The solution is to set realistic “performance indicators” specific to different types of services (eg drug treatments, group support, one to one with a practice nurse, very low calorie diets). These very specific “performance indicators” should be grounded in what the research indicates is achievable and should form the basis for any “payment by results” scheme. It is unfortunate that discussions that Weight Watchers has had with commissioners across England so far regarding this issue have indicated that their desired results are certainly not based on the evidence of what is achievable for a specific intervention, but appear to be simply plucked out of the air.

These specific performance indicators could be shared with indicators for GPs. Weight Watchers submitted suggestions for QOF indicator topics in 2010, suggesting that in order to truly make weight management a priority in primary care, it is recommended that QOF indicators be developed to measure and incentivise the following:

— % of patients over a BMI of 25kg/m$^2$ being offered weight management services;
— % of referred patients who complete with their chosen weight management solution; and
— % of referred patients achieving a weight loss of at least 5% of their initial weight.

10. WEIGHT WATCHERS RECOMMENDS AN APPROVED PROVIDERS LIST OF WEIGHT MANAGEMENT SERVICES

A nationally maintained list of approved providers of effective weight management services to the public sector is vital to ensure people are offered safe and quality interventions. The weight management arena is diverse. Interventions and services are available from a wide range of agencies in the public and private sectors. These services vary in lots of different ways—but perhaps most pertinently in the level of data which has been collected on their effectiveness and their compliance with NICE best practice standards (NICE, 2006). In Weight Watchers’ experience the NHS commissioning process often lacked the specific expertise and interest in differentiating between effective and ineffective services. Whilst Weight Watchers welcomes the move towards integrating more clinical expertise into the commissioning of health services, an approved weight management service provider list would save everybody’s time and money in identifying services which meet NICE best practice standards, have proven effectiveness, are cost effective for the NHS and have the capability to deliver the scale of services needed across the country.

11. WEIGHT WATCHERS IS PROVEN TO DELIVER EFFECTIVE AND COST-EFFECTIVE INTERVENTIONS

Over the last six years Weight Watchers has developed its health care services business. It:

— is a “willing provider” of weight management services;
— has a weight management programme which works—and (through independent research) knows what results it can achieve and meets NICE best practice guidelines for weight management interventions (NICE 2006);
— stands ready and has a tried and tested national operational infrastructure of over 6,500 weekly meetings which are embedded in local communities and run by local experts; and
— knows how to work with the public sector and has partnerships with over 100 PCOs across England.

Over the last decade Weight Watchers has made significant investment in research to evaluate the efficacy of its methods, and the effectiveness of its Referral Scheme.

The economics are simple. A 12-session course of Weight Watchers (which on average achieves a BMI drop of 1.5 BMI units equivalent to 5–6kg) costs the NHS £55/patient. A single individual 12 minute consultation with a GP costs £36 and with a practice nurse £10 (Curtis, 2009). Weight Watchers has been proven to be a cost effective intervention for healthcare to help prevent and manage obesity, with a cost effectiveness ratio of £1,022 per QALY (Trueman and Flack 2006).

LIST OF REFERENCES:
Memorandum submitted by the Men’s Health Forum (HS 83)

1. WHO WE ARE

The Men’s Health Forum (MHF) is a charity that provides an independent and authoritative voice for male health in England and Wales and tackles the issues and inequalities affecting the health and well-being of men and boys.

The MHF vision is a future in which all boys and men in England and Wales have an equal opportunity to attain the highest possible level of health and well-being.

We have been a Strategic Partner of the Department of Health (DH) since February 2009.

2. INTRODUCTION AND SUMMARY

We welcome the publication of the Health and Social Care Bill. We believe that the reform of the NHS offers an excellent opportunity to address the poor health outcomes of men in this country. The vision set out for the NHS, particularly the commitment to tackling health inequalities, is encouraging.

However, in summary, we do not feel the bill goes far enough to deliver on this vision so our conclusion sets out amendments to ensure that systems are in place within the NHS Commissioning Board to tackle health inequalities and that there is engagement with organisations that can advise on, and help monitor, progress.

In the following sections, we set out our perspective on the Bill and highlight areas that we believe require further attention.
2.1 Current state of men's health in England and Wales

Before addressing the detail of the Bill, we would like to contextualise our response by reflecting on the current state of men's health in this country. We believe that too many men suffer unnecessarily poor health and die too young from preventable causes.

— A baby boy born in 2006–08 can expect to live 77.4 years and a baby girl 81.6 years, a difference of 4.2 years.

— Premature death mainly affects men. 42% of men die prematurely (before the age of 75) from all causes compared to 26% of women. 21% of men aged 16–64 die from all causes compared to 12% of women.

— Unskilled manual men have an average life expectancy of 73 and, in some parts of England, male life expectancy is as low as 65. The mortality rate of men in routine and manual occupations is 2.3 times that of men in managerial and professional occupations.

— The social gradient has a greater impact on men's health than women’s—the life expectancy gap between men and women widens as deprivation increases.

— Coronary heart disease kills more men than women and on average men develop it 10–15 years earlier. South Asian men living in the UK have an even higher premature death rate from heart disease and stroke than men generally.

— Men are 60% more likely to develop and 70% more likely to die from a cancer that “should” affect men and women equally (ie excluding breast cancer and the sex-specific cancers).

— Men use the range of primary care services far less than women and, crucially, take longer to present and receive a diagnosis.

— Men are slightly more likely than women to use Accident and Emergency Services. However, in the age-group that makes by far the most use of A&E, 20–29 year olds, men are in a significant majority.

— NHS smoking cessation programmes are less well used by men than women as are weight management services and health trainers.

— Black and ethnic minority men are less likely to seek help for mental health problems.

3. Men’s current level of engagement in health

We know that men, particularly men from marginalised and seldom-heard groups, have generally not been actively engaged in their health and have not accessed services or participated in health improvement programmes, to the same extent as their female counterparts. This phenomenon has a significant impact for men’s health outcomes.

3.1 Men accessing services

In Great Britain, men visit their GP 20% less frequently than women. The difference in usage is most marked for the 16–44 age group—women of this age are more than twice as likely to use services as men.170

Women have higher consultation rates for a wide range of illnesses so the gender differences cannot be explained simply by their need for contraceptive and pregnancy care.171

Men, especially young men, are much less likely than women to have regular dental check-ups172 or to use community pharmacies as a source of advice and information about health.173 Just 10% of NHS community contraception service users are male.174

NHS smoking cessation programmes are less well used by men than women175 and the same is true of NHS and commercial weight management services,176 health trainers177 and of disease-specific helplines run by third sector organisations.178 Male uptake was markedly lower than female uptake in the pilot programmes for the NHS Bowel Cancer Screening Programme.179

173 PAGB and Reader’s Digest (2005), A Picture of Health: a survey of the nation’s approach to everyday health and well-being.
176 Men’s Health Forum (2005), Hazardous Waist? Tackling the epidemic of excess weight in men.
177 Eg 18% of health trainer clients in Manchester are male. See Manchester Public Health Development Service (2009), Manchester Health Trainers Monitoring and Evaluation Report.
178 Men’s Health Forum (2007), Men and long term health conditions: a policy briefing paper.
3.2 Consequences of lack of engagement for men’s health

An analysis of men’s use of GP services shows the potential impact on men’s health and the healthcare system. This research was based on a total of 35.8 million contacts with GPs and 1.2 million hospitalisations in Denmark in 2005.180 (Like the UK, Denmark has free access to primary and hospital healthcare.) The data is compatible with a scenario in which men are reacting later to severe symptoms than women with the result that they are more likely to be hospitalised or die.

3.2.1 This is also consistent with UK and Europe-wide data on malignant melanoma which shows that while women are more likely to develop this type of cancer, men are more likely to die from it.181 This is almost certainly because men present to health services when the cancer is more advanced and harder to treat. Also, nearly four men in 10 are not diagnosed with prostate cancer until it has spread.182

3.2.2 Diabetes UK data suggests that middle-aged men are not only twice as likely to have diabetes as women they are also twice as likely not to know that they have the disease. This is particularly important given the predicted large rise in diabetes over the next 30–50 years due to the increase in obesity rates, especially in men.

3.2.3 One secondary consequence of men’s poorer use of health services is that many attempt inappropriate self-diagnosis and self-treatment. Every year in the UK, an estimated 330,000 men purchase prescription-only medicines without a prescription from illicit sources, particularly internet sites.183

3.2.4 Thus, men’s poor access to services and engagement in health has serious consequences for their individual health. The burden of costly treatments on the NHS when men are treated in the later stages of illness is also significant, necessitating more costly and intensive treatments.

3.3 Men’s reluctance to seek help is an underlying cause of their poor use of primary health services.

3.3.1 This is a result of the way men are brought up to behave. Men are not supposed to admit to personal problems, weakness or dependence. Many want to appear strong, independent and in control, including in front of a health professional.184 As a consequence, men often wait until they are in considerable pain or are convinced they have a serious problem.185

3.3.2 Male socialisation is not easy to change but, in our view, improved health education for boys in school would help. MHF believes that boys should not leave school without knowing the role of GPs and how to register and make an appointment. We also believe that as the health system as a whole begins to take men’s health more seriously and as health initiatives and campaigns aimed at men become more common, taking more of an interest in health issues will feel normal for men.

3.3.3 But men’s unwillingness to seek help is reinforced by a number of practical barriers, including the demands of long working hours and problems with accessing primary care services near the workplace.186

3.3.4 Anecdotal evidence suggests that some men are deterred by a perception that GP and pharmacy services are aimed mainly at women and children and feel like “feminised” spaces. “It’s like visiting a ladies’ hairdresser” was the comment of one man responding to a MHF survey on men’s use of GP services. Another man, commenting on the ambience of pharmacy services, highlighted the “racks and racks of make-up”.187

3.3.5 Lack of familiarity with the health system may also be a factor. Women are much more likely to use health services routinely—for contraception, cervical cancer screening (after the age of 25), pregnancy, childbirth and for their children’s health. When they are ill, they are more likely to know how to access services, and which services to use, and to feel more comfortable with a healthcare professional.

3.3.6 Men in specific groups may be deterred because they fear or experience discrimination. There is evidence of widespread homophobia among health professionals that impacts on the ability of gay and bisexual men to access healthcare.188 African and Caribbean men can be deterred from approaching mental health services because of a belief that they will be discriminated against.189

3.3.7 Gypsy and traveller men—the group with the lowest life expectancy in the UK (estimated at 48)—face particular difficulties accessing mainstream primary care services.190

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183 Pfizer (2009), www.pfizer.co.uk/Media/Pages/Getrealcampaign.aspx
186 Men’s Health Forum (2008), Improving male health by taking action in the workplace: A policy briefing paper.
187 Men’s Health Forum (2005), Men tell us why they don’t go to the doctor’s.
Although men have poor health outcomes, these barriers to men’s effective use of health and related services have not yet been systematically addressed. Services are not routinely being delivered in ways that take proper account of men’s attitudes and behaviours. This is despite the Gender Equality Duty, in force since April 2007, which requires services to be tailored to the specific needs of men and women and to work towards achieving more equitable outcomes. The implementation of the NHS reforms offers an important opportunity to rectify this. In the next section we will outline a number of steps that can be taken, to this end.

3.4 What can we do to address men’s lack of engagement in health and to place them at the centre of the NHS?

The MHF firmly believe that the Bill should include provision for “gender sensitive” service delivery.

— 3.4.1 Underlying the Bill is the assumption that the quality of interaction with the health professionals that serve the public and patients is important. In the past the NHS has failed to engage men in “traditional” primary care services. Research tells us that men are far more likely to engage in health services, if they are adapted to become more gender sensitive.

— 3.4.2 The changes required are often subtle and straightforward, for example by making GP waiting rooms welcoming to men as well as women through the use of appropriate posters, leaflets, men’s as well as women’s magazines.

— 3.4.3 One of the simplest ways to ensure that General Practice is more accessible to men is by extending opening hours. Many GPs have extended their hours in recent years but this is still far from universal, often not on a daily basis and still rarely at weekends. We advocate longer opening hours, which would particularly help men who work full-time, work more than 40 hours a week, or who have lengthy commutes to work, as well as the White Paper’s suggestion to allow men to register with any GP surgery. However, we suggest that this will only be truly useful if patients are allowed to register at more than one GP practice, eg near their place of residence and near their place of work. While it may be convenient to be able to attend a GP practice nearby for routine appointments, if one is ill at home and needs to see a GP urgently, this obviously will not work, particularly for those who commute long distances to work. There is also an issue for transient workers. In the course of our consultation process, the situation of construction workers was raised. These workers tend to move from workplace to workplace to the extent that having access to only one GP surgery is impractical. The increased availability of NHS walk-in services is likely to serve this population best, as would improved occupational health services.

— 3.4.4 We believe that male take-up of GP services could be improved by the more rapid adoption of online self-booked appointments. Men often report feeling intimidated by the current appointments process—phoning at 8–9 am, a time when many are travelling to work, “interrogation” by a receptionist—off-putting and are more likely to use a straightforward, always-accessible and anonymous service. To mitigate the risk that this development would favour men with access to the Internet, we recommend that the potential for making universal automated bookings by telephone is also explored.

— 3.4.5 The workplace as a source of health information, advice and treatment should be better utilised generally. There is good evidence that workplaces with large male populations can help to deliver improved health outcomes through targeted health programmes. For example, worked with the MHF to deliver a successful health improvement campaign (“Work Fit”) to over 16,000 staff, the overwhelming majority of whom were men.

— 3.4.6 As already outlined, although men often report being uncomfortable seeking help for health issues in traditional settings such as General Practice, they often welcome the opportunity to undertake health checks in non-traditional, but male-friendly environments such as football stadiums and pubs. Many successful men’s health initiatives have sought to take services and health improvement campaigns to men—at work, sports stadia, military bases, pubs and prisons—and have used male-targeted health information, such as MHF booklets designed to look like Haynes’ car maintenance manuals. There are now a number of excellent examples of how these initiatives can be undertaken in a cost-effective manner.

3.5 Examples of cost effective methods of adapting health services to become more gender sensitive

— Knowsley PCT/MBC’s Pitstop programme used social marketing principles to deliver health checks to over 3,000 local men. 85% of men who were followed up reported lifestyle changes.

— NHS Halton and St Helens’ Go campaign encourages men over 40 in deprived areas to take better care of their health and to make more use of health services. 57% of men attending health checks have gone on to access further services, including diet and exercise interventions, smoking cessation and health trainer services.

— Through Premier League Health, 16 top football clubs have developed physical activity and wider health programmes targeting a total of some 4,000 men in deprived communities near their stadia.

192 Department of Health (2009), Transforming Community Services and World Class Commissioning: Resource Pack for Commissioners of Community Services.
3.5.1 This work demonstrates that men are willing to take greater responsibility for their own health if the services provided are sensitive to their needs. These examples provide a good evidence base for further innovative activity in the area of men’s health. Men’s personal responsibility for health must be balanced with the availability of appropriate and accessible gender-sensitive services.

4 Commissioning and Democratic Legitimacy

4.1 Health and Well-being Boards

The idea of establishing health and well-being boards to promote integration across NHS health services, public health and social care is ambitious. An issue of particular concern is the representation of voluntary sector interests on Health and Well-being Boards. There is currently no statutory duty for this. We believe that it is vital that the voluntary sector is represented (probably through the local CVS) at this level.

4.1.1 Careful consideration must be given to the responsibilities of the health and well-being boards and accountability mechanisms at a local and national level. We believe that greater clarity is still required in the Bill in this area.

4.1.2 In the proposed format, it appears that Health and Well-being Boards will contain representatives from GP consortia (who will be working to deliver outcomes, to meet the indicators set out in the NHS Outcomes Framework), the Local Authority (who will be working to deliver national social care outcomes) and Public Health (who will be working to deliver outcomes, to meet the indicators to be set out in the national Public Health Outcomes Framework). However, in theory, the local Joint Strategic Needs Assessment should serve the function of identifying the local needs that all statutory bodies should be addressing.

4.1.3 There are a number of potential conflicts within this system:

4.1.3.1 National vs local priorities

Although the Bill provides for a move towards localism, there is a danger of confusion arising amongst GP consortia and others about the outcomes they should be working to achieve. On the one hand, it is proposed that GP practice income is linked to how well the commissioning of services to meet NHS Outcome Framework indicators is carried out. However, it is the JSNA that will determine the needs of the local community and identify those who are experiencing the worst inequalities. Unless there is integration between local needs and the national NHS Outcomes Framework, there is a danger that these needs may be overlooked. It is vital to bring clarity to this situation.

It is important that the meeting of local health inequalities is monitored. We believe that Health and Well-being boards should have the statutory powers to do this, in collaboration with the NHS Commissioning Board.

4.1.3.2 Who takes responsibility for meeting local needs?

With Local Authorities, GP consortia and the Public Health service all working to meet the needs outlined by JSNA, there must be a mechanism in place to ensure that the most vulnerable and those who it is difficult to access do not “fall through the cracks”. There may well be the temptation to pass responsibility to another statutory agency for time-consuming and expensive-to-access groups. There must be a means to ensure that this does not happen. Again, with all bodies working towards different sets of national outcomes, there is the potential for this situation to be problematic, if there isn’t sufficient local and national oversight. Thus it is important that Health and Well-being Boards have an overview and scrutiny function. There should also be an inbuilt mechanism for HWBs to feed back concerns to the NHS Commissioning Board, if they feel that GP consortia are not addressing the needs of local populations as identified by JSNA.

4.1.4 Local and National HealthWatch

Service user representation must not begin and end with local HealthWatch.

4.1.4.1 In order to reach out to marginalised and seldom-heard groups, local authorities and GP consortia will have to engage with these groups in a manner appropriate to them. Traditional consultation methods, such as surveys and focus groups, often overlook these groups. We believe the local HealthWatch groups should be required to engage with the groups identified within the Joint Strategic Needs Assessment as experiencing the greatest health inequalities. This should be done using the most suitable means available within the community, eg by working with community, voluntary and faith groups.

HealthWatch England has the potential to become a useful and relevant body. In order for this to happen, it must have real engagement with the NHS commissioning Board.

4.2 Commissioning

4.2.1 NHS Commissioning Board

— 4.2.1.2 We welcome the explicit duty of the NHS Commissioning Board, to promote equality in line with the Equality Act (2010) and tackle health inequalities in access to healthcare. We suggest that in order to fulfil this duty the NHS Commissioning Board should establish a Gender Equalities Board. This Board could take responsibility for developing guidelines to help GP consortia to promote gender equality and tackle inequalities, and to monitor progress on this duty.
The Board should be required to publish an annual report on progress towards gender equality in health and the steps it will take to achieve further progress. This work will need to be undertaken in collaboration with the Equality and Human Rights Commission. It is important to note, however, that the EHRC’s ability to lead change within the NHS is limited. The Commissioning Board will therefore have a crucial role. We recommend that this Board co-opt members from relevant statutory and voluntary organisations with expertise in this area. We would be pleased to offer the assistance of the Men’s Health Forum in this endeavour.

4.2.1.3 We are unclear as to exactly how the NHS Commissioning Board will monitor the performance of GP consortia in meeting duties to tackle health inequalities and promote equality in line with the Equality Act (2010). The Bill specifies that the NHS Commissioning Board will take over current CQC responsibility of assessing NHS commissioners and will hold GP consortia to account for performance and quality, but it is unclear how this will actually work in practice. We believe that it is important that if the NHS Outcomes Framework is to provide that main means of monitoring performance, that it has indicators around health inequalities built in.

4.2.1.4 We believe that the NHS Commissioning Board’s role in providing leadership for quality improvement through commissioning is extremely important. We believe that the commissioning guidance the Commissioning Board will develop in this capacity, will be key to GP consortia commissioning appropriate services and standardising good practice across consortia. We suggest that particular guidance around the commissioning of male-friendly services should be developed.

4.2.1.5 We also welcome the duty that the NHS Commissioning Board will assume to tackle inequalities in outcomes from healthcare. Again, in order to fulfil this aim it is vital that the indicators developed within the domains of the National Outcomes Framework reflect this objective.

4.2.1.6 The undertaking of the NHS Commissioning Board to promote patient and carer involvement and choice is encouraging. In order for this involvement to be worthwhile, patients must have early input into key decisions. The idea of involving patients in developing commissioning guidelines is to be welcomed. However, it is important that sufficient resources are dedicated to these activities, to ensure that innovative consultations, to access seldom heard patients are carried out. This should be a responsibility for HealthWatch England that the NHS Commissioning Board monitors.

4.2.2 GP Consortia

There are a number of issues that we believe need to be clarified, if the new system is to work to improve the health of men.

4.2.2.1 In the past, we know that most Primary Care Trusts have not commissioned services that take proper account of men. We believe it is important to develop practical Guidance that will help GP consortia, the overwhelming majority of which will lack experience in this area.

4.2.2.2 We know that the public sector equality duty, which covers gender, will apply to the workings of the NHS Commissioning Board and GP consortia. While the proposals confirm that GP consortia will have a duty to promote equalities, and to work in partnership with local authorities, it is unclear how this will be operationalised. Thus, again we recommend that there are specific indicators within the National Outcomes Framework to incentivise this.

4.2.2.3 We also recommend that the reformed Quality Outcomes Framework should include specific indicators to promote gender equality in access to healthcare and in healthcare outcomes.

4.2.2.4 Similarly, the proposal to link GP practice income to the outcomes consortia achieve, collaboratively through commissioning and the effectiveness with which they manage financial resources, offers a mechanism for improving men’s health outcomes. We recommend that the commissioning of male-friendly services, and tackling health inequalities are factored into these stated outcomes.

4.2.2.5 It is imperative that GP consortia engage with people who do not traditionally access general practice, in order to ensure the commissioning of relevant and suitable services for these groups. The proposed GP consortia duty of patient and public involvement is a step in the right direction on this front. We recommend that this includes a duty to engage with marginalised and seldom heard groups, to take their views on service commissioning into account. This could be achieved by a number of means, eg through GP consortia patient panels, by requesting the assistance of local HealthWatch and by engaging with local voluntary, community and faith groups.

4.2.2.6 With the abolition of SHAs and PCTs there is a danger of good practice information around men’s health being lost. At the MHF we are in the course of developing a database of good practice in the area of tackling men’s health inequalities. We believe that this offers a means of capturing good practice from across statutory, voluntary and private organisation.

4.2.2.7 Extending opening hours, making it easier to book appointments and allowing patients to register with more than one GP should go some way to increasing accessibility. However, this must
be coupled with community outreach work. It is vital that GP surgeries adjust service provision to take services to the places where patients are. Opportunistic health checks and health promotion at suitable events and venues such as sports stadia and workplaces should be considered.

4.2.2.8 It is currently unclear how the “health premium” will work in practice. We believe that this should be used as a further mechanism to encourage GPs to tackle health inequalities in their communities, paid to GP practices that are particularly successful on this front. However, the level of the health premium is the factor most likely to incentivise GPs to work towards achieving it. Thus, we believe it must be at a high enough level to be attractive to GPs.

5. Conclusions
We believe that the following amendments to the Bill are necessary:

1. Establish a Gender Equalities Board within the NHS Commissioning Board, to ensure that gender health inequalities are tackled throughout the NHS and task it with developing best practice guidance for GP consortia, to assist them to commission and operate gender sensitive health services.

2. Incentivise the commissioning of services that tackle gender inequalities in health outcomes by linking these outcomes to GP practice income.

3. Ensure that local HealthWatch organisations are required to engage with those who experience the worst health inequalities either directly or through appropriate local voluntary, community and faith groups.

4. Ensure that HealthWatch England engages with organisations that represent and have access to seldom-heard and marginalised groups who experience the worst health inequalities.

5. Give Health and Well-being Boards sufficient powers to ensure that GP consortia and others, commission services to address the health inequalities highlighted by local Joint Strategic Needs Assessments.

6. Ensure that the NHS Commissioning Board has sufficient powers to ensure that GP consortia fulfil their duty to tackle health inequalities.

7. Ensure that there is a duty to include voluntary sector representation on Health and Well-being Boards.

March 2011

Memorandum submitted by Lisa Smeaton (HS 84)

I write to you as a member of the public who would like to comment as part of the Health and Social Care Bill Consultation. I have read about the proposed reforms and my conclusion is that I am not in agreement with the proposed reforms and have very serious concerns about the proposals.

My major concerns about the bill include:

The huge potential for postcode lottery care with different GP consortia approving different treatment. Will patients have to lobby for treatment?

The increasing use of private healthcare in the NHS. The goal of these organisations to make profit for their shareholders. Patients and the taxpayer will not be their highest priority. Additionally these organisations are likely to “cherry pick” the profitable parts of the sector.

Many GPs do not want to become “accountants”. The Secretary of State for Health believes that the fact that a number of GP consortia have been established is evidence of their agreement to the proposals. However from speaking to GPs who I know personally and reading information online it is quite clear that many GPs think the reforms are a “disaster” but are only establishing consortia to protect their patients from a private healthcare consortia filling the gap. There is no mandate for this Bill from the medical profession or patients.

It is not clear how training of student/newly qualified doctors, nurses and other health professionals will be addressed. Currently this is part of the NHS and more senior colleagues spend time mentoring and educating trainees. I think it is highly unlikely that any private health providers will wish to contribute to this non-profit making exercise.

The reforms will cost billions to implement at a time of budget cutting and seems an inappropriate time to spend so much money.

There will be very limited public access or involvement to the decision making process. Presently PCT’s offer some transparency and the public can become involved. I believe the engagement/auditing/reviewing process planned will be tokenism and ineffective.

Finally this reform of the NHS was not offered to the general public at the General Election and breaks the “no-more top down reforms” even though it has clearly been under development for some time and so I believe the public has been misled and lied to. The NHS is a crucial aspect of life in this country and therefore I suggest that the Bill is put on hold and offered at the next General Election.
Finally I note that the RCGP, the BMA, the RCN, Civitas, the Nuffield Trust and major health charities and the Royal College of Surgeons all have major reservations about the proposals and yet their comments and feedback has been ignored.

I would be very grateful if my comments could be taken into consideration as part of the consultation process.

March 2011

Memorandum submitted by The Roy Castle Lung Cancer Foundation (HS 85)

1. BACKGROUND INFORMATION

1.1 The Roy Castle Lung Cancer Foundation (RCLCF)

RCLCF is the only UK-wide charity, dedicated solely to the defeat of lung cancer. We fund basic science research, tobacco control initiatives and work in lung cancer patient information, support and advocacy. Ensuring equitable access, for lung cancer patients, to the best treatment and care, supported by clear and meaningful information, is of paramount importance.

1.2 RCLCF and this submission

As a site-specific cancer charity, lung cancer is RCLCF’s focus. As such, our comments are concerned with this one cancer only. Many of our observations may be relevant to other cancers, although lung cancer is characterised by many features which accentuate inequality.

1.3 Lung cancer

Lung cancer is the UK’s most common cause of cancer death for both men and women, responsible for nearly a quarter (24%) of all male cancer deaths and a fifth (20%) of all female cancer deaths. Each year around 39,500 people are diagnosed with lung cancer in the UK (more than 100 people each day).\(^{193}\)

Although a common cancer, outcomes of treatment are generally poor, with only 7% of lung cancer patients surviving five years after diagnosis.\(^{193}\) Long term survival has only improved slightly in recent years. However, patients diagnosed at an early stage have a better prognosis, largely as a result of being suitable for radical treatments, particularly surgery.

Smoking causes almost 90% of lung cancer deaths. It should, however, be noted that over 4,000 UK lung cancer deaths each year, are unrelated to tobacco.

1.4 Early diagnosis and lung cancer

The delayed diagnosis of lung cancer has been identified as a major reason for the poor prognosis for patients diagnosed with lung cancer, as well as the lower survival rates reported by the UK when compared with other countries in Europe. Research by the National Cancer Intelligence Network (NCIN) found that 38% of lung cancer diagnoses were made in an emergency setting—this further illustrates that the signs and symptoms of lung cancer are too often not identified in primary care.

RCLCF is coordinating a campaign to secure a greater focus on lung cancer within general practice, ensuring that GPs are supported in identifying the signs and symptoms of lung cancer earlier and referring appropriately.

2. SUMMARY OF RCLCF RESPONSE TO THE HEALTH AND SOCIAL CARE BILL

There are a number of opportunities within the Health and Social Care Bill to support earlier diagnosis of lung cancer in primary care. These include:

2.1 Ensuring GP commissioning consortia are given a role in guaranteeing that national guidelines such as those prepared by the National Institute for Health and Clinical Excellence (NICE) on cancer referral are implemented by GPs.

2.2 Ensuring that GP commissioning consortia take a role in encouraging active learning among their constituent practices. This could include promoting significant event reviews on cancer diagnosis.

2.3 GP commissioning consortia should work to reduce inequalities in lung cancer through raising awareness of the signs and symptoms of lung cancer to encourage earlier presentation with symptoms.

2.4 Payments in respect of performance should be taken into account measures within the NHS Outcomes Framework such as one-year survival and percentage of cancer patients diagnosed at stage 1 or stage 2.

\(^{193}\) Cancer Research UK, UK Lung Cancer Incidence Statistics.
3. RCLCF Comments on the Health and Social Care Bill

3.1 The RCLCF has identified a number of opportunities within the Health and Social Care Bill to support earlier diagnosis of lung cancer in primary care. These briefing notes outline the relevant issues that we would ask the Bill Committee to consider.

3.2 General duties of commissioning consortia (Section 22)

Section 22 details the general duties of commissioning consortia. RCLCF has identified specific duties within this which may improve referral and diagnosis rates in primary care.

3.3 Sections 14L and 14M—"Securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis of treatment of illness"

"Securing continuous improvement in primary medical services”

3.31 GP commissioning consortia should be given a role in ensuring that guidelines on lung cancer are followed by their constituent GP practices. This would ensure that the appropriate cancer referral guidance from the National Institute for Health and Clinical Excellence (NICE) is fully implemented and that patients with symptoms are referred for appropriate diagnostic tests in a timely manner.

3.32 GP commissioning consortia should take a role in encouraging collective learning among their constituent practices. This could include the promotion of significant event reviews on cancer diagnosis to encourage reflective learning and improvement in practice. The advantages of this approach are:

— There is already a precedent for significant event reviews to be included in the QOF, reflecting the Department of Health’s recognition of their value.

— Significant event reviews take place in a “no blame” environment thereby allowing all members of the team to learn from the case, even if they have not personally seen the patient.

— The learning value of these reviews is important for the ongoing professional development of GPs.

— Records of participation in significant event reviews can be submitted as part of portfolios for GP reaccreditation.

3.4 Section 14N—"Reduce inequalities between patients with respect to the outcomes achieved”

3.41 GP consortia should play a role in reducing inequalities in outcomes for patients with lung cancer. Evidence in the National Lung Cancer Audit has identified regional variations in access to lung cancer treatments and services. There are also social inequalities that GP commissioning consortia should play a role in reducing. This could include:

— Raising awareness of symptoms and encouraging all people with symptoms to present.

— Targeting people from high-deprivation groups where lung cancer prevalence is higher.

— Reducing the stigma around lung cancer to encourage earlier presentation with symptoms.

3.5 Section 14Z—“In each financial year, a commissioning consortium must prepare a report (an “annual report”) on how it has discharged its functions in the previous financial year”

3.51 The annual report should include reference to measures on improving outcomes for cancer patients (including those on lung cancer mortality). This should include use of additional GP powers on referral to diagnostic tests and adherence to existing guidelines on lung cancer.

3.52 Where the board gives directions as to the content of a report, they should refer GP commissioning consortia to outcomes strategies produced by the Department of Health, including Improving outcomes: a strategy for cancer.

3.6 Section 23—Financial arrangements for consortia

Section 23 includes measures on the financial arrangements for GP commissioning consortia.

3.61 Sections 233L—“Payments in respect of performance”
3.62 Payments in respect of performance must take into consideration details on measures to improve outcomes in lung cancer as outlined above. Given its impact on one-year survival, this will ensure that earlier diagnosis of lung cancer will be prioritised.

Memorandum submitted by British Heart Foundation (HS 86)

The Health and Social Care Bill—Directors of Public Health (clause 27)

1. Directors of Public Health in local authorities are exciting roles with great potential to tackle the wide range of social determinants of health and health inequalities.

2. But to achieve this, they must have the protected independence, credibility, and authority to influence, advocate for, and advise on all policy areas that have a bearing on physical activity, healthy eating, and all aspects of population health and health inequalities.

3. The Health and Social Care Bill must therefore:
   — Require Directors of Public Health to have Executive Director status (second tier officers), reporting directly to the Chief Executive in the Local Authority.
   — Set out the statutory roles of Directors of Public Health including being a formal consultee, advocate and advisor on all policy areas and functions that have a bearing on health (such as planning, education and transport).

March 2011

Memorandum submitted by Baj Mathur (HS 87)

Concerns and Observations on the Proposals

Notwithstanding various initiatives which are already being taken in London and particularly in Hillingdon in respect of winding down PCTs and the formation of GP Consortia, the following issues need consideration:

1. Big Business: £80 billion worth of services will be commissioned. Fully opening up the NHS to Private Health Providers is a big financial deal. Private companies with their profit motive and shareholders’ interests should be keenly watched. Measures need to be put in place in respect of excessive profiteering.

2. Consultants: Large firms of consultants are and will be employed to help in the establishment and work of GP Consortia. They don’t come cheap.

3. GP Consortia are being/will be formed. How will it be ensured, that many GPs do not turn into managers and financiers? Are there not already serious constraints on GP’s own time?

4. Transition period: Instabilities and uncertainties during the transition period in particular impact on staff. Already there are redundancies on one hand, and efforts are being made on the other to find the right calibre of staff for the proposed new organisations.

5. Premises: Ensuring that no excessive resources are directed towards constructing new buildings to accommodate the new commissioning system.

6. Postcode Lottery: The proposals could lead to more inequalities as a result of postcode lottery in the Healthcare Services. How to ensure that this does not happen?

7. Health Watch: is charged with many responsibilities including taking, investigating, and reporting concerns of Patients and Carers. It needs to be stressed that for this organisation to be effective in carrying out all its functions it should be properly resourced, and have the power to impose sanctions.

March 2011

Memorandum submitted by Fiona Day (HS 88)

I was a GP who has taken extensive additional training to be a public health specialist. I am fully qualified with the Faculty of Public Health (http://www.fph.org.uk/) of the Royal College of Physicians (the body who oversees the standards and training of Public Health Doctors and Consultants) and the General Medical Council where I am registered as a Specialist in Public Health Medicine. I spent six years additional post graduate training after GP training to be a public health doctor and finally qualified to be a public health medicine consultant in 2009, 13 years after leaving medical school. (I should add that this is the normal length of time to train to be a specialist in public health medicine or any other medical specialty such as surgery). My point being that it takes a great deal of time to achieve the level of excellence and specialism required in my practice.
I am very concerned that rather than strengthening the discipline of public health, the reforms will weaken it. I have specialised in the area of public health relating to supporting commissioning decisions, ie ensuring that health and social care services meet the needs of the local population, are evidence based, reduce and do not further inequalities, and are made on the basis of sound financial investment decisions. This is often referred to as healthcare public health.

I do not believe that being a public health medicine consultant in the local authority is a viable option for public health doctors across the country like myself. We need to be close to the health care commissioning decisions and to do this we need to have legitimacy in the NHS. I believe that being employed by the local authority will weaken commissioning decisions and lead to significant financial waste, increased health inequalities, and result in poor quality health services which are not able to respond to current or future needs. In addition as the Wanless report commissioned by HM Treasury in 2004 under the previous government showed, we must invest in a strong public health approach if we are to prevent a future catastrophe to the health of our population from the consequences of today’s lifestyles and health inequalities.

My request to you is that public health medicine consultants should be employed by Public Health England or the NHS Commissioning Board, and not by the local authority. This is the view of the BMA, as well as the majority of my colleagues.

I would be grateful if the Public Bill Committee for the Health and Social Care Bill would address these concerns, and to highlight and amend the most damaging aspects of this legislation.

I have many other concerns relating to the fragmentation of the NHS and covert privatisation and the way which the current government is basing our NHS on an American model which has been shown to lead to spiralling costs.

Finally, please find enclosed a link to the British Medical Association statement on healthcare public health (my area of responsibility).


March 2011

Memorandum submitted by Fiona Duxbury (GP in Oxford) (HS 89)

Aspects of the Bill, such as the greater involvement of clinicians in planning and shaping NHS services, have the potential (if implemented well) to improve patient care. However, benefits that clinician-led commissioning can bring are threatened by other parts of the Bill, particularly:

Enforced competition: Forcing commissioners to tender contracts to any willing provider—including commercial organisations—could destabilise local health economies and fragment care for patients. Research indicates that healthcare is not like buying a shampoo. Choice of product worsens quality of care often and is usually more expensive. I like NICE: it ensures “best practice” scientific care, and helped us deliver cost-effective care. Most doctors would sign up to NICE. What we do not sign up to is “Choice” where NHS money is likely to be spent on the richer, worried well. Health inequalities are likely to be increased by enforced competition. The poor, sick and vulnerable, many of whom do not have access to the internet or the ability to fully understand choices, will be disadvantaged.

Price competition: The Bill will allow providers and commissioners to agree prices below the tariff set by Monitor (to be paid for different sorts of treatments), opening the door to price competition. I am concerned that such a move could allow some providers to chase the most profitable contracts, possibly using their multinational size to undercut on price, which could ultimately damage local services. Price competition has been shown to lead to a reduction in care quality.

Pace and scale of change: At a time of huge financial pressure, these major, untested reforms are, undoubtedly, a massive gamble. The deadline for all trusts to achieve foundation status, for example, is 2014. There is a real risk that forcing all hospitals to become foundation trusts before they are ready could lead to a focus on achieving financial stability rather than maintaining high quality patient care.

We GPs have a day job and are relative amateurs as regards management. I know some of my colleagues will be happy to move away from frontline service into administration and learn fast, but they will be rather expensive administrators compared to many at the PCT. They will be tempted to spend NHS money buying in expensive management consultancy firms.

I was pleased with the removal of the Strategic Health Authorities, and the drive to reduce PCT bureaucracy but that could simply and cheaply have been done by stopping the more daft Labour initiatives that had no outcomes research base for the value of the proposed intervention behind them. A slimmed down PCT focused on the essentials with clinician expertise as input advice would be a much simpler way of delivering a cost-effective NHS rather than destroying the NHS with this bill that is likely to cost £1.2 billion to implement and lots of TUPE payments to staff.
The proposed structure lacks democratic input. In Oxfordshire only we GPs have voted on the shape of things to come. There is no obligation to involve the public or hold meetings in public which the PCTs were obliged to do. So less public say with this new NHS Bill?

In Oxfordshire we are going to inherit a budget deficit. The deficit is partly the result of the tug of war between the Oxford Radcliffe Hospital Trust and the PCT. If the ORH “over-performs” on its contract the PCT has to pay up and whoever negotiates the hardest comes out the winner. All this juggling of paper leads to its own costs called “transaction costs” which are again a distraction from money going direct to patient care. The NHS Bill is about to encourage an escalation of “transaction costs” and meetings to negotiate prices. Actually what my patients repeatedly tell me they want (when offered choice of provider for a service through “choose and book”) is a local hospital or provider that does the job well to agreed standards. Audit of services: yes, with expert agreement on “best scientific practice”, ignorant choice: no.

To see how cost-effective the NHS currently is and understand how people feel about the NHS please look at this paper on comparisons between 11 different countries’ health care systems.

A selection of findings from the 2010 Commonwealth Fund International Health Policy Survey were originally published in:


Access to the paper can be found at http://content.healthaffairs.org/cgi/content/full/hlthaff.2010.0862?ijkey=Ho5xazsdWlHE&keytype=ref&siteid=healthaff

There are no doubt some doctors are motivated by money but many more of us genuinely just want to do the right thing by our patients. We will work hard in a system that has that ethos at its heart. The NHS competitive Bill will endanger that professional ethos forcing one part of the system to scheme against another instead of cooperate together.

March 2011

Memorandum submitted by PharmaTrust UK Limited (HS 90)

1. SUMMARY AND CONCLUSIONS

We would request that, in considering the draft bill, attention is paid to single integrated commissioning arrangement for medicines in order to reflect the following:

1. The need to quickly adapt to the further integration of care and shift of services between traditional providers. Thus a single integrated approach to commissioning of medicines management is required that doesn’t create arbitrary barriers between primary, specialist and hospital services.

2. A strategy led and integrated approach to how clinical services are commissioned through the National Commissioning Board and local commissioning consortia to ensure an integrated approach focused on patient need.

3. Commissioning and payment systems that reward and encourage desired behaviours to enable integrated medicines management. The focus should be on professional activities that are aligned to reducing errors and incorporate requirements for a pharmacist to interact with and counsel the patient (or carer/representative) in all cases when new medicines are dispensed regardless of location, rather than the current focus on payment for premises and dispensing processes.

4. Flexible approaches to pharmacist supervision and intervention that harness the use of modern technology and innovation. Thus allowing consistent and direct pharmacist involvement in all scripts regardless of the location and time of day without requiring actual physical presence.

The MedCentre provides the technology that enables delivery of higher quality pharmacy services, by ensuring personal one-on-one counselling and care from a pharmacist, with fewer errors and in a more accessible and ubiquitous manner. This model is exciting and disruptive and could revolutionise the delivery of safer and more accessible urgent care and related pharmacy services. It enables the Government’s legislative goals in that it puts patients first and at the centre of care. The PharmaTrust system improves efficiency and has enormous potential to improve health outcomes. Yet, the biggest risks to achieving these goals in terms of the delivery of pharmacy services (and elsewhere in the health care system) are the potential for vested interests to block such innovation and the potential for legislation and regulation to not be aligned to the goals of an integrated system.

We respectfully recommend that:

1. Government include key stakeholders, from all sectors, in the ongoing process to define an integrated and flexible commissioning process capable of driving and aligning the strategic imperatives and that these participants also include non-traditional suppliers such as PharmaTrust UK Ltd.
2. Proposed structures and models are flexible enough to anticipate the future integration of PharmaTrust type approaches to increase efficiency, better management of medicines and truly put the patient at the centre of care.

3. Legislation and regulation is drafted in a manner that encourages strategic imperatives to be addressed and enables new and innovative models of care using the latest technology enablers as opposed to protecting the status quo, presenting barriers to innovation or becoming quickly outdated.

Effective Medicines Management can help relieve the disease burden and save patients and the NHS untold hardship and cost burdens. Medicine errors, non-adherence and other failures have been identified as major challenges to the system that add dramatically to unnecessary admission and readmission rates and cause unacceptable levels of morbidity and mortality. This Bill is an opportunity to address some of the structural and alignment problems that are seen as major contributors to the problem.

2. Introduction to PharmaTrust UK Ltd

In response to the Health and Social Care Bill 2011 and the request for submissions and comments, PharmaTrust UK Ltd respectfully submits the following input and asks that it be taken into consideration as legislation is refined and further developed.

PharmaTrust UK Ltd is an organisation that enables the provision of enhanced pharmacy services through its patented technology (MedCentre™ and MedHome™) that has the potential to make pharmacists and medicines available wherever and whenever patients require them. The PharmaTrust technology was originally developed and validated in Ontario, Canada where MedCentres have been operational since 2008. The MedCentre enhances the availability and reach of pharmacists so that they can truly be the most accessible frontline health care professional.

The MedCentre is a complete pharmacist controlled, point-of-care medicines dispensing system. It can stock and dispense over 2,000 different medications. The MedCentres are under the direct supervision of a pharmacist who can intervene in real time at any point in the process. It ensures 24-hour access to medicines anywhere without the costs of traditional “bricks and mortar” pharmacies through the pairing of pharmacist expertise and innovative technology. The PharmaTrust system will significantly improve the management of medicines by enabling immediate access to medicines and pharmaceutical advice at point of care.

The MedCentre benefits to patients and the NHS are as follows:

1. Immediate access to prescription medicines at the point-of-care for all patients.
2. 24-hour pharmacies anywhere without the barriers of time, distance, or costs.
3. Pharmacists relieved of routine dispensing tasks to focus on patient counselling and clinical tasks.
4. Specialty or foreign language pharmaceutical advice available to all, wherever and whenever required.
5. Guaranteed full counselling of all patients by a pharmacist at the time of dispensing and as a routine follow up.
6. Reduced errors and untoward events through contraindications, compliance etc.
7. Consequential reduction in emergency hospital admissions.
8. Potential for new models for reimbursement for dispensing that get away from facility and script based reimbursement.

3. Our Interest in the Health and Social Care Bill

We recognise Pharmatrust has a legitimate commercial interest in how this legislation is framed. However the pace of change and innovation is accelerating and the MedCentre is just one example of a rapidly increasing myriad of new enabling technologies for which the NHS Act will need the flexibility to respond and adapt to if patient benefit is to be fully maximised.

We also recognise that the UK has been slow among developed countries to embrace the strategic opportunities to enable the shift in the locus of care from inpatient to ambulatory settings that modern technology facilitates in the management of complex diseases.

We firmly believe in the principle that any new legislation should be enabling and not prescriptive so it can adapt to the future unknown innovations that will be rapidly upon us. Without such flexibility we risk the possibility of the new Act being obsolete before it is on the statute book resulting in legislation and regulation being the barrier to innovation rather than the enabler.

The effectiveness of prescribed medicines is dependent on a number of factors involving the clinician, the pharmacist and the patient. The optimisation of these is a major challenge in developing effective medicine management systems. The potential negative factors are:

— The wrong medicine is prescribed.
— The patient fails to have his or her prescription filled.
— There are errors in the dispensing process.
— The patient fails to adhere to the required regime.
— The desired clinical outcome is not achieved.

Recently, a study conducted by Professor Nick Barber (Garfield, Barber, Wilson, Walley. BMC Medicine 2009) and other similar studies have indicated a minimum of 60% of prescriptions fail to deliver their maximum potential benefit. Thus any innovation that addresses the causes of these failures will:
— Contribute to the improvement in patient outcomes.
— Reduce the frequency of untoward events that lead to complications.
— Avoid unnecessary hospital admissions/readmissions.
— Reduce the cost of waste and unused medicines.

PharmaTrust believes its approach will help reduce these failures by ensuring all patients receive immediate access to their medicines and guaranteed patient communication with, and access to, a pharmacist at the time of dispensing and subsequently.

In section 4 below, we outline our concerns and the suggested approach to making the legislation more enabling. In section 5 we have addressed specific amendments to the current and proposed legislation that we believe should be considered by the Bill drafting committee. Our brief conclusions are in section 6. A specific example of how such changes will enable the more effective management of medicines in the proposed Urgent Care Centres is attached, as an addendum, in section 7.

4. KEY ISSUES TO BE ADDRESSED BY THE LEGISLATION

We believe that the causes of some of these failures identified above are the behaviours and incentives that the current bifurcated structures and reimbursement systems encourage. Our submission is intended to address some of the fundamental issues that the new Health and Social Care Bill and related legislation should address to facilitate a more integrated approach to medicines management, how it is reimbursed and how new integrated strategic innovation can be encouraged.

The most critical needs are that the new legislation will:

1. Ensure a single integrated approach to commissioning of medicines is established in such a way that funding and incentives will drive behaviours that are aligned with the patient’s and the system’s best interests. We have examples, at present, where cost shifting causes patient delays in access to their medicines and robust pharmaceutical advice. The consequence is that some prescriptions remain unfilled and the lack of immediate and ongoing access to robust pharmaceutical advice contributes to the high level of potential errors or adherence issues identified above.

2. Ensure that the structure and reimbursement systems are aligned to the goal of true integration of services. Examples currently exist where, on a single campus, an Accident and Emergency Department, an Urgent Care Centre and a GP Out-of-Hours service co-exist; each separately reimbursed, and managed and operating from physically remote locations with no common triage. This leads to patient confusion and duplication and doesn’t allow cost effective provision of medicine management services.

3. Recognise that the location of care is no longer an indication of the complexity of service (see schematic below). Secondary and Tertiary complex care is now delivered by specialists in home and ambulatory settings. The idea that all care delivered outside of hospitals is only delivered by GPs is no longer valid. To ensure provision for this trend there needs to be a single integrated approach to commissioning and funding of medicine management services. This should be aligned around the patient with the patient’s best interest driving all decisions and not be subject to an arbitrary split between GP and Specialist services.

THE HISTORIC CONNECTION BETWEEN LOCATION OF SERVICE AND LEVEL OF CARE NO LONGER APPLIES

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4. Remove the protectionist and silo mentality. This has led to inappropriate lines being drawn between levels of care and the evident hostility that exists between primary and secondary care providers. These behaviours can, to some extent, be traced to the way that services have been independently organised and...
commissioned around care levels rather than patient need. It should be recognised that care can be led and integrated by specialists into the community or vice versa. Both approaches are appropriate and should be dependent on the circumstances and nature of the patient’s condition and his or her needs.

5. Enable the use of new technologies that allow innovative approaches to more effective medicines management. The ability of a pharmacist in a registered premises or designated call centre, to oversee and intervene in dispensing in a remote location is essential to harnessing the capability of providing more accessible and safer access to medicines and pharmaceutical advice. This can be achieved through “Hub and Spoke” models utilising the responsible pharmacist in an existing registered facility (hub) to supervise the MedCentres (spokes) or pharmacists in a purpose designed call centre with delegated responsibility.

Using our own innovative technology and remote services, the attached example (see Section 7 Addendum) demonstrates how the proposed new models for “Urgent Care Centres” addressed in the new Act can be developed. The model incorporates an integrated approach to medicines management to produce improved patients’ outcomes and at lower costs. However, it requires flexibility in its governance commissioning and reimbursement.

The issues identified above need to be addressed by the Committee in drafting the Bill’s approach to the structure and alignment of the commissioning functions. In addition, we have identified below in section 5, suggested issues and legislative concepts for the Bill and related legislation that would assist in removing some of the existing barriers to effective remote supervision and intervention. The suggested amendments ensure consistent medicine management support at the point-of-care and ensure patients can receive essential pharmacist support to address, heretofore mentioned, causes of failure or error.

5. LEGISLATIVE SECTION

This part of PharmaTrust’s submission:

— Provides an overview of the current legislative framework relevant to the use of the PharmaTrust MedCentre, and similar technologies, in the United Kingdom; and

— Makes proposals for the amendment and clarification of the current legislative framework through the implementation of secondary legislation in connection with the Health and Social Care Bill.

1. Overview of relevant legislation

1.1 The starting point for an examination of the current legislative framework for the dispensing of medicines in the United Kingdom is the Medicines Act 1968 (as amended) (the “Act”). Part III of the Act contains provisions relating to the sale or supply of medicinal products. More specifically, section 52(1) of the Act provides that:

“... no person shall, in the course of a business carried on by him, sell by retail, offer or expose for sale by retail, or supply in circumstances corresponding to retail sale, any medicinal product which is not a medicinal product on a general sale list, unless—

(a) that person is, in respect of that business, a person lawfully conducting a retail pharmacy business;

(b) the product is sold, offered or exposed for sale, or supplied, on premises which are a registered pharmacy; and

(c) that person, or, if the transaction is carried out on his behalf by another person, then that other person, is, or acts under the supervision of, a pharmacist.”

1.2 Put briefly, there are—on a generalised level—three conditions that must be fulfilled for the dispensing of a medicinal product in a manner that is lawful and that complies with the Act:

(i) the person dispensing must be lawfully operating a pharmacy;

(ii) the dispensing takes place on a premises that is a registered pharmacy; and

(iii) the dispensing must be carried out by, or under the supervision of, a pharmacist.

1.3 The requirements in the Act in relation to condition 1.2(i) above are set out in Part IV of the Act. More specifically, section 69(1) provides that the person dispensing must be a pharmacist, and that the conditions set out in section 70 of the Act must be fulfilled in relation to the retail pharmacy business. Section 70 states that a “responsible pharmacist” must be in charge of the business at the premises where the retail pharmacy business is carried on.

1.4 Section 72A of the Act provides that it is the duty of the responsible pharmacist to secure the safe and effective running of the pharmacy business at the relevant premises. It also states that a person may not be the responsible pharmacist in respect of more than one set of premises at the same time.

1.5 In relation to condition 1.2(ii), section 74 of the Act provides a definition of “registered pharmacy” as the “premises for the time being entered in the register”. The register referred to in section 74 is maintained by the General Pharmaceutical Council.
1.6 Section 69(2) of the Act states that where: “a business which— . . . so far as concerns the retail sale of medicinal products, or the supply of such products in circumstances corresponding to retail sale, is or is to be carried on in one or more separate or distinct parts (but not the whole) of a building…each such part of that building shall be taken to be separate premises.”

1.7 There is one further section of particular relevance in the Act: section 54 provides that “. . . no person shall sell, or offer or expose for sale, any medicinal product by means of an automatic machine unless it is a medicinal product in the automatic machines section of the general sales list.”

2. Proposals for amendment of the current legislative framework
Mechanisms for amendment

2.1 The discussion and enactment of the Health and Social Care Bill represents an important opportunity for amendments to be made to the current legislative framework to more clearly enable the widespread use of remote dispensing technology in the United Kingdom. Furthermore, the groundwork for such amendments was laid by the Health Act 2006, which introduced sections 10(7A)—10(7C) and sections 52(2)—52(4) into the Act.

2.2 Section 10(7A) of the Act states that:

“The Ministers may make regulations prescribing conditions which must be complied with if a thing is to be considered for the purposes of [Section 10 of the Act] as done under the supervision of a pharmacist.”

2.3 Section 52(2) and 52(3) of the Act provide that:

“(2) The Ministers may make regulations prescribing conditions which must be complied with if a transaction mentioned in [section 52(1)(c) of the Act] is to be considered for the purposes of [section 52 of the Act] as done under the supervision of a pharmacist.

(3) Conditions prescribed under subsection (2) may relate to supervision in the case where the pharmacist is not on the premises…”

2.4 There is, therefore, an opportunity for secondary legislation to be enacted in parallel with the Health and Social Care Bill to more clearly enable the widespread use of remote dispensing technology.

Suggested legislation

2.5 We have set out below the key points that PharmaTrust believes should be addressed in secondary legislation enacted pursuant to sections 10(7A) and 52(2) and (3) of the Act:

2.5.1 Pharmacist supervision by video and secure audio link is supervision by a pharmacist for the purposes of section 52 of the Act.

<table>
<thead>
<tr>
<th>Key issue</th>
<th>Core legislative concepts</th>
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<tbody>
<tr>
<td>Video and secure audio link</td>
<td>A live video link to a pharmacist, combined with a secure, private audio link, should be regarded as appropriate supervision by a pharmacist of the dispensing of a medicinal product to the patient or carer using that link.</td>
</tr>
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</table>
| Remote dispensing kiosk | A “remote dispensing kiosk” is a machine that:
(i) is physically remote from the place from which the pharmacist responsible for dispensing from the machine (or his or her agent) is present at the time of dispensing;
(ii) is controlled remotely by a suitably qualified and trained pharmacist;
(iii) enables such pharmacist to counsel the user via a video and secure private audio link in relation to the dispensing of a medicinal product;
(iv) provides such pharmacist with the ability to verify the prescription provided by the user through the use of appropriate high resolution scanning technology;
(v) provides for the safe storage of medicinal products as well as users’ prescriptions that have been verified via, and retained by, the kiosk; and
(vi) enables the relevant pharmacist to determine in his or her sole discretion whether or not to dispense the prescribed medicine. |
| The ability of a pharmacist to intervene | A remote dispensing kiosk (as defined) shall be regarded as providing the pharmacist controlling the kiosk at the relevant time with the ability to intervene in the dispensing of a medicinal product from such secure dispensing kiosk. |
| Section 52(1)(c) of the Act | The use of a remote dispensing kiosk for the sale by retail, offer or exposure for sale by retail, or supply in circumstances corresponding to retail sale of any medicinal product which is not a medicinal product on a general sale list shall be regarded as being in compliance with section 52(1)(c) of the Act. |
### 2.5.2 A remote dispensing kiosk is an extension of a registered pharmacy

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<thead>
<tr>
<th><strong>Key issue</strong></th>
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<tbody>
<tr>
<td>Remote dispensing kiosk</td>
<td>See above in 2.5.1.</td>
</tr>
<tr>
<td>No independent registration of a remote dispensing kiosk</td>
<td>No independent registration of a remote dispensing kiosk shall be required provided that such kiosk is under the control of a registered pharmacy. A remote dispensing kiosk shall be regarded as being under the control of a registered pharmacy where the responsible pharmacist at such pharmacy is able, whether on his own or through his employees or agents, to authorise, intervene in or prevent the dispensing of any medicinal product from that kiosk.</td>
</tr>
<tr>
<td>Under the control of a registered pharmacy</td>
<td>Each remote dispensing kiosk shall be under the control of a registered pharmacy.</td>
</tr>
<tr>
<td>Section 52(1)(b) of the Act</td>
<td>The dispensing of a medicinal product from a remote dispensing kiosk shall, for the purposes of section 52(1)(b) of the Act, be regarded as taking place on the premises of the registered pharmacy by which such remote dispensing kiosk is controlled.</td>
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### 2.5.3 Responsible pharmacist: application to a pharmacy and related remote dispensing kiosks.

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<tr>
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<th><strong>Core legislative concepts</strong></th>
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<tbody>
<tr>
<td>Responsible pharmacist for a remote dispensing kiosk</td>
<td>A responsible pharmacist shall be regarded as being in charge of the business carried out at the remote dispensing kiosk where such pharmacist is the responsible pharmacist in relation to the pharmacy by which such remote dispensing kiosk is controlled. A pharmacist may act as the responsible pharmacist in respect of one or more a remote dispensing kiosks and the registered pharmacy by which they are controlled.</td>
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<tr>
<td>Lawful conduct of a retail pharmacy (Section 69(1) of the Act)</td>
<td>A person shall be taken to be lawfully conducting a retail pharmacy business through a remote dispensing kiosk where (i) such remote dispensing kiosk is under the control of a registered pharmacy and (ii) the responsible pharmacist for such registered pharmacy is also designated as the responsible pharmacist in charge of the business carried out at the remote dispensing kiosk.</td>
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### 2.5.4 Responsible pharmacist: appropriate delegation of operational responsibility.

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<tr>
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<tr>
<td>Appropriate delegation of operational responsibility in relation to the remote dispensing kiosk</td>
<td>The responsible pharmacist in relation to a remote dispensing kiosk shall be entitled to delegate operational responsibility in respect of the relevant kiosk to an appropriately qualified pharmacist provided that the responsible pharmacist (i) shall remain liable for the acts and omissions of any such agent(s), and (ii) shall put in place appropriate contractual provisions with such agent(s) to ensure compliance by the agent(s) with all applicable legislation and professional standards and guidance.</td>
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<tr>
<td>Delegation of out of hours operational responsibility in relation to a remote dispensing kiosk</td>
<td>To enable patient access to a remote dispensing kiosk at times when the pharmacy which formally controls such kiosk is not open, the responsible pharmacist at that pharmacy shall be entitled to delegate operational responsibility in respect of the relevant kiosk provided that the responsible pharmacist (i) shall remain liable for the acts and omissions of any such agent(s), and (ii) shall put in place appropriate contractual provisions with such agent(s) to ensure compliance by the agent(s) with all applicable legislation and professional standards and guidance.</td>
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### 2.5.5 Responsible pharmacist notice requirements: application to a remote dispensing kiosk.

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<tbody>
<tr>
<td>Responsible pharmacist notice requirements at a remote dispensing kiosk</td>
<td>There shall be displayed at any remote dispensing kiosk a notice that complies with section 70(3) of the Act, provided that the name of the relevant responsible pharmacist displayed shall be the name of the responsible pharmacist carrying on business at the relevant time at the registered pharmacy by which the remote dispensing kiosk is controlled.</td>
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2.5.6 A remote dispensing kiosk shall not be regarded as an “automatic machine” for the purposes of section 54 of the Act.

<table>
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<tr>
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<tr>
<td>A remote dispensing kiosk is not an “automatic machine” (section 54 of</td>
<td>A remote dispensing kiosk shall not be regarded as an “automatic machine” for the purposes of section 54 of the Act where such kiosk is under the control of a registered pharmacy.</td>
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<tr>
<td>the Act)</td>
<td>A remote dispensing kiosk may be used for the dispensing of general sales list products as well as prescription-only and pharmacy-only medicinal products.</td>
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2.5.7 Use of remote dispensing kiosks in the course of business of a hospital or health centre.

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<thead>
<tr>
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<th>Core legislative concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote dispensing kiosk use where compliance with section 52 is not</td>
<td>The use of a remote dispensing kiosk in a hospital or health centre shall be permitted where section 55 of the Act applies.</td>
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<td>required</td>
<td>Consistent with the application of section 55 of the Act, in such a case the remote dispensing kiosk need not be under the control of a registered pharmacy, and the responsible pharmacist regime will not apply.</td>
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<td></td>
<td>Operational delegation of responsibility for dispensing via a remote dispensing kiosk in a hospital or health centre may be delegated on the same basis as set out in 2.5.4 above*.</td>
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* The absence of any required pharmacists involvement in the counselling of patients and the ability by a responsible pharmacist to intervene is inconsistent with the intent of the legislation. Remote supervision through video conferencing etc. addresses the logistic issues which precluded this requirement in hospital and health centres. The patient’s interest would be better served if the requirements were consistent regardless of the location of dispensing.

6. CONCLUSIONS

We respectfully recommend that:

— Government include key stakeholders, from all sectors, in the ongoing process to define an integrated and flexible commissioning process capable of driving and aligning the strategic imperatives and that these participants also include non-traditional suppliers such as PharmaTrust UK Ltd.

— Proposed structures and models are flexible enough to anticipate the future integration of PharmaTrust type approaches to increase efficiency, better management of medicines and truly put the patient at the centre of care.

— Legislation and regulation is drafted in a manner that encourages strategic imperatives to be addressed and enables new and innovative models of care using the latest technology enablers as opposed to; protecting the status quo, presenting barriers to innovation or becoming quickly outdated.

Effective Medicines Management can help relieve the disease burden and save patients and the NHS untold hardship and cost burdens. Medicine errors, non-adherence and other failures have been identified as major challenges to the system that add dramatically to unnecessary admission and readmission rates and cause unacceptable levels of morbidity and mortality. This Bill is an opportunity to address some of the structural and alignment problems that are seen as major contributors to the problem.

7. ADDENDUM—A NEW APPROACH TO MANAGEMENT OF MEDICINES IN URGENT CARE CENTRES

Situation

The further development of Urgent Care Centres (UCCs) is seen by the Government as a means of improving access to care. These Centres will be part of an integrated offering either in a hospital, as an adjunct to the A&E department, or as freestanding centres located in the community. In either case they will bring local GPs into a structured system of governance with clear accountability for managing the urgent care of defined populations and communities. The characteristics are as follows:

— Resources for out-of-hours and urgent care will be concentrated into centres with sufficient critical mass.

— The intent is to reduce demand for or replace the ad hoc system of GP on-call.
— Where appropriate the centres will be integrated with existing A&E departments which already attract high volumes of “walking wounded and worried well”.
— The larger centres could have volumes of >100,000 visits pa.
— Funding will likely be a capitated budget for delivery of care and service.
— Budgets will cover the complete episode of care.
— Prescriptions could be in the form of internal hospital prescriptions. FP10 HPs or FP 10s.
— A variety of dispensing services with or without the intervention of a pharmacist are likely to be deployed.

Opportunity
PharmaTrust UK Ltd has identified its purpose as “to facilitate accessible, affordable and error-free drug dispensing with the intention of reducing unnecessary hospital admissions and patient visits caused by medicine errors and non-compliance.”

PharmaTrust’s MedCentre technology allows it to offer a more cost effective dispensing process immediately available, all hours, at the point of care, with improved patient counselling and compliance. It allows customisation of the formulary to the agreed care pathways and pharmacist involvement throughout the prescribing and dispensing process. Such integration can enable a model for urgent care that would offer improved outcomes to commissioners whilst sharing the risk and controlling the overall costs.

The UCCs are ideal venues to demonstrate the company’s capability to deliver on this vision. The new UCCs are potentially vulnerable in their ability to manage and control medicines costs. FP10s filled in the community will be charged to the NHS payment authority whereas FP10HPs and internal hospital prescriptions are charged back to the individual centre’s budget. This mixture of fee-for-service funding of prescriptions is not aligned to the effective management of prescribing or dispensing.

PharmaTrust has the opportunity to offer a new model by working in partnership with the centres’ clinicians. The offer would be to manage the medicines process and related costs within a capitated local pharmacy services contract (LPS). In conjunction with the management of the UCC and its clinicians, detailed patient pathways with prescribing guidelines and a formulary would be developed. It also has the opportunity to review a patient’s overall medicines regime and avoid potential long term consequences of inappropriate medicines management.

PharmaTrust has identified a number of partners with existing or proposed involvement in UCCs. PharmaTrust has also been in consultation with the Department of Health (DH) to ascertain their interest in new innovative models that may conflict with current reimbursement practices and possibly some aspects of regulation.

Legal advice has been obtained on models and reimbursement approaches that could be employed for the UCCs. It is important, initially, to create a business model that can operate within the allowed section 55 exceptions for Hospital and Health Centres under the Medicines Act.

An option that we believe would have attractions to government and remove the ambiguity and need for a NHS contract would be a Local Pharmacy Services (LPS) contract. This is a capitated or fixed price contract for full provision of medicine management services to a prescribed population or community. Thus the government’s liability is capped or based on a capitation model. This has the potential to align and integrate the interests of the clinicians as prescribers with the pharmacists responsible for the supply of medicines as dispensers. It would also shift focus to the overall better management of the patient’s medicines needs and profile.

March 2011

Memorandum submitted by the British Society for Rheumatology (HS 91)

BSR is a medical specialty society promoting excellence in the treatment of people with arthritis and musculoskeletal conditions, and supports those delivering it. BSR has a 25 year history of promoting high quality standards of care, and providing education, training and support to those working in rheumatology. With more than 1,500 members including rheumatologists, scientists, trainees, allied health professionals and others from the UK and overseas, BSR also has close links with a number of patient groups, including Arthritis Care, National Rheumatoid Arthritis Society (NRAS) and Arthritis and Musculoskeletal Alliance (ARMA).
EXECUTIVE SUMMARY

— BSR strongly supports greater patient involvement and the emphasis on putting the patient at the centre of care and the concept of “no decision about me without me”.

— BSR welcomes the opportunity for increased chances of working directly with frontline colleagues in primary care.

— Specialists, including consultants, other health professionals and key stakeholders must be involved in commissioning in addition to General Practitioners.

— GP consortia must have robust and transparent commissioning processes.

— GP commissioning must include provision of services for complex and long term rheumatological conditions.

— Many musculoskeletal (MSK) conditions require long term multi-disciplinary and multi-specialty input. The introduction of competition in commissioning of services could create the risk of fragmentation of existing good quality clinical networks.

— The NHS Commissioning Board (NCB) should have responsibility for ensuring that regional variations to services do not increase health inequalities for people with arthritis.

— A medical expert on musculoskeletal disorders is needed on the NCB to ensure Rheumatology services are appropriately commissioned across the country and are not dependent on GP awareness.

— Providing a service commissioned by a number of consortia, where each consortia is commissioning different levels of service could lead to clinicians spending much time identifying what they can and cannot do for a patient and loss of coordination and strategic planning.

— BSR welcome the greater emphasis on quality and outcome measures rather than focussing on targets that may not be clinically relevant.

— BSR supports the strengthening of NICE and would welcome opportunities for further engagement in production of guidelines and development of national audit tools.

— BSR welcomes the greater emphasis placed on chronic diseases. We hope that it is recognised that most MSK conditions are chronic, potentially progressive and disabling and/or life shortening.

FULL RESPONSE

1. BSR promotes the involvement of patients in decisions about their care, and promotes a patient specialist partnership, as this helps to promote high quality care. Therefore, BSR supports the strengthening of the patient voice and the creation of HealthWatch. However, in order to strengthen the patient and carer voice, current systems need to be evaluated.

2. Patient involvement needs to work at all levels; nationally, locally and at individual levels. BSR works nationally with organisations such as ARMA and Arthritis Care to influence policy for those with MSK. At a local level, clinicians are working with local patient groups to help develop better services and commissioning. All clinicians discuss treatment options with their patients, and work with their patients so that they are able to make an informed choice about the treatment they receive.

3. BSR welcome the opportunity for GPs and other clinicians to be involved in commissioning services. In order for commissioning to be successful, it will be important to ensure that all stakeholders, particularly specialists, are involved in the planning and commissioning of all services. This is particularly the case for specialist services and for those with complex and long term conditions.

4. BSR believe that to ensure that services for people with MSK conditions are effective and equitable; the NCB should have an MSK expert to advice and support their work, supported by a clinical network. The recent report from the National Audit Office identified low awareness of RA among the GP community. Having expertise at a national level will help to ensure that essential services for these patients are not overlooked.

5. BSR is concerned that communication and coordination between consortia and secondary care will not be effective without specific guidance and support in place. Input from specialists will be needed for the consortia commissioning decisions. This will allow them to plan pathways across primary and secondary care, strengthen referral patterns and improve the flow of information about the quality of care.

6. There is fear that if GP consortia are to be smaller than PCTs, a loss of coordination and strategy will occur in the commissioning of hospital services. Robust governance arrangements that emphasise the quality of care rather than its locus of delivery should drive commissioning. Safeguards need to be in place to prevent bias towards primary care provision over secondary care, which cannot be justified on quality grounds. For example, clinical governance arrangements need to include a statutory requirement for external scrutiny.
7. BSR is concerned that the introduction of competition could lead to the fragmentation of services. The chronic, systematic and disabling nature of many MSK conditions requires long term multi-disciplinary and multi-specialty input. The value of the introduction of competition in commissioning of services needs to carefully be considered to ensure that fragmentation of existing good quality clinical networks does not take place.

8. To reduce the risk of such fragmentation of services occurring, specialists as well as public health doctors must share positions within the governance structures of GP consortia so that they can contribute their knowledge and expertise to commissioning care. Consortia should also have access to networks of MSK specialists, such as currently takes place in cancer and cardiac networks. It is suggested that the NCB should develop sub-groups of clinicians that look at specialised commissioning in the different specialties.

9. The commissioner provider separation should not be too rigid, as it could obstruct both cost effective service development and integrated multidisciplinary working across specialties.

10. GP consortia can most effectively take responsibility for improving the quality of the primary care provided by their constituent practices through a system of Benchmarking for Best Practice. Consortia will need to work with the NCB to ensure there are appropriate indicators of best practice. However, these should be flexible enough to recognise the varied nature of consortia and practices.

11. For an effective relationship between NCB and GP consortia to be developed there should be a system of internal and external review where results are made available to the stakeholders such as the NCB, GP consortia, service providers, commissioners, service users and the general public. It will be vital for the NCB to actively ensure that regional variation in services is minimised so all patients can access the services they need. There will need to be transparency to enable people to be aware of what services will and will not be commissioned in their locality and the reasons why. The NCB need to monitor GP consortia to ensure those that are experiencing difficulty, such as financial overspend or risk of failing, are identified at an early stage and robust processes are in place to ensure continuity of services for patients.

12. The NCB needs to gain a broad range of views about GP consortia. This should be at a regional and local level, as well as the views of stakeholders. It will be important for the NCB to have well-defined processes to gather this information. BSR anticipate that this will include formal consultation in addition to informal information gathering. It will be particularly important to ensure that a mechanism to engage all of society, including hard to reach groups, is developed.

13. It is possible that the NCB could publicise/disseminate best practice examples and awards for those consortia that show the greatest efficiency or greatest effect on service users. This could support efficient and effective local commissioning. The NCB should establish a research programme to allow good practice from the UK and worldwide to be identified.

14. The relationship between GP consortia and individual GP practices is key. More detail is needed on this area to ensure there is a sustainable relationship.

15. Involving all stakeholders in consortia is vital. Although challenging, it will be imperative that the broadest range of stakeholders is involved and that processes are developed to engage with hard to reach groups. If this does not take place there is a risk that a true representation of the community you are seeking to serve, is not gained. Each consortium will need to develop relationships in their locality. However, it would be useful for models of best practice in this area to be shared to help each consortium build these relationships effectively. Consultation will need to be proactive and passive and not reliant on those easy to reach.

16. To promote and sustain multi-professional involvement in commissioning other Health Professional representation needs to be on the GP consortia. Such individuals should have experience of the commissioning process, thorough knowledge of or the links to consult with experts across the other health professions and the ability to reflect the needs of the varied patient case-loads across the locality. There needs to be representation for nursing services, pharmacological services and support services.

17. There has already been progress in increasing close working between the NHS and local authorities and further work in this area is welcomed. However, decisions taken by either party can impact adversely on the service of the other providers. For example, if a local authority cuts access to adult social care, this can impact on the NHS ability to discharge patients back to the community. At a time when there is increased pressure on local authority and NHS budgets such scenarios are highly likely and consideration needs to be given to how decisions can be taken more collaboratively.

18. Some consortia will commission services from the private and voluntary sectors. It is vital that these are recognised as key stakeholders and engaged in the work of consortia.

19. It will be important to ensure that Health and Wellbeing Boards have a clear remit and are expected to deliver key outcomes. Without this there is a danger that they will be ineffective.

20. There are certain aspects of current practice in MSK services that would need to be preserved in the transition to new arrangements. For example, a multi-disciplinary team is a vital part of the care that patients with MSK conditions receive. Other important aspects include clinical audit, strong clinical governance and holistic services as opposed to fragmented ones.
21. There should be national standards and outcome measures for musculoskeletal conditions. Given the complex nature of many MSK conditions, there need to be a wide range of indicators, and it may be that 150 indicators are not enough. BSR is concerned that areas not covered by an indicator could fall down the priority list.

22. There needs to be adoption of national standards/outcome measures such as those exemplified by NICE guidance for Rheumatoid Arthritis as well as Cardiovascular Disease. However, there have been gains made through targets such as lowering waiting times, and it is important not to lose focus on the gains made.

23. BSR has extensive experience of working constructively with NICE since its inception, particularly on Technology Appraisals for biologic drugs and Disease Management Guidance for Rheumatoid Arthritis. BSR considers that production of quality guidelines and audit tools are required to improve quality of care for individuals with rheumatic diseases, and such guidelines should feed into on-going discussions on quality metrics and whenever possible into Quality Outcomes Framework (QOF) for primary care.

24. Specialists should support the Board and Monitor for pathways appropriate for a national tariff. Government is seeking to align tariff arrangements with clinical pathways and link quality measures to payment arrangements. There is the opportunity for specialists to use their knowledge to support the Board and Monitor in relation to the pathways that would be appropriate for a national tariff, as well as advice on what is needed to support those pathways and their implementation.

March 2011

Memorandum submitted by Dr Elisabeth Paul (HS 92)

1. I am a GP trainee and have worked as a junior doctor, in hospital and community medicine as well as in primary care, for the past five years. I am looking forward to a long career as a GP in the NHS. I am very concerned about the implications that the Health and Social Care Bill has for the way I will be able to care for my patients in the future. I am also concerned about its implications for training of future generations of doctors.

2. It appears to me that the ideology behind the Bill is one of privatisation of the NHS. I do not believe that health care benefits from functioning as a free market. The cheapest provider is not necessarily the best provider of care. Patients are not a commodity from whom health care providers should be making a profit. The most at-need patients often require the most complicated, and costly, care, and these are the patients who will suffer if for-profit companies are able to compete as “any willing providers”.

3. Andrew Lansley was elected on the basis of promises that there would be no more “top-down reforms” of the NHS. He made no mention of any of these proposed reforms prior to the election and therefore has no mandate to implement them.

4. The majority of GPs are either not trained to commission services, or do not wish to. This means that inevitably such a process will fall to outside professionals many of whom will seek to make a profit from the commissioning process. This, added to the costs of implementing the proposed changes, makes a mockery of the suggestion that the Bill will save the taxpayer money.

5. The Bill seems to have little recognition of the essential role of the NHS in educating the next generation of doctors. Our time at medical school provides us with a grounding, but the real education comes from working as a doctor. Our Deaneries are vital to ensure that junior doctors are receiving adequate training to enable us to continue to improve and provide the high quality of care to our patients, and I cannot see any good reason for proposing their abolition. There needs to be regional and national structures to oversee our training, without it there is the risk of geographic variations in quality and poorer standards overall. I find it hard to believe that private companies will be as well equipped to provide adequate training. The junior doctors of today (and we are the doctors that you see in the middle of the night, in A+E, the “frontline of the NHS”) need to be well supported and trained so that we can develop into the excellent senior clinicians of the future.

March 2011

Memorandum submitted by Dr Claire Royston (HS 93)

Medical Director, Care Principles

Key areas covered in this submission by Care Principles to the Health and Social Care Bill Committee:

— Need for specialist NHS commissioning body for vulnerable learning disabled patients with complex difficulties, particularly those who have committed serious offences and require secure care and treatment. Other vulnerable groups include individuals with complex presentations of autism or Aspergers syndrome.
— Need for specialist psychiatrists to be significantly involved in commissioning for these patient groups.
— Commissioning to be flexible, least restrictive and to provide a total care pathway, rather than a single episode of care.
— There should be recognition of the need for specific facilities for women learning disability and complex needs particularly those with personality difficulties or a forensic history.
— Payment by results and fixed national tariffs work less well in care for patients with very complex needs arising from learning disabilities as such patients needs fluctuate between various secure environments and service providers.

PART ONE

1. Introduction

1.1 Care Principles is an independent provider of services for people with learning disabilities and mental health problems. Founded in 1997 by a group of clinicians, Care Principles has established extensive clinical expertise in treating patients and has specialized in developing care pathways for individuals with complex difficulties arising from a learning disability including those with challenging behavior or a forensic history, personality difficulties and individuals with autism or aspergers syndrome. Care Principles’ patients are, almost without exception, NHS patients. Care Principles proudly sees itself as working in partnership with the NHS.

1.2 Care Principles now offers over 450 beds in 17 secure hospitals, community hospitals and care homes around England, and employs 1,500 clinical and healthcare professionals, including psychiatrists, clinical psychologists, specialist nurses, occupational therapists, social workers and support workers.

1.3 Care Principles is part of an independent sector that leads the field in secure care for people with learning disabilities. The independent sector now provides half of beds for people with learning disabilities detained under the Mental Health Act. (In 1998 15% of individuals with a learning disability were detained within independent hospitals. This had grown to 46% of individuals (545 of 1,184) in 2008—The 13th Biennial Report of the Mental Health Act Commission.)

1.4 NHS commissioners recognise that, collectively, the independent sector has an immense knowledge base and clinical expertise in how best to provide tailor-made, personalised and specialist care to the above patient groups who often have challenging and/or offending behaviour and require secure care and treatment.

1.5 Care Principles notes that other submissions to the Health and Social Care Bill Committee—particularly that by the Royal College of Psychiatrists (RCP)—has highlighted many aspects to the bill which Care Principles shares. These include the welcoming of the bill’s focus on clinical outcomes and an increased involvement of clinicians in commissioning care and treatment.

2. Don’t forget people with learning disabilities

2.1 On behalf of Care Principles I would like to emphasise that policy initiatives to meet the clinical and rehabilitation needs of learning disabled offenders following Lord Bradley’s 2009 report must continue, and that the bill ensures this through measures laid out in Part 2 of this submission.

2.2 I would remind the committee that there are an estimated 5,800 prisoners with a diagnosis of learning disability. According to Prison Reform Trust research these individuals suffer “routine human rights abuses”. Further evidence of their vulnerability in prison is research (included in the Prison Reform Trust report, No One Knows) indicating that they are five times more likely to be restrained and three times more likely to be segregated than non-learning disabled prisoners. These are harrowing statistics. Lord Bradley, 2009, noted that “custody exacerbates mental ill health, heightens vulnerability and increases the risk of self-harm and suicide.”

2.3 Lord Bradley also drew particular attention to Baroness Jean Corston’s 2007 report focusing on women in the criminal justice system who have particular vulnerabilities, including learning disabilities.

2.4 As a consultant psychiatrist with 27 years of clinical experience I am confident most of the estimated 5,800 learning disabled prisoners, some of whom have committed serious crimes; have not been assessed to determine if specialist treatment to address both their learning disability and offending behaviour would be appropriate. It is my view that many such prisoners would be likely to benefit from specialist secure hospital care and treatment. It’s unacceptable they are not receiving it. Commissioners would share my recognition of this shortcoming.

2.5 It is vital to emphasise that the provision of appropriate assessment and treatment for this group can not only deliver significant therapeutic benefits to the individual but would also benefit society as a whole. This is because effective treatment reduces the likelihood of re-offending and the burden of harm—and associated multiple costs—to any future victims.
2.6 In its submission to this committee, the RCP highlighted the great importance of protecting the needs of patients with severe and complex mental disorders. I agree. But the bill must also make sure it protects the needs of people with learning disabilities, including those languishing in Britain’s prisons.

2.7 People with learning disabilities have historically lost out when compared to people with mental health problems. Throughout British psychiatric and mental health history—from the closing of the Victorian asylums to community care and revisions to the Mental Health Act—policy has always been weighted more towards people with mental health problems than those with a learning disability. The Health and Social Care Bill—representing the biggest-ever proposed change to NHS structures—is a watershed moment to help redress this imbalance.

**PART TWO**

3. Key areas for Care Principles—Health and Social Care Bill 2011

(i) Vulnerable learning disabled patient groups.

3.1 The bill must protect the interests, and ensure appropriate and cost-effective clinical and care pathways, for the following three patient groups.

(a) Offenders with a learning disability.

(b) Offenders with a learning disability and a personality disorder.

(a) People with complex presentations of autism.

3.2 Due to the complexity of the difficulties presented by these three patient groups and the risks they often present both to themselves and others, many will require institutional—often secure—care for a significant part of their lives.

3.3 Many patients will be managed within the framework of the Mental Health Act and/or the Mental Capacity Act.

3.4 Nationally, these three groups represent a relatively small number of individuals—perhaps less than 10,000. However, potentially they may be disproportionately vulnerable within proposed commissioning arrangements as presented in the bill. The reasons for this are laid out below.

(ii) GP consortia.

3.5 GP consortia are likely to be ill-equipped to manage and commission the complicated and often lengthy care pathways of the three patient groups I have identified. Research in July 2010 by mental health charity Rethink reported that just 31% of GPs felt equipped to take on the role of commissioning mental health services. This percentage could be lower for the very complex learning disabled patient groups I have identified.

3.6 For example, a patient who has committed a sexual offence and has been diagnosed with a learning disability may be transferred, over the course of five years, from a medium secure unit, to low secure and back up to medium secure. GPs, who may not even have had face-to-face consultations with such patients, lack familiarity with the range of clinical, risk assessment, and legal particulars (Mental Health Act and Mental Capacity Act) involved in this person's care, treatment and rehabilitation.

3.7 Plus, due to the relatively low numbers of patients within these groups most GPs would have extremely limited—if any—experience of commissioning for them.

(iii) Payment by results and national tariff.

3.8 While payment by results and fixed national tariffs may be viable and applicable in many areas of healthcare—such as surgery or treatment for depression—it works less well in care for the three patient groups I am focusing on. This is because such patients' care needs—including that of the example patient above—may fluctuate between various secure environments, and service providers, over years and even a lifetime. It will be inherently problematic to provide one national tariff for such service variations to meet the healthcare and risk-management needs of such patients.

3.9 Moreover, if a patient is in medium-secure care and it is decided that for clinical reasons they are able to move to a low-security facility, then presently a new commissioning agreement has to be initiated. Because of this, what is happening up and down the country is that even if it is in the patient’s clinical interests to “step down” to a community hospital environment, clinicians can be inhibited or delayed in arranging a transfer. Even the best risk assessment of the appropriateness of the move cannot guarantee that a patient will adapt to the new environment. Trial transfers and the ability for a clinical team to respond immediately to a failed transfer by a move back to conditions of greater security are inhibited by the current separate funding structures. The result is that clinicians feel compelled to keep patients in an unnecessarily higher level of security than their patients are rightfully, and clinically, due. This is not only wrong, it is alarming, especially when considering the additional constraints on a person’s liberty that being held in higher-than-needed security entails and the significant cost implications.
3.10 In light of this, it is important that flexible care pathways are commissioned for these patient groups, and that the pathways include transitions through various levels of security based on clinical need and not restricted by fixed and separate budgetary frameworks. Questions must be asked as to whether GP consortia, for reasons outlined above, have the skills and knowledge to handle this commissioning paradigm.

3.11 I also urge the committee to reflect on the above points while remembering that Valuing People Now (DoH 2009) trumpets inclusion, independence (personal development/competence) and choice (control) for people with learning disabilities. Valuing People Now states that people with learning disabilities should have the same rights and choices as everyone else, and should have an equal right to be treated with dignity and respect. Indeed the learning disabled patient groups I am focusing on are among the most vulnerable and marginalised people in our society. So, particularly for these patients and in order to adhere to the principles of Valuing People Now, care within the least restrictive environment must be a commissioning goal. Again, if that means a clinician deciding that stepping down to a low-secure environment is in the patient’s healthcare and person-centred interests this should be provided without the administrative requirements of a new commissioning process acting to impede the delivery and quality of clinical care.

(iv) Specialist NHS Commissioning Board Committee.

3.12 In its remit for the NHS Commissioning Board, the bill states that: “The Board may appoint such committees and sub-committees as it considers appropriate”

3.13 For the reasons I have discussed, such a specialist committee is required for the three patient groups I am focusing on. A NHS Commissioning Board specialist committee, and not stand-alone GP consortia, would be the appropriate forum for the development of commissioning expertise for these patient groups.

(v) Psychiatrists’ involvement in commissioning.

3.14 The RCP and the Royal College of Practitioners have both stated that in order to meet the needs of mental health patients with complex difficulties, the role of psychiatrists in advising commissioners will be vital. I agree. But I would add that the same applies to the learning disabled patient groups I have identified. Again I urge, don’t forget people with learning disabilities.

(vi) Joint Commissioning Sub-Panel For Learning Disability.

3.15 In its submission to the committee, the RCP discussed how it has launched, with other bodies, a Joint Commissioning Panel For Mental Health. This panel will provide commissioners with knowledge, skills, and tools and insight, as well as launching a practical framework for mental health commissioning.

3.16 I support this, but again I would ask that the committee take the opportunity to reflect on the need, as mentioned previously, to re-dress the policy emphasis towards people with mental health problems. Would a separate Joint Commissioning Panel For Learning Disabilities help redress this imbalance? Or perhaps a sub-panel for learning disabilities within the Joint Commissioning Panel For Mental Health or appropriate panel members with experience of learning disability.

PART THREE
References:
Royal College of Psychiatrists. *Health and Social Care Bill 2011*: Royal College of Psychiatrists; Second Reading Briefing; House of Commons.

Lord Bradley. Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system, 2009.


March 2011

Memorandum submitted by Bradford People First (HS 94)

1. The Guidelines for writing this letter said for us to try not to use pictures. Unfortunately we use pictures and the easy read style to make the information understandable to ourselves and to other people with learning disabilities who may wish to read this. In view, of this I hope you will allow us the use of pictures and easy read style so that we can have our voice (Illustrations not printed here).
2. We are Bradford People First a Self Advocacy charitable organisation. The organisation is run by people with learning disabilities for people with learning disabilities. We are based in Bradford and represent people with learning disabilities in the Bradford Area.

3. We also represent people with learning disabilities in the Yorkshire Region and throughout the UK when working on issues that affect all people with learning disabilities.

4. **Our Aims**
   - To promote the relief of people with learning disabilities through self-advocacy.
   - To promote the advancement of education of the public, professionals and people with learning disabilities in issues relating to learning disabilities.
   - To improve the lives of everyone with a learning disability and make sure that people with learning disabilities are treated fairly and with respect.

5. **This means:**
   - Give help and support to people with learning disabilities through self-advocacy.
   - Teach the public, professionals and people with learning disabilities about things that are important to other people with learning disabilities.
   - Making the lives of people with a learning disability better and making sure they are treated fairly and with respect.

The Government’s Health and Social Care Bill (Changes to the National Health Service)

What we would like you to be aware about

**General Practitioners Buying Healthcare**

6. We are worried that the GP’s will not know what people with learning disabilities do and what they need to make their healthcare accessible. We think all GP’s should get learning disability training and people with learning disabilities locally should be a part of this. If they do not they will be leaving people with learning disability out and providing them with an unfair and poor service.

7. We are worried that GP’s will not understand how important learning disability self advocacy groups are, in helping the local Health Services to make sure they are accessible for people with learning disabilities and that they are treated fairly. We think this is very important that the GP’s do their job right and keep people with disabilities safe in the National Health Service. Learning Disability Self Advocacy groups are the key to this because the people with learning disability that run them have the best understanding and skills to know what is best for people with learning disabilities.

The Need for Self Advocacy Services

8. There is a great need for self advocacy groups/organisations to support the National Health Service to run a fair, accessible and safe service for people with learning disabilities.

9. At Bradford People First we go out and speak to lots of other people with learning disabilities in the District and find out what they think about the services they are getting, such as Healthcare, Council, Police etc.

10. We then feed this back to the big bosses and support services to become accessible. Without the self advocacy groups doing this, we would be worried that the voices of people with learning disabilities within the district would not be heard and the services would not be accessible. This would be wrong.

11. We are also worried that if the GP’s give no funding to the advocacy groups, these groups will be unable to continue supporting healthcare services to give an accessible service to people with learning disabilities around the country.

12. People with learning disabilities may then be under threat of being treated unfairly, as their will be no self advocates to carry out Learning disability awareness training to the healthcare staff, make information easy read or help local health services to be accessible. GP’s need to be made aware of the importance of self advocacy organisations in supporting them to make sure healthcare is accessible for people with learning disability.
Health and Social Care Bill

Health Watch Meetings
Making sure people with Learning Disability are included and have a voice

13. We are worried that the way the Health Watch meetings are run, may mean that people with learning disabilities are left out and their views not heard.

14. To make sure that people with Learning disabilities are included in the Health Watch meetings they will need to be accessible for people with learning disabilities. This includes the running of the meeting and the information. We think that it is important that Health Watch representatives have learning disability training so that they can properly represent us.

15. To help people with Learning disabilities to be properly represented we think that it is very important that Health Watch representatives regularly visit advocacy organisations like Bradford People First. This is so that extra time can be given to find out what people with learning disabilities have to say and to help with preparing for Health Watch meetings.

Having more choice about the healthcare we get

16. We think it is really good that we are going to have more choice about things such as the GP surgery, Doctor, Hospital or treatment we want.

17. But we are worried that because a large amount of people with learning disabilities depend on public transport that they may not be able to access the Doctor, Hospital or Surgery they want because of transport issues. This would be very unfair. We think the Government should look at ways to making the Transport to Healthcare of people’s choice less of a hassle.

18. We are also worried that Doctors or nurses will not have the skills to support us to make the right choices and that they may be too busy to support us. Once again we think it is important that they have Learning disability awareness training and that they are aware of services that support people with learning disabilities such as learning disability citizen advocates.

19. To help people with learning disabilities make choices about their Healthcare there will be information we will need to know about. This information needs to be accessible for people with learning disabilities. It also needs to be available in different ways.

20. We think it is important that people with learning disabilities are involved in making the information accessible locally, because we know what is best for us.

21. We are worried that people with learning disabilities may not be able to give feedback about what they think about the service they are getting locally, just because the ways of giving feedback is not accessible to them.

22. Rather than just using a survey, that is not accessible for everyone with a learning disability, We think it is important to use different ways to find out what people think about a service they have used.

23. A very good way of getting information from people with learning disabilities is by going out and talking to people face to face. This is because some people find it hard to read or understand information or put down in words what they think.

24. We think people with learning disabilities as trained quality checkers would be a very good idea, as people with learning disabilities feel more comfortable talking to other people with similar disabilities, “because the person knows what you’re going through, compared to someone without” and “you feel more relaxed and able to talk”.

Five things the Government want the National Health Service to get better

25. These are:
   1. Stopping people from dying early.
   2. Making sure people with long-term illnesses have a better life.
   3. Helping people to get better quickly.
   4. Making sure people are happy being looked after by the National Health Service.
   5. Looked after people safely.

26. We think all these five things that the Government want to make better are important for people with learning disabilities, because people with learning disabilities have sometimes not been cared for properly in the National Health Service.

27. Some people have even died because the hospitals did not know how to care for someone with learning disabilities.
28. All our concerns and our ideas in this letter of how to make things better for people with learning disabilities supports and fits into the 5 things the Government want the National Health Service to get better at. We think the Government need to listen to what people with learning disabilities need to make sure we get a safe, equal and fair Healthcare.

March 2011

Memorandum submitted by the National Centre for Independent Living and Radar (HS 95)

ABOUT NCIL

The National Centre for Independent Living (NCIL) is a national campaigning, support, advice and consultancy organisation that aims to enable disabled people to be equal citizens with choice, control, rights and full economic, social and cultural lives. www.ncil.org.uk

ABOUT RADAR

The Royal Association for Disability Rights (Radar) is a pan-disability organisation led by people with lived experience of disability or health conditions. We work in broad partnerships to have the widest impact. Our vision is a just and equal society whose strength is human difference. Our mission is to enable individuals, networks and policy-makers to do things differently—and better. www.radar.org.uk

INTRODUCTION AND SUMMARY

We welcome the Health and Social Care Bill as a starting point to improved involvement but we are concerned about several aspects of the proposals. Please note our detailed responses to the NHS reforms www.ncil.org.uk/categoryid1.html. Given the enormous scope of the intended reforms, we miss in particular any provisions for the effective promotion and facilitation of choice at an individual level. Greater individual choice is essential to balance the abolition of other safeguards for the quality and continuity of care such as the waiting times targets. For the reforms to be effective they must work for every individual during every single encounter, and involvement cannot be limited to the very few and same individuals representing all others solely at a strategic level, eg at Joint Strategic Needs Assessments.

In this short briefing we firstly outline how we think health and social care need to be truly centred around the individual to achieve “nothing about me without me” (1.–6.):

— Care and support should be contextualised within the person’s life domains (eg family, work, hobbies) so that people’s lives can be improved and not just conditions.
— Effective provisions for the promotion and facilitation of choice and control.
— Peer support needs to be recognised and expanded wherever possible.
— Ensuring the role of user-led and patient organisations at individual and local leadership levels.
— Sub-contracting primary and “secondary” choice-supporting providers on fair terms.
— Shifting from a capacity-driven system to a demand-led model.

Next, we attend to the concerns about more global provisions in the bill which we share with many other organisations, most notably with the King’s Fund (7.–9.):

— Patient choice alone cannot prevent fragmentation of care and support.
— Transition to “any willing provider” must be clear, fair and comprehensive.
— Local system leadership must be established, joined up and made accountable.

1. Care and support should be contextualised within the person’s life domains (eg family, work, hobbies) so that people’s lives can be improved and not just conditions

We have noted the statement in the NHS White Paper 2010 that “involving patients in their support and treatment improves their health outcomes”. Indeed, people with similar conditions can experience not only different qualities of life but also different health outcomes, depending on disabling barriers faced and individual responses that people themselves are taking. This suggests that choice and control do not just have “soft” add-on effects but should be seen as integral to care and support pathways. There is a choice pathway just as there are (clinical) care pathways: many people are initially resistant to making choices for various reasons which may relate to fear of reduced attention from a professional for example, whereas others recognise and benefit greatly from full involvement early on.

The exclusive focus on clinical care pathways wastes millions of opportunities to improve health outcomes. People must be given the space to contextualise their support and treatment within their life domains. Professionals should work with the person, pick up on that context and improve people’s lives rather than maintaining the traditional roles of an efficient “case manager” and “consultant-led teams”.

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Alternatively, such choice-supporting functions should be given to suitable (secondary) providers. Likewise, inter-professional communication must no longer be driven by insular professional cultures and systems but opening up to opportunities for further meaningful involvement with the person.

Greater choices should become the norm even in matters that many people would locate outside of their control or expertise. Public education is needed not just for people with additional needs but for everyone to understand and make best use for themselves of the link between involvement and health outcomes. It is then for people to decide whether to go for a set “decision aid” (for the specific care area or treatment at stake) or more personalised one to one support from someone they trust.

Further scoping should be done to explore and operationalise the ways and degree to which people make active and informed choices (including how the degree of choice impacts on health outcomes within and across care areas). We would be very happy to assist any such redesign or whole systems change.

2. Lack of provisions for the promotion and facilitation of choice and control

Several provisions in the Bill (e.g. “any willing provider”; right to request/provide, etc) will spark greater competition, which places significant demands on disabled people to exercise choice and control. Given the significant decrease in targets, regulatory frameworks, and regional leadership, people’s informed choices become key drivers towards quality, continuity of care, collaboration and equality of access within the NHS. Therefore, individual choice (and not just the voice of groups) should be placed at the centre of systems and processes.

However, the current provisions for “any willing provider” merely replicate the medical model that is so deeply rooted in the NHS. According to the plans, it is still the “what” and not the “how” which GPs will commission, while local HealthWatches will solely focus on advocacy in the form of complaints “after the event”. In the proposed NHS landscape the promotion and facilitation of choice and control is either taken for granted or there is no understanding of this kind of “commissioning support”. At any rate, professionals hardly consider involvement as part of their role. Indeed, choice starts with equal access to information and peer support prior to crisis point in either social or health care. A responsive mindset and readiness for individual involvement need to develop over time across the different settings. The need for cultural change applies to both individuals and professionals, and so both sides of the relationship need to be supported and trained.

Support and information to promote and facilitate choice should become integral, recognised and paid parts of any healthcare pathway. These parts should be separately commissioned or subcontracted to suitable providers. Such a two-pronged approach (to direct “primary” providers and “secondary” choice-supporting providers) needs to be reflected in extensive staff engagement. It is certainly not sufficient to make it a requirement for a provider to be listed under “Choose and Book”. Any technical or system (e.g. software) changes should be supported by an extensive, parallel cultural change programme, in order to approach and overcome staff resistance within the NHS and primary provider organisations. For example, any primary provider should be allocated a percentage for the promotion and facilitation of choice and should be required to report on how this amount has been spent. Beforehand, it would be beneficial to map and think through the relevant systems and processes of any care pathway.

3. Peer support needs to be recognised and expanded wherever possible

All good care and support starts and ends with good relationships, and people have different ways to go about them. It is advisable to start involvement at a lower level of (social care) needs or way before that rather than introducing the benefits of involvement once life-threatening situations have been reached. While the NHS Greater Choices consultation outlined the scope of available choices to achieve better outcomes, the actual case studies only confirmed the obvious gaps in going about them in real life: how do the various patients in those “cases” actually come to meet and share personal experience and empower each other so effectively?

There needs to be more facilitated activity-based community space exceeding health and social care issues, coupled with targeted outreach activities to seldom heard groups. If people are supported to share, pass on and exchange information on support and care and are encouraged early on to pool personal (health) budgets, this fosters not only public health but also a strong base of social capital within the communities.

Many user-led organisations (ULOs) and also patient-led support organisations help form and build on these relationships, and their focus has always been on the person in context. Paid “patient buddies” could also be called upon where this is requested by the person so that they can hear directly from a peer who has gone through a similar path previously. In addition, user-led mutuals could be funded to be set up and run so that both individuals and groups who share certain needs are supported. The Expert Patients Programme or Experts by Experience could assist widely in this respect, and we would be happy to facilitate this if requested.

ULOs have widened access to their support services to accommodate for and actively reach out to individuals with any of the protected characteristics. It will be particularly crucial to continue to engage seldom heard or reached groups via other community links. For instance, there are very successful partnerships between community hubs that are good at engaging with specific ethnic minorities (where people would gather for social activities) and NHS services that are good at providing secondary care or...
4. Making involvement count—ensuring the role of user-led and patient organisations at individual and local system levels

User-led organisations (ULOs) already work on the delivery of personal budgets, including outreach/information, self-assessment, support planning, brokerage, monitoring and review, and pooling budgets. Some ULOs have additionally been commissioned by PCTs to support personal health budgets across “care areas” and/or to provide information and advice, for example. We feel it is important that this expertise should be built on and used to benefit both those using services and GPs in fulfilling their commissioning role. Yet, in an environment of fundamental cuts this kind of function is often the first to be overlooked by local decision-makers with potentially serious consequences for the delivery of the NHS reforms. As a result, we feel that there needs to be very clear guidance or a protocol for local authorities at least.

ULOs are also well placed to work across sectors which would ensure some strategic overview across “care areas”, a focus on aspirations rather than just needs and some independence in the bottom-up process of the proposed integration of health and social care; “bottom-up” would then mean driven by people themselves rather than by the public sector or third sector organisations. A strong ULO voice would also help to balance the different views and experiences that GPs will have within their consortia about different patient groups and health inequalities distributed differently across any single locality.

The current provisions for patient and public engagement in the Bill are weak, and we find it inappropriate that there is no mandatory patient representation on either GP consortia, health and well-being boards or the NHS Commissioning Board. Meaningful involvement would include a public right to petition the NHS Commissioning Board to undertake a review into a particular health service or a thematic issue, such as health inequalities. Finally, the NHS Commissioning Board and GP consortia should be under an obligation to publish all information relating to their commissioning strategy and planning, results and outcomes including their rationale and justification for decisions.

As the Bill currently stands we cannot see how people would be able to directly influence the commissioning of the services they use. This flags up questions about the demarcation between the DH, GP commissioners and people who would all make choices: What is the reach of the “any willing provider” concept? Will GP consortia be permitted to commission and therefore select particular providers or will they simply determine what types of treatment are to be offered?

There is some indication that the GP consortia will be compelled to offer all patients a choice of any nationally licensed provider who offers the relevant treatment and has applied to the consortium. However, the Department of Health seems to be denying this. It is at least insufficient to disregard “any willing provider” in the Bill and not to give it a legislative base. We would not want to have all these fundamental questions left open until after the Bill has passed.

5. Sub-contracting primary and “secondary” choice-supporting providers—making it work

We would hope that the government delivers a “think personal—act local” approach to GPs commissioning primary providers. A more levelled playing field is key to this.

There should be clear provisions that require GP consortia to enhance active engagement and involvement of patients. As outlined in section 2, we would propose that any primary provider should be allocated a percentage for the promotion and facilitation of choice and be required to report on how this amount has been spent. Further criteria which we would expect to be applied to ensure the fitness of a primary provider or associated secondary choice-supporting provider) are:

- “Social return on investment” that can reasonably be claimed for previous work by any provider should become an essential criterion for fitness—as set out in the Public Services (Social Enterprise and Social Value) Private Member’s Bill.

- Service agreements or preferred provider lists to be opened up to more flexible and informal types of support, user-led mutuals, self-employed people or micro enterprises and all those support services that are exempt from CQC regulation.

- Ability and willingness to cooperate with information and support providers on a level playing field and clear accounting of how a set percentage of unit costs would be or has been spent on information and support to promote and facilitate choice.

- Wherever possible, the “right to a personal health budget” should be applicable so that the service or support concerned can be paid out of personal (health) budgets, either directly as a cash payment or through third party organisations.

Furthermore, small providers (both primary providers and secondary choice-supporting providers) should be supported in the following ways in order to create a more level playing field:

- CQC to set out “softer” requirements at an affordable cost for emerging small providers.

- Wherever possible, the “right to a personal health budget” should be applicable so that the service or support concerned can be paid out of personal budgets, either directly as a cash payment or through third party organisations.

- Wherever possible, the “right to a personal health budget” should be applicable so that the service or support concerned can be paid out of personal (health) budgets, either directly as a cash payment or through third party organisations.
— CRB checks—which often “passport” contracts—must be provided to everyone including self-employed people who currently cannot request CRB checks on themselves (which CQC requires them to have).
— Improving “test-trading” and permitted earning provisions to enable people to make the transition from benefits to becoming a small provider.
— Payment by Results (PbR) to be abolished for all commissioning and purchasing activity involving those smaller providers who are not able to entertain PbR because they do not have the necessary reserves to underwrite service delivery in advance of payment.
— Start-up or transition funding would enable the necessary fitness for emerging support and information facilitators in the community or existing ULOs and patient-led support organisations intending to widen their remit.
— Private Hire Vehicle Legislation should not prevent willing providers from occasional transport of people just because they do not reach the economies of scale required to pay such expenditure.

The approach to providers should be varied depending on size and the types of support provided. A directory with all providers should be established to ensure effective choice at the outset.

6. Shifting from a capacity-driven system to a demand-led model

We also believe that people’s choices—if supported and strengthened—will enhance the desired shift from a capacity-driven system to a demand-led model. There are some indications that the proposals in the Bill will kick off such a shift, which we welcome. We support the “right to choose to register with any GP practice” and the envisaged “right to a personal health budget”. We would hope that personal health budgets will be extended beyond the existing pilot schemes to become the norm. In some respect, the service user or patient is becoming a “change agent” to ensure a great deal of the requirements for quality and continuity of care will take place. We hope that ULOs and other patient organisations will be equipped to stand by disabled people in this change agent role, inform them and support both shaping new ideas for support and making them happen.

The NHS and councils should redesign parts of their business processes and focus on support that is demand-led rather than driven by staff capacity. There is as yet no indication of innovative approaches which allow both choice and control at a larger yet meaningful scale and the required shift in power—central government has not put in place effective levers which require providers to co-produce new types of support together with user-led organisations. Instead, locally, disabled people are served packaged choice options if anything. Yet, we could go even further than merely co-producing new services. If the “right to request” (NHS) and the “right to provide” (Adult Social Care) through employee-led mutuals would be extended to a “right for disabled people to provide (paid!) support for and by themselves”, we would see a considerable reduction of waste and increased choice and control and more disabled people leading full economic, social and cultural lives. This prospect would also give some practical meaning to the proposed “right to challenge” for the community to replace services that are not demand-led and lack sufficient quality and continuity of care.

We hope that further work will be undertaken on pooling budgets and user-led mutuals to the benefit of the proposed health and social care reforms.

7. Patient choice alone cannot prevent fragmentation of care and support

While we have pointed out the great benefits of effective choice and involvement, there are also significant concerns about fragmentation of care and support which cannot be prevented by stronger patient choice alone. This applies in particular to unplanned care and care areas where outcomes cannot be clearly measured or where it would be very difficult to identify peer support and promote and facilitate effective choice.

It seems that patient choice, continuity and quality of care could be undermined by the provisions for Monitor to specify a maximum tariff—thus allowing competition on price: will patients then only be able to choose between the cheapest providers?

Collaboration and integration between health and social care is paramount, and we welcome the proposals to enable the NHS Commissioning Board or consortia to pool funds. However, the absence of a duty to promote integration on the part of GP consortia could mean that positive links established between councils and PCTs will be lost.

We think that a rigorous evaluation to address the effects on the current 141 GP pathfinder sites must be carried out before the proposed reforms and GP consortia would be rolled out nationally.

8. Transition to “any willing provider” must be clear, fair and comprehensive

For “any willing provider” to be effective, some resources must be freed up to benefit new more effective and more demand-led types of support and care. While we favour the shift from a capacity-driven system to a model that is based on user-demand, we have concerns that transition plans will not be clear and comprehensive. As yet, de-commissioning of large block contracts or in-house provision is either avoided
or rushed without clear and comprehensive transition plans that make full use of the savings and pass them on to more innovative types of support. The process must be flexible enough to challenge existing providers and allow new and innovative providers to enter the market. Patients need to be assured that continuity of care where people live will be paramount and that any (desirable) changes of providers in terms of location and service re-configuration will be carefully scoped and not just down to the choices of the majority of patients.

Care needs to be taken that conflicts of interests are first identified and then tackled (rather than simply avoided), if GPs are to commission and to provide local services. Transparency including published minutes of GP consortia meetings will be key to this. But we note that there is a serious concern about commercial confidentiality, which provides a wide-ranging exemption under Section 43 of the FoI Act. The constitutions of GP consortia may only provide very limited safeguards to any of these concerns, and GPs should of course still be able to focus on providing services by themselves.

The removal of direct reporting lines and the introduction of non-public providers will place the NHS out of the reach of Parliamentary scrutiny. The Bill makes some weak provisions for Select Committees to request information from the NHS bodies but the indirect relationships between them and the Secretary of State, who is accountable to Parliament, leaves open what the scope of ordinary Parliamentary Questions and other Parliamentary processes will be in relation to their work. More concerning will be the scope of Parliamentary scrutiny over providers and consortia who are even further removed from the Secretary of State.

Amendments on FoI and other transparency rules should go hand in hand with provisions to guarantee that all the NHS bodies, including all providers, will be accountable to Parliament, especially as this is likely to be something that attracts wider political support in Parliament itself.

9. Local system leadership must be established, joined up and made accountable

We have great concerns that local players are being left to their own devices without a minimum of public accountability (despite all the rhetoric to the contrary). Furthermore, GP consortia will only have a limited duty to involve the public (but many patients would of course know that the most effective place to be heard will be their GP’s surgery).

The proposed Health and Well-Being Boards would be largely run as public sector clubs without any local democratic representation (apart from one councillor); not even third sector organisations are to be included under the current provisions let alone ULOs. On the other hand, it is unclear what powers those local boards actually have. Currently, this does not even include powers to require information, without protection of commercial confidentiality, from consortia, their contractors, and all providers of NHS care in their area. Indeed, these powers should be used as a way of bringing firms contracted to undertake commissioning functions in to the range of public accountability, which would sit with the concept of the Boards overseeing the consortia in a strategic way.

HealthWatch is without any teeth—locally, HealthWatches would be built on LINks but not even enjoy their predecessors’ relative independence: future contracts will be issued by councils directly to a set organisation and not to an overarching forum of community voluntary sector providers. We would still hope that the national body had powers over private providers so that it could be used to expose them for bad practice and/or deter them from the market in a similar way to other provisions for further transparency and oversight.

All these concerns about global provisions (for local voice and campaigning) should not distract from the need to enable the promotion and facilitation of choice at individual level to which we have dedicated the first part of this briefing.

March 2011

Memorandum submitted by Lloydspharmacy (HS 96)

ABOUT LLOYDSPHARMACY

Lloydspharmacy is a leading community pharmacy operator with over 1,600 pharmacies across the UK. Our trusted staff, working at the heart of local communities, serves over two million people each week and 90% of our business is directly related to healthcare. With strong relationships with patients and vast experience of front-line health service delivery, community pharmacy plays a vital role in the health of the nation.

SUMMARY

1. This briefing sets out Lloydspharmacy’s position on the Health and Social Care Bill. We welcome the broad thrust of the bill, but believe that further attention is required to improve the legislation in order to deliver an enhanced patient-centred service with improved clinical and public health outcomes, together with greater efficiency. In particular, there are four areas we believe deserve particular attention:
— The National Commissioning Board.
— Commissioning Consortia.
— Licensing, competition, and pricing.
— Health and Wellbeing Boards.

**The National Commissioning Board**

2. Clause 5 establishes the National Commissioning Board, and Clause 11 sets out the power for the Secretary of State to require the National Commissioning Board to commission certain services. Pharmacy is not explicitly mentioned in any of these clauses.

3. Lloydspharmacy believes that the National Commissioning Board and its committees must draw upon appropriate expert advice. This will inform and enable good commissioning decisions, and enable the Board to benefit from existing expertise in the health service. We welcome the discussions that have occurred in Committee on this point, and welcome all parties’ views that pharmacists, alongside other healthcare professionals, should assist the Board. We believe that as the Committee considers further aspects of the formation and the powers of the National Commissioning Board, due regard must be given to the need for the Board to consult expert advice.

4. This is particularly important for community pharmacy, as the Board will be responsible for the Community Pharmacy Contract—an agreement with a funding budget of £2,486 million (2010–11) and which affects millions of patients every day.

**Commissioning Consortia**

5. Lloydspharmacy believe that the creation of GP Consortia affords the possibility of better-integrated care for patients.

6. Around 12% of the total NHS expenditure in England is spent on medicines, equating to around £10 billion. Effective use of medicines plays a crucial role in meeting the QIPP agenda, and it is essential that experts in medicines are represented on commissioning bodies.

7. Community pharmacists also bring a unique frontline perspective. Their expertise and understanding of the local pharmacy environment will be crucial for effective GP commissioning.

8. As Pharmacy Voice has noted, community pharmacists see many patients who are not registered with GPs—and it is vital that the interests of this group are considered if public health outcomes are to be maximised.

9. As such, while we note the Committee’s discussions on the clauses and schedules establishing consortia, we believe that to make better-integrated care a reality, relevant healthcare professions should have appropriate representation on the boards of GP Consortia, including community pharmacists.

**Licensing, Competition, and Pricing**

10. As the Royal Pharmaceutical Society (and others) have argued, it is essential that a transparent and level playing field exists for providers to compete to deliver services in the new NHS. We believe that NHS services should be delivered by a broad range of providers, with the most appropriate and cost effective resource utilised, not only to draw on expertise but also to deliver additional capacity.

11. We agree with the principle of licensing for providers, as set out in Clause 74—so that commissioners have confidence in the legitimacy of an organisation delivering services on behalf of the NHS.

12. Lloydspharmacy welcome Clause 56, outlining Monitor’s requirement to ensure it does not impose unnecessary regulatory burdens. Pharmacy is already a highly regulated profession, and this is an important clause for ensuring that it can make a contribution to health outcomes—licensing arrangements should not deter valuable healthcare providers.

**Health and Wellbeing Boards**

13. Clauses 178–183 establish Health and Wellbeing Boards. Lloydspharmacy agree with the establishment of the Boards, and believe that they can bring healthcare decisions closer to patients.

14. We agree with the membership of the Boards, as representation from different parts of social and health care will improve the quality of local decision-making.

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194 PSNC’s brief guide to community pharmacy funding http://www.psnc.org.uk/pages/funding.html
196 Pharmacy Voice is an organisation which brings together the three largest community pharmacy associations; the National Pharmacy Association (NPA), the Company Chemists' Association (CCA) and the Association of Independent Multiple Pharmacies (AIMp).
197 The Royal Pharmaceutical Society is the professional body for pharmacists and pharmacy in England, Scotland and Wales.
15. With around 10,000 pharmacies in England, community pharmacies provide frequent opportunities to engage with target populations. Initiatives such as the Health Living Pharmacy model, where pharmacies in one area agree to support and implement public health programmes, shows the potential to use existing infrastructure and expertise to improve public health.

16. As with GP Consortia, we believe that it is important that the leadership of these organisations includes representatives of pharmacies. We believe that there are further opportunities for providers to be represented by existing groups—such as local pharmaceutical committees.

17. As such, we welcome Clause 179’s Duty to Encourage Integrated Working. We would add that Clause 178.2 should include a statutory duty to include a representative of healthcare professionals, including pharmacists, to support effective public health provision particularly in the development of Pharmaceutical Needs Assessments (Clause 190).

March 2011

Memorandum submitted by Help the Hospices (HS 97)

1. ABOUT HELP THE HOSPICES
   1.1 Help the Hospices is the leading charity supporting hospice care throughout the UK. We want the very best care for everyone facing the end of life.

   1.2 The majority of hospice care in the UK is provided by our member hospices—local charities rooted in the communities they serve. Care is given free of charge to the patient and their friends and family. It can be at home, in the hospice and in the community and can be for days, months or years. We are here to represent and support our members. We work with our members and other organisations as they strive to grow and improve hospice and palliative care throughout the UK and across the world.

   1.3 Our services are here to support hospice people and champion the voice of hospice care. They include a wide range of training and education programmes, informative and practical resources for hospice staff, work to influence government policy and support for quality care and good practice.

2. ABOUT THIS MEMORANDUM
   2.1 This memorandum draws on the experience of independent charitable hospices around England, and is supplemented by references to research conducted by Help the Hospices and others.

   2.2 We have limited our comments to three key issues: commissioning, competition, and the transitional arrangements.

3. SUMMARY OF KEY POINTS
   — It is essential that the reform of commissioning promotes and encourages partnership working between providers. (4.3.1)

   — The commissioning reforms should recognise the ‘co-commissioning’ role played by local charitable hospices. (4.3.3)

   — There should be penalties for GPs who fail to make appropriate referrals for patients, or fail to deliver improved patient outcomes. (4.4.3)

   — The quality of care commissioned should be included as a specific duty of GP consortia. (4.4.5)

   — The Department of Health (DH) should provide further clarification on its approach to the tendering of integrated care services. (5.2.5)

   — Regulation of the healthcare market must not increase bureaucracy for charitable providers such as local hospices. (5.3.1, 6.4.3)

   — The momentum in palliative and end of life care must not be lost during the transitional period. (6.4.1)

   — There should be robust accountability mechanisms to make sure that patient outcomes are improved in the new system. (6.11)

4. COMMISSIONING
   4.1 Help the Hospices has previously drawn attention to the deficiencies of the current commissioning system, which supports the uneven provision and funding arrangements across the country.198 The existing commissioning arrangements hamper the development of new services, reduce efficiency and act as a disincentive to service integration and were recognised in the End of Life Care Strategy (2008) as significant barriers to meeting the increased demand of the country’s ageing population.

198 Help the Hospices. Submission to the Health Select Committee inquiry into commissioning, 2010.
4.2 We continue to support the End of Life Care Strategy but are aware that its impact has often been blunted by current commissioning practice. For this reason Help the Hospices welcomes the Coalition Government’s commitment to reform commissioning in England, although we have some concerns about the mechanisms being established through the health and social care bill.

4.3 Partnership in commissioning with the voluntary sector

4.3.1 We are concerned that the content of the bill that covers commissioning does not take into account the specific circumstances and contributions of independent charitable hospices to the health economy. Nor do we believe that it will sufficiently support the development of a vibrant health provider market in which partnership working is encouraged, as set out in part 3, chapter 1.

4.3.2 The independent charitable hospice sector provides two-thirds of specialist inpatient palliative care in the UK. However, the majority of the care provided by hospices is provided in the community; in the past five years there has been a 58% increase in the services provided by hospices to people in their own home.

4.3.3 Not only are hospices substantial providers of hospice and palliative care they are also significant funders of such care; in 2009 hospices spent £686.9 million. In short, for every £1 the state invests in local charitable hospices, those hospices deliver £3 worth of care. Hospices are unique among providers of healthcare because they contribute so significantly to the funding and provision of hospice and palliative care. We are concerned that this “co-commissioning” role played by the voluntary sector is not recognised in the proposed commissioning reforms.

4.4 GP consortia

4.4.1 Help the Hospices supports the application of the principle of subsidiarity in NHS commissioning, but we are concerned about some of the practical considerations in the move towards GP commissioning.

4.4.2 Historical evidence with regards to past GP commissioning activities alongside international experience suggests it will take several years for GP consortia to become effective at commissioning across the full range of health services. For the commissioning of hospice and palliative care this may be exacerbated by a deficit in end of life expertise among GPs.

4.4.3 A recent survey by Help the Hospices uncovered that one in four GPs are not confident in their ability to provide information to a patient with less than six months to live. This is despite GPs seeing on average more than four patients a month with a terminal illness. For GP commissioning to work there is an urgent need for GPs to work closely with local hospices to build expertise around the delivery of hospice and palliative care in their communities. Consortia will need support to develop capacity and capability and to make sure they have access to the management and strategic skills required of effective commissioning, and individual GPs will need support and incentives to deliver quality outcomes for their patients. One way to achieve this would be to introduce penalties for GPs that fail to make referrals to appropriate services.

4.4.4 Many hospices have already begun to cultivate relationships with local GP leaders. However, this process alone is not sufficient to make sure that the knowledge and confidence of GPs is increased sufficiently to end the problems associated with the current commissioning system and deliver effective outcomes for patients.

4.4.5 While there is potential in the Government’s commitment to “aligning the clinical and financial aspects of commissioning” to generate efficiency savings by “enabling clinicians to prioritise the best and most appropriate care for local populations” this is dependent upon GPs developing their knowledge and confidence of end of life care. A structural change to the mechanics of commissioning is not enough, on its own, to ensure better outcomes for patients. Help the Hospices recommends that the quality of care being commissioned is specifically included as a responsibility of GP consortia.

4.4.6 Research conducted by the Commission for the Compact and Help the Hospices has highlighted the critical importance of personal relationships in the commissioning of hospice care, and the wide variation in the approaches taken by commissioners. Lessons should be learned from areas where relationships between hospices and commissioners are strong and where the planning of care is more effective than others.

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200 Unpublished analysis of the Minimum Data Set for Palliative Care, Help the Hospices, 2009.
203 Primary Healthcare Professionals Monitor, September 2010, nfpSynergy.
4.5 NHS Commissioning Board

4.5.1 While the bill outlines a system that divides responsibilities between local GP consortia and the national NHS Commissioning Board, we question whether consortia will always be of a sufficient size to commission hospice and palliative care as a relatively low volume and specialised service. In our view, the NHS Commissioning Board should have the power to require consortia to collaborate on the commissioning of such services, to maximise efficiency and to help minimise the transactional costs associated with local hospices needing to forge relationships with multiple consortia. It would help to ensure that commissioning of such services operated at a population size that would enable effective commissioning. We would strongly support consortia being required to collaborate in the commissioning of hospice and palliative care services.

5. Competition

5.1 Help the Hospices supports a mixed economy in the healthcare market. Independent charitable hospices, as major providers of palliative care, are themselves outside of the immediate NHS family. However, we believe that further consideration needs to be given to the potential destabilising effect of a rapid expansion of providers on existing established services.

5.2 Any willing provider

5.2.1 In his letter to the NHS in February 2011 concerning the transitional arrangements, Sir David Nicholson indicates that the principles of “any willing provider” set out in the bill would not apply to complex integrated services, such as end of life care. Help the Hospices has also had discussions with the DH that have reinforced this proposal. Instead, the commissioning of such services would operate on the basis of a local tender, with long-term contracts awarded to encourage investment and development of services locally.

5.2.2 While in principle we believe that this approach makes more sense for the commissioning of complex palliative care services, we are concerned that there is limited information on how such a system would work in practice, and believe that any tendering process should provide tangible incentives for partnership working, service improvement and integration.

5.2.3 This proposal begs further questions, not least in relation to the population that would be included within such a tendering arrangement. In our response to the DH consultation on commissioning for patients, we highlighted our view that consortia should be required to collaborate on the commissioning of hospice and palliative care services, and in our view, the mechanics of how such collaboration would be mandated are even more important if commissioning will be undertaken on the basis of tendering arrangements. Help the Hospices believes that it does not make any practical sense to commission complex yet relatively low volume services such as hospice care at an ultra-local level.

5.2.4 Clarification is also needed on the potential impact of such tendering on the “joint strategic needs assessments” that will become the responsibility of upper-tier local authorities, particularly where the population for which services are being put out to tender might cross local authority boundaries.

5.2.5 Help the Hospices therefore encourages the Committee to seek further clarification on the arrangements for such integrated services, and the circumstances in which “any willing provider” might be replaced by a tendering arrangement.

5.3 Regulating the healthcare market

5.3.1 We are concerned that the new role for Monitor as the economic regulator for healthcare runs the risk of creating an additional layer of bureaucracy for independent charitable hospices, and that there is potential for duplication of information required by Monitor and the Charity Commission.

5.3.2 In the current system, hospices, as charities in their own right, are required to provide the Charity Commission with information relating to their financial management, governance and viability. Help the Hospices is concerned that in licensing providers, Monitor is likely to be requesting similar information. We are concerned that this runs counter to the Coalition Government’s commitment to reduce the regulatory burden on charities. We recommend that wherever possible, information be shared between the Charity Commission and Monitor to reduce the risk of duplication for local charitable providers.

6. The Transitional Arrangements

6.1 Help the Hospices is concerned about how the scale, pace and cost of the reforms may affect those receiving hospice and palliative care and, in particular, the continuity and quality of care.

6.2 Alongside providing health and social care services, hospices play a crucial role in delivering the healthcare workforce through their expertise in the local provision of education about palliative care needs. This contributes significantly to the continuing professional development of a high quality, flexible palliative


207 Help the Hospices. Liberating the NHS: commissioning for patients—a response from Help the Hospices, 2010.
6.3 It is vital that transition arrangements, in particular the transitional process for changes to the commissioning of hospice and palliative services, do not destabilise existing provision.

6.4. Maintaining the momentum

6.4.1 Progress and momentum in end of life care enabled by the 2008 End of Life Care Strategy and the inclusion of end of life care as one of the eight high-level priorities in the NHS Next Stage Review208 programme must not be lost during the transition period. While we have welcomed the Coalition Government’s commitment to end of life care, the proposals outlined in the white paper include end of life care as only one discrete priority among many other competing priorities. Within a forthcoming challenging period of transition, we have concerns that this could lead to a weakening profile of hospice and palliative care in the NHS agenda, at a time when our population is ageing, and more people will be living and dying with complex comorbidities.

6.4.2 In July 2010, the Economist Intelligence Unit identified the UK as having the best-developed palliative care services out of the 40 countries surveyed. The ranking was attributed, in part, to the “well-established hospice movement”.209 It is vital that transition arrangements, in particular the transitional process for changes to the commissioning of hospice and palliative services, do not further destabilise this valuable provision.

6.4.3 We are concerned that the transitional process of devolving commissioning to GP consortia will increase the complexity of the relationships between hospices and commissioners without adding value to the commissioning of hospice and palliative care, adding significantly to the transactional costs for independent charitable hospices. In the present system, many hospices provide services on behalf of two or more PCTs. This is particularly true for children’s hospices, which cover much larger populations. Under the proposed system, local hospices are likely to need to negotiate with significantly larger numbers of GP consortia. If hospice and palliative care services are to be put out to tender, we believe that there is an opportunity to make sure that individual consortia collaborate on the commissioning of such services, as described above.

6.5 Promoting stability in hospice provision

6.6 We are also concerned that the timetable for the introduction of GP consortia as set out in the white paper will lead to a confusing fragmentation of commissioning decisions during the next two financial years, at a time when statutory income streams for hospices are uncertain.210 During this period, different GP consortia will be at different stages in their development, resulting in a situation where our member hospices who work with more than one PCT in the current system could find themselves working with multiple commissioners within multiple systems. If the resources the NHS currently provides to hospices are devolved, there is a danger running costs will increase and efficiency will be threatened by increasing the number of commissioning relationships that an individual hospice will need to negotiate, thereby increasing costs, rather than promoting greater efficiency.

6.7 The Government’s reforms propose substantial change and will require significant expertise to be implemented smoothly. Our members have expressed concern that PCT management and commissioning expertise and “institutional memory” are already being lost in the rapid shift to GP commissioning. While we support the view that commissioning by PCTs requires reform, further consideration needs to be given to how to sustain and safeguard commissioning capacity and capability during the transitional period.

6.8 We would support recommendations that shadow GP consortia should be expected to meet explicit performance markers before proceeding to fully fledged consortia status.211 Similar to the authorisation regime for foundation trusts outlined in part 3, chapter 101, GP consortia should have a process that enables them to commission good quality care across a progressively wider range of services, as well as handle increasing amounts of NHS funds effectively.

6.9 We have concerns regarding that decisions on the transitional arrangements for the new commissioning system are being taken before a decision on the funding of hospice and palliative care. The Palliative Care Funding Review currently underway is due to report in summer 2011. While we have welcomed the review, we believe significant risk is presented by the fact that the decisions on the transitional arrangements for the new commissioning system will be taken before a decision is made on hospice and palliative care and how it should be funded, and therefore commissioned, in the future.

210 A Help the Hospices/National Council for Palliative Care (NCPC) survey undertaken in October 2010 found that 30% of hospices had already seen an in-year reduction in PCT funding, and a third of respondents were aware of care staff cuts in local palliative and end of life care services. Help the Hospices/NCPC, National survey of adult palliative care providers, 2010.
6.10 In complex areas of care such as hospice and palliative care, there is strong evidence to suggest that there should be emphasis on collaboration and integration between health and social care. Recognising the activity of hospices as providers of integrated health and social care, we have concerns that although ministers have stressed the need for integration, there are no powers within the bill (part 3, chapter 1) for Monitor to promote such integration. Decisions on the transitional arrangements for the new commissioning system will also be taken before the reforms in social care are agreed. Indeed, as with the Palliative Care Funding Review, the Commission on Social Care is not expected to report until summer 2011.

6.11 The transition period for reform will only work if new and existing structures within the system are supported by strong accountability mechanisms. As the NHS is also expected to deliver £20 billion of efficiency savings by 2014 and the financial environment is pressured, accountability needs to be strong enough to ensure the system achieves improved outcomes and greater responsiveness to patient need. We are pleased the bill goes some way in explaining how consortia, the NHS Commissioning Board and regulators will be held to account, although much of the detail is left to regulation. The key test will be how the new system and proposed accountability arrangements deal with issues that emerge. For example, the bill does not explain how the board’s mandate is passed down to consortia, how their performance will be measured or published, or how failure will be determined.

March 2011

Memorandum submitted by York LINk (HS 98)

One aspect of the proposals in the Health and Social Care Bill that York LINk discovered is missing is a statutory requirement for patient’s representatives to be a part of the GP commissioning process.

The LINk is aware that the Bill proposes that GP’s listen to patients and the public on a regular basis. However, at present in York there is only one GP practice that has a Patients Participation Group (PPG) to facilitate this. The LINk recently supported a surgery attached to the Priory Group to try to establish a PPG and although it is very early days we are hopeful that this will eventually incorporate people from the other five surgeries in the practice. We have also offered to assist all GPs in the York area in the emerging GP Consortium to establish PPGs and understand that they will receive additional funding to help with this.

The LINk also had representatives on a Patients Panel in the former York Health Group (PbC) and is aware that there are proposals to include these lay representatives in the emerging GP Consortium. Although we welcome this inclusion, our concerns are that as there is no statutory requirement to have patient representatives and their views will be sidelined in favour of other concerns. We would be grateful if you could bring this anomaly to the attention of the Minister for Health in the hopes that the final Bill can be more prescriptive regarding patients and public inclusion.

March 2011

Memorandum submitted by the Association of British Healthcare Industries (HS 99)

The Association of British Healthcare Industries (ABHI) represents the UK medical technology sector. Our purpose is to promote the rapid adoption of medical technologies to ensure better outcomes for patients. The medical technology sector in the UK employs 57,000 people at over 1,500 manufacturing sites and has a turnover of £13 billion. The relatively large size of this industry sector reflects UK strengths and heritage.

The ABHI warmly welcomes the duty in Clause 19 for the NHS Commissioning Board to promote innovation (new clause 13H for National Health Service Act 2006). This is vital:

— The NHS has identified a clear need to innovate in order to meet its changing demographic demands and financial pressures.
— There has been a poor link between development of new treatments and technologies and their adoption in the NHS to provide better care at better value.
— A strong demand for innovation from industry can continue to support the UK as a base for high value manufacturing jobs and the NHS can be an innovation champion for the lifesciences industry.
— Several recent National Audit Office reports\(^\text{212}\) suggests that various parts of the NHS overlap and duplicate each other, incurring unnecessary costs in procurement.

ABHI suggests that the duty to promote innovation should be strengthened to make it more explicit (a possible amendment is at annex A).

This duty is key to the adoption and diffusion of new treatments and technologies. The NHS Commissioning Board should ensure that evidence for medical technologies leads directly through to appropriate adoption and diffusion in the NHS and to transparency of resulting outcomes for patients. Existing barriers are:

(i) Clinical coding does not link clearly to ensuing tariff for new procedures. Governance and future development of the tariff needs careful attention by the NHS Commissioning Board as well as by Monitor.

(ii) There is minimal support for adoption and diffusion of technologies in the NHS. The NHS Technology Adoption Centre could support the Commissioning Board in this.

(iii) Measurement of uptake of both existing and new medical technologies is lacking. This should be linked to the NHS Atlas of Variation, for patients and professionals to consult and to reinforce patient choice and control.

Whilst the ABHI welcomes those parts of the Bill which seek to improve the quality of services in the NHS through innovation, attention also needs to be given to areas of existing policy which act as a brake on innovation and also add costs to the NHS. This is especially true as regards commercial policy in the NHS and in particular the way this affects procurement, for SMEs and large companies alike.

**Procurement—alignments do exist between the NHS and its suppliers**

— The NHS needs products which will save it money and industry wants to provide such products. The Department of Health (DH) is putting systems in place to accentuate the NHS focus on this.

— Long term trends in costs of healthcare technologies show increases below those in the wider economy—and very much lower than those in healthcare overall (ONS data).\(^{213}\) The NHS can better receive the benefits of these trends through adopting a new approach to the productivity which technologies can provide and by disinvesting from activity that yields lower benefits for patients.

— Sustainable pricing is needed—understandable by/within the NHS and assuring best value for purchasers. DH is taking steps to reinforce the appropriate behaviours but needs to act also on the issues below.

. . . *but there exist many unnecessary costs that should be removed from the supply chain*

There is insufficient “Do It Once and Once Only.” Particular issues are:

— there are multiple points of entry to the NHS, in conjunction with a variety of onerous conditions and fees required to take part in the procurement process. The purpose of this is to raise “Activity Based Income”, charging suppliers a percentage of total sales organised by the intermediary. These practices add to supply chain and health care costs and the basis for their existence is challenged in recent NAO reports.\(^{214}\) There is no national consistency in these policies, and they are difficult to defend in terms of international codes/conventions of business practice (eg UK Bribery Act, US Foreign Corrupt Practices Act:);

— there are varied terms and conditions for contracts and ancillary documentation, with competing NHS stakeholders at national, regional and local levels; and

— NHS Supply Chain, as a national agent of the NHS, run by DHL through its subsidiary Exel Europe, commissions production of “own label” products “direct from manufacturer”. This treats products as commodities, in order to reduce price. Supply Chain thus has a dual role as both a tenderer for public supply and a competitor with incumbent suppliers, with the benefit of privileged market information including its suppliers intellectual property. This issue has not yet been exposed to full transparency. These questions on NHS Supply Chain business processes extend to its regulatory compliance, which has been thrown into doubt by a recent report.

**Examples of barriers to uptake**

Exmoor Innovations (SME, Somerset) produces Epidural System, “Epiderm”, a drug delivery system that allows clinicians more accurately to identify the epidural space. The system has a shorter learning curve for clinicians and has been proved to reduce the number of negative episodes from around 50,000 to 10. It was developed by this UK company working closely with a Somerset Hospital. Despite the hospital currently owning 10% of the patent, the sales in the UK are currently zero as procurement managers fail to recognise the wider benefits of the system and only assess the upfront cost. Epiderm is currently in use in a number of markets including Australia, Europe and the Middle East.


Medtronic’s device system allows patients with implanted devices to be monitored at home, obviating the need for follow up appointments. In order for a Hospital trust to start using this system it must first approve the terms, conditions and patient privacy statements. Each NHS Trust has its own unique series of forms to complete to gain approval. Despite the benefits to patients and the savings that can accrue, this process has had to be run 85 times with different trusts.

Pathogen Solutions Ltd (SME, West Midlands) has a UV steriliser for killing airborne bacteria and viruses, reducing health-care acquired infections. Despite positive review by the Rapid Review Panel under the Health Protection Agency scheme and subsequent acceptance in the NHS catalogue, in order to sell this innovative product the company had to approach each NHS Trust individually to obtain approval.

Safe Patient Systems, founded by Consultant Surgeon David Morgan and based at the Heartlands Hospital in Birmingham (10 staff), has a passive radiofrequency identification (RFID) tagging system to monitor patients and operating theatre throughput, ensuring the correct patient is operated on and that the correct procedure is conducted on the correct organ/limb. Despite being based within a hospital Trust, and having insider knowledge, the company has had to approach each Trust individually throughout the country and is struggling to gain widespread adoption.

Seating Design & Development Ltd (less than 10 staff, university collaboration in Midlands and Essex base) produces a range of seating technologies to reduce the risk of deep vein thrombosis (DVT) for long-term wheelchair users. In order to sell this innovative product onto the market it has had to replicate slightly revised trials with each NHS Trust across the country.

In summary, as regards its acquisition of technology:

— The NHS continues to focus on price, rather than value and to see suppliers as transactional rather than business partners.

— NHS systems tend to increase supply chain costs, through the variety of intermediary organisations involved.

— There are specific issues on NHS Supply Chain business processes.

Annex A

Possible amendment to clause 19, for the NHS Commissioning Board to promote innovation (new clause 13H for National Health Service Act 2006)

The NHS Commissioning Board should in pursuit of its duty to promote innovation:

1. Ensure that evidence-based medical technologies, of which some are assessed by NICE, lead directly to appropriate changes in the NHS “adoption architecture”:
   — clinical coding and ensuing tariff for procedures;
   — support for uptake through the NHS Technology Adoption Centre, or a similar function embedded in NICE;
   — measurement of uptake of new medical technologies with:
     — links to the NHS “Atlas of Variation” for patients and professionals to consult; and
     — strong link to patient choice and control.

2. Take into account the NHS’s role as an innovation champion for UK healthcare/lifesciences industry which employs almost 140,000 people in the UK, has a turnover of about £34 billion and has a record of innovation greatly exceeding its size in global terms. The Commissioning Board’s annual report should demonstrate how it has taken this into account with reference to the points at 1 above inter alia.

March 2011

Memorandum submitted by The King’s Fund (HS 100)

1. The King’s Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.
Health and Social Care Bill

INTRODUCTION

2. The Health and Social Care Bill goes much further than previous reforms in applying market-based principles to the provision of healthcare. The aim is to increase diversity of supply, promote competition and increase choice for patients. This will be achieved by establishing Monitor as an economic regulator, extending choice of provider to a wider range of services and allowing providers from all sectors to compete on an equal footing.

3. This submission focuses on Part 3 of the Bill which sets out the legislative framework for the economic regulation of health and social care.

MONITOR

4. The establishment of Monitor as a powerful economic regulator is very significant. From April 2012, it will be responsible for three key functions across health and social care: promoting competition, setting prices and ensuring continuity of essential services. The Bill gives Monitor wide-ranging powers to impose licence conditions to prevent anti-competitive behaviour, apply sanctions to enforce competition law and refer malfunctioning markets to the Competition Commission.

5. The framework set out in the Bill appears to be modelled on the approach taken in the utilities sector and will open up the NHS to challenge by the Office of Fair Trading and the Competition Commission. It places a heavy onus on Monitor to deliver an optimal configuration of services that balances access, quality, efficiency and cost.

Monitor’s principal duty

6. Monitor’s principal duty is to “protect and promote the interests of users of health care services by promoting competition where appropriate and through regulation where necessary”. Both competition and regulation are means, not ends. As the duty currently stands, it appears that competition and regulation are viewed as alternatives, with the inference that regulation should be used where competition is not deemed appropriate. In fact, as experience in other sectors has shown, regulation is a necessary pre-requisite if competition is to be beneficial to service users.

7. Given that the framework set out in the Bill appears to mirror the approach taken in the utilities sector, there may be lessons to be learned from previous experience. During the last parliament, Ofgem was widely criticised for interpreting its functions too narrowly and placing too much emphasis on promoting competition. Its principal duty was eventually amended by the Energy Act 2010 to make it clear that its main objective is to promote the interests of consumers and that competition should be used only in order to achieve this.

8. Recent government statements have stressed that competition should only be used in health care where it will deliver benefits to patients, and that it is not an end in itself. However, although it is qualified by the reference to using regulation where necessary, the way Monitor’s duty is framed is strikingly similar to the original duty on Ofgem (as set out in Utilities Act 2000), in that the duty to promote competition is closely linked to the duty to protect and promote the interests of service users.

The Committee may wish to consider whether the principal duty on Monitor, as it is currently framed, will achieve the main objective of promoting the interests of users of health care or whether it tips the balance too far in favour of promoting competition as an end in itself.

9. If the clause remains as it stands, the definition of “where appropriate” will be critical. Competition may be beneficial to patients in some areas such as simpler elective services or small scale community provision. In other areas, competition may make it more difficult to commission services that best serve patients’ interests, for example, where partnerships are needed to ensure provision of seamless care between providers of hospital and community services, or where, as with stroke and trauma care, hospitals need to work together across wide geographical areas. In both these examples, competition for the market could be organised through a tendering process, but the result would be that the choice of individual patients would be limited to the chosen partners or specialist centres.

The Committee may wish to seek assurances that the exercise of competition powers by Monitor will enable partnership agreements to continue where these are in the interests of patients.

Other duties and powers

10. Monitor also has a duty to promote the economic, efficient and effective provision of services (section 52(3)) and must have regard to safety, continuous improvement in quality and efficiency and fair access (section 54), as well as a number of other factors. These provisions do not make it clear how the balance between these various duties and considerations should be struck and how conflicts between Monitor’s policies and those of the Care Quality Commission and NHS Commissioning Board, for example, should be resolved. The Bill does not adequately define the role of Monitor in relation to these bodies. For example, it does not make clear the circumstances determining whether the Secretary of State should turn to Monitor or the NHS Commissioning Board to deal with performance issues.
11. Under the framework set out in the Bill, no single organisation is responsible for overseeing the NHS as a whole, in terms of both provision and commissioning. In the case of the energy industry, this difficulty has been resolved in part by giving ministers powers to issue general directions relating to the policy framework within which the regulator should operate. However, these sectors have a much simpler governance structure and there are no equivalent bodies to the Care Quality Commission or the NHS Commissioning Board.

12. In relation to specific trade-offs such as cost or access versus quality, other regulators have commissioned research from service users to help define where the balance should be struck. In one case, the water regulator asked ministers for a decision as the cost implications of implementing higher standards were so considerable.

The Committee may wish to consider whether the framework set out in the Bill is sufficiently clear about the balance between Monitor’s duties and its relationships with other key organisations. There may also be case for specifying how decisions about difficult trade-offs should be supported in terms of analysis and the process for doing so.

Consumer voice

13. In other sectors strong bodies have been set up to represent consumers and ensure regulators take their preferences into account. Although it is being abolished, Consumer Focus is a good example of this. In contrast, HealthWatch, which is being established as an “independent consumer champion” in health care, will be a sub-committee of the Care Quality Commission—it is hard to see it having much influence on a regulator as powerful as Monitor.

The Committee may wish to consider whether HealthWatch will have sufficient power to act as an effective consumer champion.

PROCUREMENT AND COMPETITIVE COMMISSIONING

14. The Bill gives the Secretary of State powers to allow Monitor to “impose requirements” on the NHS Commissioning Board and consortia so that they adhere to good practice in relation to procurement, protect patients’ right to choice and promote competition. Specifically, it refers to Monitor’s ability to require competitive tendering. Under section 64 (3) it appears that Monitor could require a consortium or the NHS Commissioning Board to tender services.

15. The same risks arise here as with Monitor’s principal duty ie whether promoting competition might be placed above other factors affecting the interests of patients such as integration of services based on collaboration between providers. For example, a commissioning body may wish to procure an innovative community-based service where only one organisation is in a position to pioneer it. In this case, a less formal process such as market testing may be more appropriate.

The Committee may wish to seek assurances that the requirements on commissioners to competitively tender services will not prevent them from deciding not to use the full tendering process in specific circumstances.

16. A major benefit of GP involvement in commissioning is the potential for GPs to design innovative forms of primary care provision and new models of care in the community. This creates a potential conflict of interest for GPs as both commissioners and providers of services. An appropriate balance needs to be struck that does not stifle the potential for creativity under the burden of highly bureaucratic processes or complex procurement and tendering rules. However, it will be important that such decisions are made and reported transparently to avoid conflicts of interest.

The Committee may wish to seek assurances that the NHS Commissioning Board and Monitor will be able to develop a proportionate approach that allows GPs to develop and deliver innovative services, while providing reassurance that conflicts of interest will be managed effectively and transparently.

DESIGNATION OF SERVICES

17. Under the more market-based approach outlined in the Bill, providers unable to compete will be allowed to “fail” and exit the market. Monitor will be responsible for protecting the public interest in these circumstances by guaranteeing the continuity of “designated” services, for example ensuring access to A&E and maternity services within safe travel times. The process must be flexible enough to challenge incumbent providers and allow new and innovative providers to enter the market.

18. Before a service can be designated, commissioners must consult “relevant persons” and demonstrate to Monitor that there would be a “significant adverse impact on the health of persons in need of the service”. The expectation is that the case would be made primarily by local professionals in GP consortia. The burden on commissioners making an application will be considerable if it is to be evidence-based. For example, the relationship between travel times and outcomes are not well established in many areas of care. They may also find it difficult to assess the interdependencies between different services. It is not clear therefore whether GP consortia will have the technical skills and evidence base to make the case for designation.
19. The Bill does not acknowledge that people (and professionals) outside the immediate local area may be affected by a loss of service. For example, tertiary and specialist services often serve wide catchment areas. It is not clear what happens if no local consortium chooses to designate such a service. There is provision for NHS Commissioning Board to step in and “facilitate agreement between commissioning consortia” to decide whether to designate and who should apply, but it is not clear what should happen if that does not work.

   The Committee may wish to seek further clarification about the regime for designating services.

20. It will also be difficult for GP commissioners to drive major reconfigurations within secondary care. The importance of the system leadership role currently provided principally by strategic health authorities is underlined by a new report published by The King’s Fund on the reconfiguration of hospital services. The report shows that essential changes to improve quality and tackle financial deficits in some hospitals are unlikely to happen if left to market forces alone.

21. The Bill enables GP consortia to collaborate to address issues across consortia boundaries. However, they may not have the appetite or the skills to tackle large, complex and contentious service changes, with the result that the pressing need to reconfigure hospital provision in some areas may not be addressed quickly enough, if at all. A strong, strategic commissioning function able to look across large geographical areas is needed for these purposes. In a recent radio interview, the Secretary of State indicated that the NHS Commissioning Board may have a role in this, although he did not explain how this might work.

   The Committee may wish to clarify how major service reconfigurations will be overseen in future.

**PRICE SETTING**

22. The NHS currently operates a system of national tariffs, where providers are paid a fixed amount for providing a particular service and compete on quality. The Bill will make Monitor responsible for publishing a national tariff setting out the prices of health care services, doing so in agreement with the NHS Commissioning Board. Currently, responsibility for publishing the tariff rests with the Department of Health, so this part of the Bill builds on current practice, although it also introduces some new elements.

23. Firstly, it provides for a higher tariff where a provider of a designated service cannot cover its costs even if operating efficiently. This is important as it will enable providers to maintain provision, for example, in rural areas where costs may be high or where, if they lose some services to other hospitals, they cannot reduce their fixed costs. However, it may mean that commissioners in areas with a large number of designated services will have to pay levies to Monitor for designating services and higher tariffs. This seems unfair. A solution would be to take these factors into account through the allocation formula, but the Bill makes no mention of this.

24. Secondly, the tariff can “comprise two or more services which together constitute a form of treatment”. This possibility seems to open the way for tariffs that cover more than simply an episode of care. This is a welcome development as it should help to support integration of care by for example, allowing a tariff for a course of treatment such as “a year of diabetes care”, allowing the successful contractor to combine the elements required for the whole package of care without negotiating separate deals for each one.

25. Evidence from the United States and from the NHS in the early 1990s suggests that price competition may reduce quality as providers seek to lower costs and lead to higher transaction costs, as commissioners and providers spend significant amounts of time negotiating prices. We therefore welcome the amendments tabled by the government to remove the provisions allowing Monitor to set maximum prices. However, given statements made by the Secretary of State and the new Chair of Monitor, David Bennett, indicating that price competition could be permitted in some circumstances, the position is still not entirely clear.

   The Committee may wish to seek further assurances that the framework established by the Bill will deliver the government’s stated intention of preventing general price competition and about the circumstances, if any, it might be allowed on an occasional basis.

26. Experience in other regulated sectors suggests that important elements of price setting have been omitted from the Bill. Firstly, experience has shown that the level of the tariff has important implications for the level of new investment. The Bill requires Monitor to consider future health care needs but it does not explicitly refer to the link between price and new investment. In other industries, the regulator has taken a view on future investment needs as part of tariff setting to ensure that revenue is sufficient to improve and expand the capital stock. It is not clear which organisation will be responsible for setting out what these investment needs might be. Within the NHS, the capital budget has been persistently underspent. There is a case for allowing commissioners to pay a supplement, for a limited period, above the current capital allowance implicit in the tariff to encourage new investment.

27. Secondly, the Bill does not address the use of the tariff to promote specific objectives. The current NHS tariff embodies incentives set by the Department of Health to promote quality and reductions in emergency readmissions. While it is clear that Monitor and the NHS Commissioning Board will be required to work together to set specific prices, it is not clear which organisation will be responsible for requiring that
such “incentive” tariffs should be introduced in future. The Bill gives the Secretary of State powers to direct the Commissioning Board but these are intended to be rarely used leaving it open as to where decisions will lie on a day to day basis.

The Committee may wish to seek clarification about whether the new tariff regime will allow flexibility for encouraging new investment and promoting specific policy objectives.

LICENSING

28. Licensing allows the regulator to impose conditions on providers, for example, requiring information about costs of services to inform price setting or to adhere to specific standards. The regime set out in the Bill is similar to the approach taken in other regulated sectors.

29. A key element of the licence is the requirement that providers should allow other providers to use their services. This will allow Monitor to require a provider such as a large foundation trust to make some of its facilities available to a competitor. Currently, private sector providers usually have access to NHS intensive care facilities in the event of a major incident in their own facilities. If they were denied this, the scope of their activity would be severely limited. Similarly, a new provider may wish to access the diagnostic services of an established larger provider to allow it to enter a market without major investment. But if there is no spare capacity available, then to do so would disadvantage the larger provider. The terms on which access of this kind is provided will have to be carefully worked out to ensure that such arrangements are limited to circumstances where the required capacity exists.

The Committee may wish to seek further clarification about the detail of the licensing regime.

March 2011

Memorandum submitted by the Children’s Commissioner (HS 101)

OFFICE OF THE CHILDREN’S COMMISSIONER

The Office of the Children’s Commissioner is a national organisation led by the Children’s Commissioner for England, Dr Maggie Atkinson. The post of Children’s Commissioner for England was established by the Children Act 2004. The United Nations Convention on the Rights of the Child (UNCRC) underpins and frames all of our work.

The Children’s Commissioner has a duty to promote the views and interests of all children in England, in particular those whose voices are least likely to be heard, to the people who make decisions about their lives. She also has a duty to speak on behalf of all children in the UK on non-devolved issues which include immigration, for the whole of the UK, and youth justice, for England and Wales. One of the Children’s Commissioner’s key functions is encouraging organisations that provide services for children always to operate from the child’s perspective.

EXECUTIVE SUMMARY

This briefing considers the possible impact of the Health and Social Care Bill 2011 on children’s rights outlined in the United Nations Convention on the Rights of the Child.215

The Office of the Children’s Commissioner has assessed that the Bill has the potential to improve health outcomes for children in a number of areas, including helping realise children’s right to participate in decisions affecting them through Local HealthWatch and HealthWatch England.

However, we share the concerns expressed by a number of the Royal Colleges, including the Royal College of Paediatrics and Child Health (RCPCH) that:

— the increased fragmentation of the NHS and the introduction of full price competition may both tend to undermine children’s right to health; and

— the reforms risk undermining partnership working across children’s services and may fracture continuity of care, particularly for children with long term conditions or specialist or complex healthcare needs.216

We therefore urge parliamentarians and the Government:

— to ensure that children are a priority group for the NHS, both locally and nationally, by requiring health and wellbeing boards to have specific regard to the health and wellbeing of children;

to ensure that both GP consortia and the NHS Commissioning Board are focussed on improving the quality of care to children, including primary care services to all children and specialist services to children with specific needs and vulnerable children, including children in care, youth justice settings and asylum seeking children;

to ensure that GP commissioning consortia should have access to training and expertise to commission child health services;

to ensure that the NHS Commissioning Board be given a clear remit to commission high quality services for children with rare disorders and other complex needs, and vulnerable children;

to ensure that all bodies have a senior staff member with responsibility for ensuring high quality health outcomes for children;

to require directors of children’s services to be members of health and well-being boards;

to require joint strategic needs assessments (JSNAs) to address current and future health and well-being needs of their population, which must of course include children’s health; and

to place an explicit duty on Healthwatch England and Local Healthwatch to involve children in the development of services and decisions about their care.

Introduction

This briefing considers the major reforms to the NHS proposed in the Health and Social Care Bill 2011. It focuses on the possible impact on children’s rights, particularly those set out in the United Nations Convention on the Rights of the Child (UNCRC). The key rights engaged by the Bill are:

Article 2: The right to enjoy all human rights, without discrimination.

Article 3: That the best interests of the child must be a primary consideration.

Article 6: The right to life and to develop “to the maximum extent possible”.

Article 12: The right for children to participate and express their views.

Article 16: The right to private and family life.

Article 19: The right to protection from child maltreatment.

Article 22: If a child is a refugee or seeking refuge, the government must ensure they have the same rights as any other child.

Article 23: The right for disabled children to enjoy a “full and decent life” and their right to “special care”, including health care.

Article 24: The right to enjoy “the highest attainable standard of health” and to be able to access suitable health facilities.

Article 33: The Government must protect children from the use of illegal drugs.

Article 34: Governments must protect children from sexual abuse and exploitation.

Article 39: Children neglected, abused or exploited must receive special help to help them recover their health dignity and self-respect.

Article 4 of the UNCRC states that the Government must take “all appropriate legislative, administrative and other measures” to ensure the realisation of rights protected under the UNCRC, and must also apply “the maximum extent of their available resources” to this purpose.

Concerns in relation to poor health outcomes for children are set out in the most recent UK report from the UN Committee on the Rights of the Child (October 2008). The Committee stated as follows:

“. . . Despite the State Party’s efforts to tackle inequalities in access to health services through, inter alia, substantial investments, inequalities remain a problem, as demonstrated by the widening gap in infant mortality between the most and least well off groups.”

The Committee called for these inequalities to be addressed through “a coordinated approach across all government departments and greater coordination between health policies and those aimed at reducing income inequality and poverty.” The Committee also called for:

— additional resources to meet the needs of children with mental health problems;
— intensified efforts to improve reproductive health services;
— greater support for children to reduce substance abuse; and
— better training for health staff in relation to the specific needs of disabled children.

However, we are unaware that a specific budget has been allocated to the implementation of the UNCRC or that any action has been taken to address the recommendation for a clear central health budget for children proposed by Sir Ian Kennedy in September 2010.217

CHILDREN’S HEALTH—THE BACKGROUND

Realising a child’s right to health requires the best quality health services to be available. Children are heavy users of health services. A child under two will visit their GP practice an average of six times a year, and children and young people constitute around 40% of each GP’s workload. An increasing number of children and young people, including disabled children and children with life-limiting conditions, will need to access secondary and tertiary health services. Around 100,000 children in England with complex care needs will require support from a wide range of services.

A report by the Every Disabled Matters Campaign shows that disabled children use NHS services significantly more than other children, yet they and their families consistently report poor experiences of both universal and specialist health services. A young disabled person talks about lack of access to therapeutic services saying:

“I went to a mainstream secondary school. I did not get to see a physio or OT [occupational therapist] regularly. This is because I didn’t go to a special school for disabled people. I think health, education and social services need to work more closely together.”

We are conducting our own research around children and young people’s views of using GPs’ services. Initial findings show that there are issues children and young people would not feel comfortable talking to GPs about. When asked what they would not want to talk to a GP about, young people said:

“It’s hard talking about eating disorders to strangers and people you feel may judge you, specifically after negative experiences with doctors in the past. I have been called psychotic . . .”

“Anything that is personal, for example, irregular periods, skin deformity, things like that. Reason being, he makes me feel stupid and it feels like my appointment is being rushed and I’m just a number.”

“Mental health—they are very insensitive about this. When I moved to the area and registered with this GP, I was on a prescription psychiatric medication, and as soon as my GP found out he told me to stop taking it . . . He didn’t ask my opinion or give any advice on withdrawal, and never followed it up.”

THE BILL—KEY ISSUES FOR CHILDREN

We have chosen to focus the analysis below on the following four areas:

1. Structural reforms.
2. Public health and promoting positive outcomes.
3. HealthWatch.

This is not because other aspects of the Bill are not important to children, but because we consider that these areas are those with the greatest potential impact on children’s rights.

1. Structural Reforms

The main structural reforms created by the Health and Social Care Bill 2011 are set out in Part 1, The Health Service in England. These extensive reforms include the establishment of a new NHS Commissioning Board, the abolition of primary care trusts (PCTs) and strategic health authorities and their replacement with GP commissioning consortia as the primary bodies with responsibility for local health services. There is also a far greater role for local authorities in the promotion of public health, working with the Secretary of State for Health.

The following aspects of the structural reforms contained within Part 1 of the Bill clearly have the potential to improve health outcomes for children:

— GP commissioning consortia may be closer to individual children and families than primary care trusts and may be able to commission packages of care with greater sensitivity to individual needs.

— The specific focus on reducing inequalities has the potential to lead to a greater focus on children’s health outcomes.

— The focus on public health has the potential to lead to improvement in areas such as substance misuse identified by the Committee to be particular problems in relation to children.

— Each GP commissioning consortium must produce a commissioning plan each year (clause 22) which must “in particular explain how the consortium proposes to discharge its duties to seek continuous improvement in the quality of services”.

221 See Explanatory Notes at para 274.
— There is a specific new duty on local authorities to help deliver and sustain good health among the prison population (clause 25). Given the concerns about all outcomes, including health outcomes, for children in custody this duty may benefit this particularly vulnerable group of children.

— The requirement on directors of public health to publish annual reports on the health of their local population (clause 27) gives an opportunity for children’s health outcomes to be subject to ongoing review in every local area—albeit that there is no specific requirement for directors to consider children’s health outcomes.

However, we would wish to highlight the following specific concerns about these proposed structural reforms:

— As set out above, many children and young people currently have negative experiences of engaging with their GP practices. Given the central role for GP commissioning consortia, the ability to work effectively with children and their families with a range of needs must be an essential element of the training programme which must accompany these reforms. A further concern is that valuable relationships between children and families and their GP may be undermined if GPs are responsible for ensuring that their consortium’s referral budget is not breached.

— Given the existing time pressures on GPs, it is unclear how and to what extent GPs themselves will be involved in the commissioning of specialist health services for children, or if this will continue to be done by managers. This raises the question as to what practical benefit for patients (including children) the transition from primary care trusts to GP commissioning consortia will entail.

— The introduction of full price competition within the NHS has led to concerns that the duty to promote quality in children’s health services will be undermined by an incompatible duty to achieve the best price for a service. The RCPCH has stated that “Market-based competition in health without more collaborative commissioning will undermine leach expertise, reduce service availability and increase waits. There must be safeguards in the Bill to ensure that services for children, which may not be lucrative enough for competitive market improvement, do not suffer.”

— The very significant changes to the way in which mental health services are commissioned and provided (clauses 30–37) must not undermine the recent and vital focus on improving child and adolescent mental health (CAMHS) services.

— The processes for determining whether the NHS or local authorities should lead on providing care for children with complex needs (“continuing care”) are already far from clear. There is an opportunity, not currently in the Bill, to specify the requirements on GP commissioning consortia in relation to assessment and provision of services for children with complex health needs.

— Currently, transition from child to adult services is very poorly managed in many areas, with particular difficulties with respect to the transition from paediatric to adult health services. Again, the Bill could include how the new structures can improve this process.

In relation to GP commissioning consortia, the equality impact assessment notes a concern that consortia may have “insufficient knowledge of the range of services for vulnerable children”. The mitigation for this risk is said to be the power for consortia to enter into partnership arrangements with local...
authorities. We are concerned that in the absence of central direction or guidance from the secretary of state, this power will be insufficient to ensure that all GP commissioning consortia have adequate understanding of child health issues to meet the health needs of children and families. We therefore propose that the legislation should:

— ensure that children are a priority group for the NHS, both locally and nationally, by requiring health and wellbeing boards to have specific regard to the health and wellbeing of children;
— ensure that both GP consortia and the NHS Commissioning Board are focussed on improving the quality of care to children, including primary care services to all children and specialist services to children with specific needs and vulnerable children, including children in care, youth justice settings and asylum seeking children;
— ensure that GP commissioning consortia should have access to training and expertise to commission child health services;
— ensure that both GP consortia and the NHS Commissioning Board are focussed on improving the quality of care to children, including primary care services to all children and specialist services to children with specific needs and vulnerable children, including children in care, youth justice settings and asylum seeking children; and
— ensure that all health bodies have a senior staff member with responsibility for ensuring high quality health outcomes for children.

2. Public health and promoting positive outcomes

In addition to those duties on the Secretary of State outlined above, the Bill makes proposals (in Parts 1 and 5) in relation to public health and the promotion of positive health outcomes. Key proposals include the establishment of directors of public health within local authorities and the requirement for local authorities and GP commissioning consortia to prepare joint strategic needs assessments (JSNAs).

The following aspects of parts of the Bill clearly have the potential to improve health outcomes for children:

— The requirement for directors of children’s services to be members of health and well-being boards (clause 178).
— The requirement for joint strategic needs assessments (JSNAs) to address current and future health and well-being needs of their population, which must of course include children’s health (clause 176).

However, we would wish to highlight the following specific concerns about several parts of the Bill in relation to children:

— There is nothing in the Bill which explicitly requires health and well-being boards to prioritise the health needs of children.
— There is not any specific requirement for child health to be a priority in joint health and well-being strategies.
— Health and well-being boards have a duty to encourage joint working across agencies—but no powers to compel it.

We therefore propose that:

— Children should be clearly signalled as a priority group for the NHS, both locally and nationally, by requiring health and well-being boards to have specific regard to the health and well being of children in their decision-making.
— There should be a strong direction to health and well-Being boards from the Secretary of State and the NHS Commissioning Board as to the central importance of improving outcomes for children.

In relation to public health, it is essential that the guidance to be issued to directors by the Secretary of State makes it clear that children’s public health is a key priority.

3. HealthWatch

The context in which the Bill proposes to improve public engagement with the NHS is one in which it is widely acknowledged that children’s views have been marginalised for too long. The Bill’s equality impact assessment notes (in its section on “Input to decision-making”) that “One area for improvement is increasing the influence of children and young people.”227 The equality impact assessment notes further that there is “significant scope to better focus advocacy services on…providing help for children”228 and that “advocacy for complaints does not appear to be adequately focussed on children.”229

The proposals on public engagement are found in Chapter 1 of Part 5 of the Bill. They include the establishment of Local and National HealthWatch (“HealthWatch England”) to represent the views of the public in relation to the NHS Commissioning Board and GP commissioning consortia. Further, local authorities rather than the Secretary of State must make provision for independent advocacy services in relation to complaints (clause 170). These may be commissioned from Local HealthWatch or another provider.\textsuperscript{230}

This part of the Bill has the potential to:

— help realise children’s rights to participate and to have decisions taken in their best interests through proper engagement with them by Local HealthWatch and HealthWatch England; and

— improve advocacy services by transferring responsibility to local areas.

However, we would wish to highlight the following specific concerns about these proposed reforms:

— children’s participation will only be a reality if all HealthWatch organisations make children a priority and adopt best practice in participation; and

— improvements in advocacy services will only happen if sufficient specialist advocacy to assist children to make effective complaints is available in every local area.

We therefore propose that the Bill should:

— place an explicit duty on Healthwatch England and Local Healthwatch to involve children in the development of services and decisions about their care.

4. National Institute for Health and Clinical Excellence standards

The role of the National Institute for Health and Clinical Excellence (NICE) is dealt with in Part 8 of the Bill. Importantly, a new NICE function is proposed to develop “quality standards” on being so commissioned by the NHS Commissioning Board (clause 218). The Secretary of State and the Board must have regard to these standards in discharging their health improvement duties.\textsuperscript{231} The standards will have statutory force once approved by the Secretary of State or the Board.\textsuperscript{232}

There is obvious potential for NICE quality standards to improve the standard of child health services. This would be assisted by a specific duty imposed on NICE through the Bill to have due regard to the interests of children in developing its quality standards. This would make children a priority both in terms of general health standards and in terms of ensuring that NICE focuses on the need for specific quality standards in relation to child health.

In a system where decision-making is being devolved down to local areas, NICE quality standards and guidance are essential in ensuring that minimum standards are adhered to. In order for the Bill to deliver improvements to children’s health it will be necessary for quality standards and guidance to address the issues that matter to children—and for all relevant bodies to be required to act upon the standards and guidance.

CONCLUSION

It is beyond doubt that this Bill will have a very significant impact on children’s health services and children’s rights, and much of the essential detail will be left to secondary legislation and guidance. Few of the currently proposed outcome standards relate to children’s services and there are no outcome standards defined yet for children with developmental disorders and disabilities.\textsuperscript{233}

If the Bill is to deliver improvements on child health it is vital that children are a priority across all directions and guidance issued to local bodies—including health and well-being boards, GP commissioning consortia and Local HealthWatch. The recent review by Sir Ian Kennedy demonstrates that children will not automatically become an NHS priority but that child health must be set as a priority both nationally and locally. If this happens, then there is certainly the potential that the Bill could lead to the better realisation of children’s right to health—and the delivery of the requirement under the UNCRC that the “maximum available resources” are allocated to this task.

If, however, children are not placed at the centre of these reforms then the devolution of power to localities is likely to result only in an unacceptable increase in the “postcode lottery” of children’s health and social care services which currently exists. As the RCPCH rightly states, “Clear minimum standards of care and expertise in commissioning for children must be in place” if this Bill is to deliver on the universal commitment to improving children’s health.\textsuperscript{234}

March 2011

\textsuperscript{230} See Explanatory Notes at para 922.
\textsuperscript{231} Being the duties contained in clause 2 and clause 19 respectively; see Explanatory Notes at para 1141.
\textsuperscript{232} See Explanatory Notes at para 1141.
Memorandum submitted by Royal College of Physician’s (HS 102)

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 25,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

Summary

The RCP has a well established role in promoting quality. We are making our recommendations with a view to maximise the best results for patients. We make 14 recommendations in this paper, recommendations 2, 3, 5, possibly 9 and 10 would require amendments to the Bill, the remainder call for clarity and further guidance from the Department of Health. Our recommendations are as follows:

To enshrine quality at the heart of the reforms:

1. At a national level the NHS Commissioning Board is responsible for setting the standards for consortia. The medical royal colleges are well placed to offer advice on these standards and should be central to the governance of the commissioning board.

To enable clinician-led commissioning that draws from the full variety of specialists and wider health professionals the RCP is calling for:

2. A tighter requirement for consortia and the national NHS Commissioning Board to involve practising specialists, public health and social care professionals at the highest levels of commissioning decision making. We believe this is crucial to the success of commissioning and should be on the face of the Bill, and would therefore require an amendment (clauses 19 and 22).

3. The national NHS Commissioning Board’s duty to encourage integrated working currently includes consortia and local authorities. This should be expanded to include hospital based specialists, with explicit reference to encouraging integration across primary and secondary care (clause 19, insertion 13J). A similar duty to integrate should be placed on consortia (clause 22).

4. Guiding principles for specialist involvement, including public health doctors, should be laid out in accompanying guidance documents. This would ensure all consortia adhere to the same general principles for commissioning, without being too prescriptive on consortia’s ability to find locally appropriate mechanisms. The RCP believes these guiding principles will promote integrated care.

To ensure services do not fragment and quality and integration are not at the expense of competition and are enshrined in the commissioning and providing of services the RCP recommends:

5. Monitor’s role is amended to promote competition on quality. They should be given the responsibility to grade providers on quality and disseminate this information to commissioners. This should be reflected in the Bill and would require an amendment (clause 52).

6. Work to identify quality measures and how consortia will be assessed against these metrics commences now. Due to the RCP’s well established role in setting standards we should be central to this process.

7. A “best practice tariff” which would reflect the cost of delivering a good service that is value for money and based on quality outcomes.

8. Further clarity to ensure inherent conflicts of interest does not prevent integrated working.

9. “Commercial sensitivities” are not allowed to block information sharing, transparency, accountability. This may need to be on the face of the Bill.

10. The considerations that Monitor must make when carrying out its functions should be extended to include consideration to the overriding principles of collaboration, integration and sustainability when licensing providers (clause 54).

11. Further guidance from the Department on how the designation of services (clause 69) will work in practice

12. Clarity on the process for service reconfiguration including, for example, further detail on accountability and community involvement in the decision-making process.

13. Include how whistleblowing will be supported in the constitution of the national commissioning board and local consortia. Monitor and CQC should also state how it will support the raising of concerns regarding poor standards of care.

14. A vision on how services for rare and uncommon conditions will be commissioned is required. We would recommend the national board, using a sub-national structure, assumes responsibility.
INTRODUCTION

The Royal College of Physicians (RCP) welcomes the opportunity to submit written evidence to the Health and Social Care Bill Committee, which builds on our oral evidence. We value the opportunity to provide further evidence on how the new arrangements for commissioning, laid out in Equality and Excellence, can maximise the best results for patients.

The RCP is in a powerful position to help improve commissioning and standards overall. No other body offers such a full range of evidence based quality guidance; we perform audits, issue clinical guidance, conduct clinical effectiveness studies, provide accreditation and write clinical pathways. The medical royal colleges are well placed to offer advice on quality and standards. The RCP believes we should be at the heart of national commissioning decisions, advising the NHS Commissioning Board on how to raise quality throughout the NHS in England.

One of the underpinning principles of the reforms to the health service in England is the aim to put both patients and clinicians at the heart of commissioning. The RCP fully supports this; we believe it will result in better patient care. However, we are concerned that some of the arrangements that are expected to deliver this remain too loose and there is a danger this vision will not be achieved. In our evidence laid out below, the RCP provides details on how we believe this risk can be mitigated and the vision of effective commissioning can be achieved. Further, the RCP has some concerns that under the proposals as they stand, competition could be at the expense of quality, collaboration and integration. We have proposed some safeguards to prevent this.

Integrating the full range of clinical expertise into commissioning

The Government clearly wants all healthcare professionals to work together to deliver effective commissioning. The Government’s response to the Health Select Committee’s recent Commissioning Report states, “The GP practice and registered patient list will be the building blocks of commissioning consortia, but successful commissioning will clearly also be dependent on the wider involvement of other health and care professionals.” The RCP, along with other medical royal colleges, supports “teams without walls”, an integrated model of care, where professionals from primary and secondary care work together across traditional health boundaries, to manage patients using care pathways designed by local clinicians. Additionally, the BMA believes that successful commissioning can only be achieved with GPs, secondary and tertiary care consultants working together. We would all like to see “commissioning without walls” and are therefore pleased to see that the Government’s intention reflects a model of care that we have been advocating for some time.

However, the RCP fears that there may be some distance between rhetoric and reality, which could threaten achieving the best outcomes for patients. To achieve the best commissioning arrangements for patients, which draws from the expertise of specialists and other healthcare professionals, the RCP is calling for:

— Amendments to the Bill that would:
  — strengthen the duty in the Bill to involve a full range of health professionals when commissioning (clause 19 and 22) and
  — hospital specialists and public health doctors to be included with local authorities and consortia in the duty to integrate services (clause 19, insertion 13J).
— Guiding principles which will facilitate effective clinician led commissioning to be developed which will support the policy intentions in the white paper Equity and Excellence.

A tighter requirement in the Bill for commissioners to involve a full range of health professionals

The RCP is strongly advocating for the highest level of commissioning decision making to involve the expertise of the full range of healthcare professionals. There is much consensus from the Government, the Health Select Committee, the opposition that effective commissioning would require this. At present, however, the provisions in the Bill are too loose, meaning efficacy will often depend upon local relationships.

The Health and Social Care Bill Committee discussed specialist involvement in commissioning on 3 March when amendments 113 and 114 in clause 19 were debated. As the RCP understands it, the aim of these amendments was to ensure that commissioners, both in the national board and local consortia, have a duty to obtain expert guidance on the conditions that they are commissioning services for—in practice it

would be legally mandated for an oncologist to be consulted when commissioning services for cancer patients. Although the RCP supports this aim, we understand that it would be difficult to single out particular experts that should be involved in commissioning to sit on the face of the Bill. The RCP would not want large specialties being favoured over small, which could be an unintended consequence of these amendments.

That said, the RCP believes that the current duty in the Bill for both consortia and the national Board to obtain appropriate advice when commissioning (clauses 19 and 22) should be strengthened to be a duty to involve specialists. As it stands, we fear that the duty to obtain appropriate advice may become a tick box exercise, which has the potential to damage patient care. The RCP will be submitting an amendment to the Bill once it reaches Committee Stage in the House of Lords with the aim of strengthening this clause. We strongly believe that the best results for patients depend on specialists and public health doctors being involved at the highest level of governance in consortia. In practice, we would like to see all consortia being required to have a board where specialists sit to input into commissioning decisions.

To achieve effective commissioning across the country, the RCP believes that greater responsibility could be placed on the NHS Commissioning Board to promote specialist involvement and integrated working across primary, secondary, tertiary and social care. This should be reflected in the Board’s duty to encourage integrated working (clause 19, insertion 13J), which currently references only consortia and local authorities. The RCP would like this clause to reflect the need for specialists to be involved in the delivery of seamless patient pathways and recommends hospital specialists be referenced on the face of the Bill.

Guiding principles for effective clinician-led commissioning and integrated care

The RCP has proposed two amendments above to strengthen specialists’ involvement in commissioning. We believe that effective commissioning will also require guidelines from the Department of Health that compliment the Bill, but do not require amendments. The RCP expects local solutions to commissioning to evolve over time. There are some principles for successful commissioning, however, that are applicable across all localities. We recommend these to be maintained by the NHS Commissioning Board and cascaded to local consortia in advance of them taking responsibility for commissioning from PCTs in April 2013. The general principles we recommend for commissioning are as follows:

(a) There should be transparency on how a full range of health professionals will be involved in commissioning. We believe this will strengthen accountability of consortia to their local populations. Each consortium should publish information on how they will involve and have involved specialists in their annual plan, annual report and constitution. The Board should assess the extent to which consortia have collaborated with other professionals and integrated primary, secondary and social care and public health in their annual assessment.

(b) Strong professional networks to further enable a wider range of specialists to feed into commissioning decisions should be established and developed. Existing cancer and cardiac networks provide models from which best practice can be drawn. A network of the appropriate specialists should always be involved in commissioning decision that affects the services they provide.

(c) Patients and communities should be empowered and enabled to be fully involved in commissioning decisions of both consortia and the national board. We are consulting with our Patient and Carer Network on effective structures that would enable meaningful involvement from these groups.

(d) Consortia will be responsible for a significant amount of public money. They should be accountable and transparent organisations, and these principles should be embedded in their cultures and structures. Further consideration needs to be given to how this can be achieved.

(e) Health and Wellbeing Boards should involve specialists when assessing needs via the Joint Strategic Needs Assessments, when setting priorities via the Health and Wellbeing Strategy, and when considering the extent to which consortia commissioning plans reflect local priorities.

(f) Consortia and the national board should have a full understanding of commissioning for best value, and this should be considered over price when commissioning.

(g) Due regard to the integrity of the range of a hospitals’ services should be considered to ensure there is a comprehensive, sustainable healthcare service for local populations when making commissioning decisions at both a national and local level, and when licensing new providers.

(h) The national board and consortia should consider the longer-term sustainability of services, including education and training, when exercising their commissioning functions.
Safeguards against service fragmentation and enshrining integration

The RCP welcomes services becoming more responsive to local needs, an aim of the reforms. However, we would like to recommend that strong safeguards against the potentially damaging effects of service fragmentation be put in place.

The RCP is concerned that under the current proposals, services could fragment and competition could be at the expense of quality and integration. Although we welcome professional competition as a means to drive up standards, we wish to ensure that collaborative working is enshrined in the culture of commissioning and delivery of care. To achieve this we are calling for a range of safeguards that will ensure quality is at the heart of all commissioning decisions, that collaboration and integration of services are promoted, that common cultures of accountability and transparency apply across all providers, that service continuity is protected and that there are structures to facilitate the commissioning of “uncommon conditions.” More detail on each of these recommendations is given below.

The importance of quality

The Royal College of Physicians understands quality. We have a 500 year history of setting standards. Quality is at the centre of RCP’s mission and objectives. No other body offers such a full range of evidence based quality guidance; we perform audits, issue clinical guidance, conduct clinical effectiveness studies, provide accreditation and write clinical pathways. Quality should be at the heart of the Bill. Currently we are concerned that there are inadequate safeguards to ensure competition does not threaten quality.

The RCP welcomes the evidence from Sir David Nicholson and Rt Hon Andrew Lansley CBE MP to the Health Bill Committee stating that competition in the NHS will be based on quality, not price. However, we still have concerns, particularly in the context of the £20 billion efficiency challenge.241 that quality could slip as providers are under pressure to offer services at decreasing rates. This could result in low price at the expense of value for money when making commissioning decisions. To mitigate against this the RCP would like to see competition on quality on the face of the Bill. We believe that this should be written into Monitor’s role, which should be amended to promote competition on quality (clause 52).

On listening to the Cynthia Bower’s evidence to the Health Bill Committee we are further concerned that there will not be a body that will be tasked with rating quality. The Chief Executive of the Care Quality Commission made it clear that CQC’s role is a safety net, monitoring only essential standards of quality and safety. If competition is to be based on quality, it is unclear who will be monitoring quality and awarding the quality indicators that would allow comparison and competition. If there is no body responsible for measuring and grading quality, it will be impossible for competition to be based on this. The responsibility for grading services on quality needs to be given to an organisation. The RCP would recommend that Monitor’s role be altered to promote competition on quality and thus be given the responsibility to grade services and share this information with commissioners. We would welcome inclusion of this in the Bill, and believe clause 52 should be altered accordingly.

The risk of competition on price not quality is exacerbated as there are currently no clear measures for quality. We would not expect measures for quality to be included in the Bill, but we believe work needs to be initiated now to identify quality measures. This will enable the intention to measure success for providers on outcomes. Although we see the identification of quality measures as an ongoing process that will need continuous review, we expect a suite of quality measures to be ready by April 2013 when consortia and the national board take responsibility for commissioning. Identifying quality measures earlier will help pathfinder consortia, the shadow national NHS and health and wellbeing boards develop. The urgency of this crucial task cannot be underestimated. We offer the RCP’s services in identifying quality measures, which have a strong evidence base that can be used to drive up standards. The RCP is meeting with Sir David Nicholson in May to discuss this further.

Price

To further support consortia and the national board in considering value rather than price when commissioning the RCP urges the Department of Health to consider using a “best practice tariff”. This would not be an average tariff, but the cost of delivering a good service. This would be linked with quality and outcomes and based on value for money, rather than solely low cost. This should be designed by the NHS Commissioning Board, with support from the medical royal colleges. The RCP envisages it as a mechanism to promote integrated pathways, define quality and standards. We would not expect it to threaten competition because it would not stipulate preferred providers.

Integrated care

Collaboration and integration could be undermined by the requirement on Monitor to promote competition. We strongly believe that collaboration is more likely to improve patient outcomes than competition. Monitor’s role in promoting competition must not prohibit the involvement of secondary and tertiary care specialists in service planning. The RCP accepts that there are potential conflicts of interests

241 The challenge, first articulated by the NHS Chief Executive, Sir David Nicolson, in 2009 to achieve an efficiency gain of 4% per annum from 2011–12 (also expressed as the need to make £15–20 billion in efficiency savings.)
with a representative of a ‘provider’ contributing to and signing off consortiums’ commissioning plans. There are various other potential areas of conflict of interest around the commissioner and provider role inherent in the Bill. For example, GPs will be both providers and commissioners and some providers will be required to join consortia because they hold primary medical services contracts. We do not believe, however, that these conflicts should be allowed to jeopardise integrated care. The RCP is calling for clarity to reassure the sector that inherent conflicts of interest in the system will not be allowed to prevent integrated care.

Furthermore, the RCP remains concerned that competition in a market of “willing providers” will make it difficult for primary care and secondary care physicians to collaborate without fear of legal challenge from “competitors”. We have heard mixed evidence that this could be a threat. It is our understanding that if bodies within the NHS, such as foundation trusts, are behaving like private companies, they will be treated as such in law. However, the Secretary of State argued during his oral evidence session to the Health Bill Committee that the only circumstance where competition law applies is if the intention is to restrict provider access to commissioning services. There is still uncertainty in the sector over where and when competition law will apply under the reforms. We would like clarity on this and to recommend that that ‘commercial sensitivities’ are not allowed to block information sharing, transparency, accountability. The RCP is seeking legal advice as to whether a clause to this effect needs to be on the face of the Bill or accompanying guidance from the Department of Health would be sufficient in preventing this. We strongly urge the Department to clarify this issue, so there is no chance for a future test case and the decision on commercial sensitivities to be taken in the court of law.

Services should be integrated to ensure seamless pathways of care for patients. The RCP would like to highlight the risk of fracturing the patient experience if certain services are removed from hospitals. This would also risk destabilising foundation trusts. For example, if a urology service is removed from a large hospital, there could be no acute urology provision left. This can also affect continuity of care for patients, a particular issue for those with long term and/or complex conditions. Integrated care pathways and integration across care pathways, particularly for those with complex conditions and complex co-morbidities need to be protected. For example patients with diabetes may have to travel to several different locations and providers to receive a full range of care. In this paper the RCP has already called for due regard to the integrity of the range of a hospital’s services to ensure there is a comprehensive, sustainable healthcare service for local populations to be a guiding principle for commissioning, which could be a safeguard against fracturing the patient experience. The RCP also sees a role for Monitor in enshrining integrated working into the new commissioning arrangements. Clause 54 provides a list of the considerations that Monitor must make when carrying out its functions. RCP believes these considerations should be extended to include consideration to the overriding principles of collaboration, integration and sustainability when licensing providers.

Failure and reconfiguration of services

More detail is required on how service continuity and patient health will be protected in the event of provider failure. Clarity is required on how the “designation” of services by Monitor will work in practice (clause 69). Further guidance which fleshes out the intentions of the clauses in the Bill is necessary.

The RCP is also calling for clarity on the mechanisms that local populations can use if a reconfiguration is proposed in their area. The consultation process for a reconfiguration needs to be made clear. Would local populations appeal to the local authority scrutiny committee, Health and Wellbeing Board, Monitor and/or the NHS Commissioning Board? How will complaints be escalated? There should be accountability to the local population for these decisions.

Whistleblowing

The RCP would like to ensure the positive staff cultures apply across all service providers. The RCP sees these as a key tool in preventing a repeat of the events that occurred principally between January 2005 and March 2009 in the accident and emergency (A&E) department, the emergency assessment unit (EAU) and Wards 7, 8, 10, 11 and 12 at Mid Staffordshire NHS Foundation Trust.

All healthcare professionals, including managers and those working outside the NHS must be fully supportive of whistleblowing and work to support the open and frank discussion of any concerns on standards of care. The RCP sees the reforms of the health service in England as an opportunity to develop these cultures and there is an opportunity to support this in the legislative framework. The RCP recommends that the constitution of all consortia and the national board (the requirement for the national board is in clause 19 and consortia in clause 21 of the Bill) detail how whistleblowing will be supported. We further recommend that Monitor publish guidance on how it will support the raising of concerns regarding poor standards of care.
Uncommon conditions

Service fragmentation has the potential to harm the NHS’s ability to commission services for uncommon conditions. A clear vision from the national Board on commissioning arrangements for “uncommon conditions” is required. Facilities such as a trauma centres, or severe burns units, and conditions such as immunodeficiency, haematology, and haemophilia require a critical mass to be cost effective and are therefore currently commissioned on a regional basis. Consortia and the national board will need to work together to commission these services. The RCP would recommend that the NHS Commissioning Board takes responsibility and uses a sub-national structure to commission effectively.

CONCLUSION

The RCP’s role is to set higher standards. We work to ensure patients receive the best possible care. The RCP has used its expertise to highlight some risks in the reforms and suggest safeguards to mitigate against them to the Health Bill Committee. Some of our recommendations require changes to the Bill, most require clarity and additional guidance from the Department of Health.

March 2011

Memorandum submitted by Managers in Partnership (HS 103)

MANAGERS IN PARTNERSHIP

1. Managers in Partnership (MiP) is the representative body for nearly 6,000 senior health service managers including over 200 chief executives working in all areas of healthcare.

1.2 It will fall to NHS managers to implement the proposed changes brought about by the Bill and to ensure a smooth transition, whilst at the same time maintaining service standards and delivering efficiency savings of up to £20 billion by 2013–14. MiP members are therefore at the forefront of current health service delivery and commissioning and are very well placed to inform the debate on the impact of the proposed NHS reforms as set out in the Health and Social Care Bill.

SUMMARY

2.1 The Health and Social Care Bill represents the biggest shake up of the NHS since its inception and we are very concerned not only by particular aspects of the reforms proposed but also the extremely swift pace of change proposed for their implementation, for example SHAs ending in 2012 a full 12 months before GP commissioning consortia are statutorily in place. There must be sufficient checks, locks and controls to ensure stability and an orderly, successful transition.

2.2 The ambitious reforms proposed in the Bill will founder without talented and skilled management to implement them. The retention of good managers is therefore extremely important at this time, however it is put at risk both by the Government’s negative rhetoric around NHS management and bureaucracy, and job losses which are already taking place at PCT level. The Government should adopt a more strategic approach to transition to ensure that vital resources are not wasted on needless staff reorganisation.

2.3 If possible, all the management needs of the GP consortia should be met from the population of existing managers, via transfer and not redundancy. While the Government appears to be moving in this direction (eg by stating its best estimate that 60% of current PCT and SHA will be employed in “the new system architecture”) many GPs still believe they will have full freedom of choice over staff and, furthermore, they will incur no liability for redundancy costs if they choose other options.

2.4 The NHS will need an effective strategic intermediate tier to operate after the abolition of SHAs: clarification of the remit, funding and staffing of “outposts” of the National Commissioning Board referred to by David Nicholson at the Health and Social Care Bill Committee should be considered for inclusion on the face of the Bill.

2.5 There are some other parts of the Bill which particularly require further consideration and amendment:

— There is a lack of detail in the Bill about the corporate governance and management arrangements for GP commissioning consortia as well as the democratic legitimacy of Health and Wellbeing Boards

— An increased reliance upon competition to drive up standards in the NHS may have the unintended consequence of reducing quality. The introduction of competition also risks undermining the public service ethos of the NHS.
**Governance**

3.1 MiP has concerns about the accountability of commissioning consortia. Consortia have responsibility for writing their own constitution, to be approved solely by the NHS Commissioning Board (clause 21). With up to 500 local commissioning consortia to oversee, we have concerns that the Board will not be able to provide a suitable level of scrutiny over consortia.

3.2 Unlike almost all other corporate governance structures, commissioning consortia are not required to have a board with externally appointed non executive directors or to hold meetings in public. There is one reference—in schedule 2 clause 4—to the need to make provision in the constitution for dealing with conflicts of interest but this is clearly not a sufficient level of accountability for organisations responsible for hundreds of millions of public money. The Bill should be more prescriptive on how the governance arrangements of commissioning consortia should be set up.

3.3 The relationship between GP consortia and local Health and Wellbeing Boards also fails to provide sufficient accountability. The consortia must only have “regard to” the local health and wellbeing strategy (clause 177) and it is only “a representative” (clause 178) rather than the accountable officer who must sit on each Health and Wellbeing Board. We also have concerns that Health and Wellbeing Boards are not fully democratically accountable, as it is only necessary for one councillor to sit on the board (clause 178). In order to have greater local authority involvement in the setting of the Health and Wellbeing Strategy, the Board should include an obligation for greater representation of local authority councillors on the board.

3.4 All NHS staff, including managers and doctors, need to be held to account robustly but we have doubts whether Health and Wellbeing Boards will be sufficiently empowered and that the NHS Commissioning Board will be sufficiently well resourced. If the only proper oversight is to be exercised by the NHS Commissioning Board then this represents a significant centralisation, instead of the intended devolution, of powers.

3.5 The Bill also needs to address how to fill the vacuum left by the abolition of the SHAs. These are to close at the end of March 2012, a full year before the abolition of PCTs. The removal of the so-called strategic or intermediate tier has potentially serious consequences for how change is managed or to broker difficult situations, particularly in the hospital sector. Rather than orderly change with carefully managed strategic decisions, we fear an environment where highly controversial decisions are taken abruptly, with damaging political consequences locally. The NHS will need an effective strategic intermediate tier to operate after the abolition of SHAs and continue into the new system: clarification of the remit, funding and staffing of “outposts” of the National Commissioning Board referred to by David Nicholson at the Health and Social Care Bill Committee should be considered for inclusion on the face of the Bill.

**Competition**

4.1 Clause 52 redefines the duties of Monitor, the first of which in future will be to “protect and protect the interests of people who use health care services” by “promoting competition”. Whilst we recognise that competition can play a part in improving certain services, it is not the answer to driving efficiency in every service area, as many services cannot be priced up neatly or specified in fine contractual detail. The danger is that once a service is put to tender initially, EU legislation ensures that the commercialisation of that service will have to continue.

4.2 Clause 104 provides for competition by price in the provision of health services. This now requires amendment following various Government statements and the fact that NHS Chief Executive David Nicholson, said that price competition was “extremely dangerous” when he gave evidence to the Public Accounts Committee and has since written that “there is no question of introducing price competition”. For the record we are of the view that price competition can risk engendering a reduction in care quality or reduced terms and conditions for staff, risks which are well recognised within the health sector.

4.3 Dr Laurence Buckman from the British Medical Association has identified how the “quality premium” under which GPs will receive increased pay through effective spending of NHS funds, may incentivise GPs to deny services to patients. We believe that another consequence of the premium would be to encourage GPs to favour lower priced and lower quality services in order to protect their salaries. We believe in clause 23 subsection 223L “Payments in respect of performance” should be deleted or amended.

4.4 In addition to the promotion of competition by Monitor, the Bill also provides for further measures to increase competition in the NHS. In particular, clause 4 ensures the Secretary of State is required to “promote autonomy” amongst those providing health services, whilst clause 150 removes the cap on the amount of private income a trust can receive from private health care services and the quantity of these services that it provides. In such a market of competing health care providers where providers could fail and services be lost MiP has concerns about how availability of services for patients will be safeguarded.

4.5 We also have concerns that a rapid move towards marketisation of the NHS would have a damaging rather than beneficial effect upon good commissioning. As the King’s Fund’s Chris Ham stated in his evidence to the Public Bill Committee:

“commissioning health care well is really hard to do. You need as much management support as you can get, as much expert advice, as much patient and public involvement.”
4.5 We believe that it is a huge risk to attempt radical reform of every part of the NHS whilst at the same time cutting the jobs of those managers with the necessary expertise. The Government should therefore relax its plans to reduce management costs by 46% during the course of the transition, or at least revisit plans in the light of an assessment of what management capacity is needed in the next two years. Meanwhile reform should be undertaken at a more cautious pace with greater inclusion of managers in the decision making process.

March 2011

Memorandum submitted by the Health and Social Care Information Centre (HS 104)

INTRODUCTION

1. The Health and Social Care Information Centre (IC) was established in 2005 as a special health authority and is the national source of health and social care information in England.

2. The Bill recognises the importance of information in improving quality and efficiency and in achieving the Government’s aim of creating a health and social care system that is much more focused on patients, delivers better care and outcomes and ensures increased autonomy and clear accountability at every level.

3. The Bill also reflects the Department of Health’s report of its Review of Arm’s Length Bodies and plans to streamline this sector. The review established the IC as a shared, central data collection service for DH and its Arm’s Length Bodies, avoiding duplication and achieving significant economies of scale and other benefits from having a single centre of expertise with a specialised and scalable infrastructure.

4. We very much support the strategic objectives for information and welcome the opportunity to consolidate and develop the important contribution that quality information can bring for:
   — the public—by helping people understand the range of health and social care services available and evaluate the factors which are important to them, including accessibility, quality of care and safety;
   — patients, service users, carers and their families—by empowering them to make choices about their health and wellbeing, and the care they require;
   — health and care professionals—by identifying areas for attention, and for designing programmes to deliver improved outcomes for patients and service users;
   — health and care organisations—to demonstrate their accountability nationally and to local people; and
   — the service as a whole—to help ensure that services are underpinned by principles of responsiveness, efficiency, and effectiveness.

ROLE OF THE IC

5. The Bill provides for the IC to be established as an independent non-departmental public body with statutory powers to collect, process and disseminate healthcare, public health and social care data for “secondary uses”, including informing patients and the public, public and parliamentary accountability, policy development and monitoring, service commissioning and improvement, supporting financial flows, and research. In essence this means that we will:
   — collect, store and disseminate national data from all health and social care bodies;
   — collect data that needs to be collected centrally to support the central bodies in discharging their statutory functions;
   — have power to require a health or social care body to provide us with information and to request any other person to provide information;
   — be able to consider additional requests from other arm’s-length bodies, and carry out those data collections if specific criteria are met;
   — have a duty to seek to reduce the administrative burden of data collections on the NHS with powers to support this—including, operating a national principle of “collect once, use many times” to ensure that the wider health and social care system works efficiently and avoids duplication; challenging those requesting datasets to be collected, identifying where those requirements can be met from existing data or can be collected in a less burdensome way;
   — publish the data that we have collected in a non-identifiable, standard, and aggregated format for wider use by a multiplicity of customers;
   — make more detailed data available directly to users with the necessary information governance approvals;
   — assess the extent to which information we collect meets standards for processing information published by the Secretary of State or the NHS Commissioning Board. Publish a record of the results of the assessment if we have or plan to publish the information;
— support transparency and openness of data quality, national indicators and statistical methods with a model of continuous improvement in all these areas; and

— develop a national framework for data quality assurance with clear national and local responsibilities for data quality and which is an integral part of our dissemination and publication processes.

6. Our statutory role also requires us to identify opportunities to collate and link data from other organisations that help to enrich the national data resource and support the Government’s policy on transparency. We are already one of the largest contributors to the Government’s data portal—www.data.gov.uk—and have plans in place to accelerate the range of data and information accessible to the public. We will continue to work closely with the Government Statistical Service to meet Public Data principles, particularly making detailed data widely available for re-use by commercial, third sector and others, while ensuring Official or National Statistics remain the key trusted source of information to support public debate.

7. Commercial, third sector and other information intermediaries will also be significant users of our data and services. We will work collaboratively with these organisations to support innovation and responsiveness to public and NHS requirements.

CHALLENGES

8. The remit we have been given does not come without challenges. To enable us to deliver these high expectations, it is essential that detail and spirit of the Bill are actually delivered in practice and that barriers are not put in place to compromise or weaken the key principles it enshrines relating to information—namely:

— need to ensure that the IC is the vehicle for the central collection, storage and dissemination of national secondary uses data from health, public health and social care bodies and that different parts of the system do not try to replicate this role. The economic situation and drive to improve public services places even greater emphasis on controlling the burden of central demands, minimising costs of data collection, making best use of what exists (including through linkage) and then making it transparently available for use by others in one place—that is the IC. The IC will need powers and authority to prevent wasteful fragmentation and duplication;

— need for clear and manageable processes for approving, managing and mandating central data returns. Controlling the burden of central data requirements on front line services is critical to reducing bureaucracy. This will not happen without the necessary authority over all central agencies, concomitant with their own formal powers;

— need to ensure that the IC is resourced adequately in order to exploit the untapped potential of data. The IC like many other public sector bodies is facing significant budget cuts and there is a high risk that the organisation will have insufficient resources to meet the needs and requirements of the system;

— need to be able to operate seamlessly across healthcare, public health and social care to drive more value out of the data currently available, through services which deliver the secure processing and linking of data from different sources and robust pseudonymisation/depersonalisation processes. Linking data from disparate existing datasets creates patient-centred and care-pathway oriented views of service use and needs, for commissioners, service managers, researchers and the public;

— public trust and the protection of patient confidentiality are paramount. The centralisation of data collection, linkage and de-identification in the IC would avoid the need for others to access patient identifiable data for secondary uses. The IC achieves and would expect to continue to be held to the highest standards of information governance and operate transparently, engaging directly with patients and service users and their representatives; and

— the realisation of the vision of the IC as new Non-Departmental Public Body is really important as the IC has to be seen to be independent and to be able to develop and execute the IC’s strategy in an independent and innovative way. It’s methods and activities must continue fully to meet professional standards, including the UK Code of Conduct for Official Statistics, and be open, transparent and subject to peer review. The IC’s collection, processing and distribution of “secondary uses” information should be separate from any central informatics agencies serving DH or it’s Arm’s Length Bodies—including the NHS Commissioning Board. It must also have sufficient direct contractual control and authority over all of its key information systems and data channels.

March 2011
Memorandum submitted by British Association for Counselling and Psychotherapy (HS 105)

The British Association for Counselling and Psychotherapy (BACP) would like to submit the following response to the Health and Social Care Bill Committee.

About BACP

The British Association for Counselling and Psychotherapy (BACP) is the leading professional body for counselling and psychotherapy in the UK, with a membership of over 35,000 practitioners across the UK.

BACP has a strong public commitment to high practice standards and public protection. All BACP members are bound by the Ethical Framework for Good Practice for Counselling and Psychotherapy and within this, the Professional Conduct Procedure. These set out the basis of good practice for BACP therapists and for their clients.

Establishment of Voluntary Registers

BACP would like to respond particularly to section 212 on the establishment of voluntary registers.

1. In Section 212m 25D “Power of regulatory bodies to establish voluntary registers” Section 4—BACP would like the Committee to give further consideration as to the reasoning behind the Health Profession Council being excluded from this restriction.

2. Section 8—BACP can see no public benefit from allowing Regulatory Bodies to jointly set up and hold voluntary registers. BACP believes this will result in confusion for the public.

3. BACP understands the proposal to allow Regulatory Bodies to set up voluntary registers for occupational groups such as healthcare and social care workers, where the professional group is itself subject to statutory regulation by that particular Regulatory Body. However, BACP believes consideration should be given to the range of proposals presented in the “Extending professional and occupational regulation: the report of the Working Group on Extending Professional Regulation (2009)” and the employer-led scheme in use on Scotland.

4. BACP supports the position that voluntary registers for professions should be quality assured by the CHRE/Professional Standards Authority, and not set up by Regulatory Bodies. BACP can see no public benefit or rationale by allowing Regulatory Bodies to set up and maintain professional voluntary registers. We believe that there is no public benefit in this only the potential for confusion from a Regulatory Body holding both statutory and voluntary registers.

March 2011

Memorandum submitted by David H Smith (HS 106)

Summary

This is a personal submission based mainly on my wife’s experience of US and UK healthcare. I have written it because for her to have to repeat her experience yet again to yourselves would be too distressing.

This story illustrates how commercial organisations simply cannot be trusted with healthcare commissioning.

My wife’s experience includes:

(a) The circumstances leading to the death of her daughter in the US, and the contrast with the excellent subsequent treatment of her son in the NHS.

(b) Her experience of working in healthcare in Portland Maine, USA and in England.

1. My wife had two children, John and Janet, by her first husband, both of whom turned out to have the hereditary disease cystic fibrosis. This disease is characterised by the inability of the body to manufacture certain enzymes in sufficient quantity. These enzymes fall into two classes, digestive enzymes and enzymes that breakup the mucus in the lungs.

2. For some years neither child was correctly diagnosed. The elder, John had some digestive problems but these were put down to other causes. This is why they did not refrain from having another child.

3. For many years the daughter Janet had no symptoms. The local hospital asked if she would go in for tests to discover why she was so healthy. Initially my wife refused because she feared hospital acquired infections. Eventually she gave way and Janet acquired B Cepacia in hospital. Her lung function rapidly deteriorated and she was told that the only hope was a lung transplant. They had the best available health insurance but that did not, of course, cover such an operation. They had to appeal on TV for funds. Having got the funds—Janet was very popular, they applied to the hospital who told them that, no, they could not do the operation because the outlook was not good for patients with superbugs. This decision was not of course based on a rational use of scarce resources, because they had the money. It was simply that the statistics would not look good if Janet did not survive. My wife and her then husband had neither the time nor the resources to take the hospital to court. Janet died. The marriage broke up.
4. Before the question of transplant arose, however, Janet had had frequent periods in hospital. In each case the insurance company wanted to halve the number of days in hospital that the doctor felt was required. Doctors had to spend far more time on the paperwork than on treating the patient, and of course the HMO would also be spending money on this bureaucracy. This is why US healthcare is so expensive.

5. We are convinced that if healthcare commissioning is left to large commercial businesses here, they will adopt identical attitudes. Access to publicly funded healthcare will be massively restricted. In this way the principle that the government claims it wishes to preserve, namely comprehensive care publicly funded and free at the point of use, will have been abandoned, the benefactors being large multinational HMOs and lawyers.

6. John’s experience in England under the NHS could not have been more different. For many years, he too had avoided respiratory problems. When they developed he was initially cared for at the local hospital. He needed frequent courses of intra venous antibiotics, which we were trained to administer. In due course he was referred to Harefield, where he received a successful double lung transplant in spite of having been infected by two superbugs. He has since taken a degree in law and is now studying for a PhD.

7. The second aspect of my wife’s experience covers her work in a gastro-enterology clinic in Portland Maine. Initially the clinic was a happy ship. Everyone cared for the patients, all the doctors lived well with houses in the posh district, boats etc. But then one partner insisted on bringing in a management consultant, who showed the partners how they could become really wealthy. Turnover increased dramatically but the standard of care dropped equally dramatically, patients being sent home far too early. All the best nurses resigned. This shows how easily money can corrupt doctors.

8. Having moved back to England, the land of her birth, my wife took a job at the local hospital in Dorchester. Part of her work was scheduling in patients who had been turned out of private hospitals too early, or after botched treatment. Once again we see the private sector making profits not out of efficient operation, but by externalising their costs. The legal duty of company directors is to make as much money as possible for shareholders, regardless of the interests of customers or anyone else. It is left up to government to try to restrain their worst excesses, and frankly in a complex area like healthcare, it is just too difficult and expensive a job. The private sector has the luxury of the better lawyers.

9. We can see no problem with GPs commissioning care so long as they feel they can manage this without contracting with a large commercial company. GPs are admittedly self employed but mercifully they still think about the good of their patients. There are surely other models for providing the support GPs need. Why can they not get together and form a co-operative?

As I understand it, the killer part of the Bill is the imposition of competition with formal tendering procedures. Whereas in theory quality can be taken into account as well as price, it is just too difficult to define quality in such a way as to hold these companies to account—to make them behave like reasonable human beings, which of course they are not. If GPs do not feel able to handle commissioning themselves, how can they be expected to cope with HMOs lawyers in negotiating contracts?

10. I have told the story of one family in the USA. It is repeated however throughout the Union. Families with the best insurance are bankrupted if a member has a long illness. Unless members of the committee have examined the evidence from the USA, I submit that they cannot form any reasonable judgement about whether the measures proposed in this Bill can work.

11. My own experience was primarily in the Energy sector and I was deeply involved in the liberalisation of the gas industry. Whereas it will remain a matter of debate as to whether the liberalisation was in the public interest, what is incontestable is the huge and continuing efforts of lawyers, consultants, business analysts, engineers and accountants in managing the relationships between the various players in the gas supply sector. This sector is simple compared with healthcare. How much more effort will be wasted if this reform goes through?

March 2011

Memorandum submitted by Tony Plumridge (HS 107)

1. As Chairman of a Primary Care Trust (PCT) for seven years my experience was that the management of the NHS would not be improved by Commissioning Consortia of GPs. In my own PCT the GPs were very reluctant to attend meetings and initially very reluctant to discuss commissioning in public. Their training and skills are concentrated individual relationships at which they are exceptionally good. These relationships are highly confidential. GPs are not trained or experienced in open debate on larger issues in public and most of them do not wish to undertake this role.

2. Contrary to public perception the PCTs were significantly under managed. Approximately 5% of our budget was spent on management compared to 10% in almost all other large organisations. This misperception in part arises from the reclassification of senior frontline staff as “managers” when in reality they had no management qualifications.
3. Existing PCTs could be simply modified to require a majority of clinicians on the key committees and the Board thus giving the power to commission to GPs but retaining the existing management structure and support. This would avoid the chaos of a large reorganisation and the inevitable decline in productivity.

4. In my experience many of the problems of the NHS have arisen from constant change and the subsequent lack of accountability. The use of private services such as Nursing agencies has exaggerated these problems. It is very difficult to provide consistent care without building long term teams.

5. GPs are excellent at their own work please do not distract them from this by imposing management duties upon them.

6. In my PCT the public were heavily involved and many attended our public meetings. So far the pilot commissioning bodies have significantly failed to involve the public in any meaningful way despite the huge changes proposed.

7. There is no political mandate for this these changes which are the largest administrative changes being attempted anywhere in the world.

8. South Cambridgeshire PCT claims that it is already achieving the Secretary of States aims under the present system of management, if this is so why spend £1.4 billion and the subsequent loss of productivity in a fruitless change.

9. I am personally deeply concerned by the Secretary of State’s apparent reluctance to engage in meaningful debate with the public on this issue.

10. The system of PCTs engaged many leaders from industry, local government, education, and management professions who were able to contribute their expertise at minimal cost to the NHS—this will be lost. The NHS is about joined up thinking and these proposals would unravel what was becoming an effective system in which the public and private sectors worked with the NHS to provide better health outcomes.

11. There was a tiny minority of doctors who tried to exploit the PCT system for their own benefit and not for the benefit of patients. I fear that this minority will seize the opportunity to exploit the NHS which these changes appear to offer.

March 2011

Memorandum submitted by the Alzheimer’s Society (HS 108)

1. INTRODUCTION

1.1 Alzheimer’s Society welcomes the opportunity to submit written evidence to the Public Bill Committee of the Health and Social Care Bill.

1.2 Alzheimer’s Society is the leading care and research charity for people with Alzheimer’s disease and other forms of dementia, their families and carers. The Society has expertise in providing information and education for people with dementia, carers and professionals. It provides a helpline and support for people with dementia and carers, runs quality day and home care, funds dementia research and gives financial help to families in need. It campaigns for improved health and social services and greater public understanding of all aspects of dementia.

1.3 Dementia is one of the biggest health and social care challenges of our time. There are over 635,000 people with dementia in England and the financial cost is estimated to be £15 billion per year. One in three people over 65 will end their lives with a form of dementia.

1.4 People with dementia are core users of health and social care services:

— Two thirds of people with dementia live in the community.

— One third of people with dementia live in care homes. Two thirds of care home residents will have a form of dementia.

— Up to one quarter of hospital beds are occupied by people with dementia aged over 65 years at any one time.


244 Alzheimer’s Society (2007) Dementia UK, a report to the Alzheimer’s Society by King’s College London and the London School of Economics. Alzheimer’s Society: London.

245 Alzheimer’s Society (2007) Dementia UK, as above.

2. SUMMARY OF ISSUES COVERED IN THIS MEMORANDUM

2.1 Alzheimer’s Society supports the government’s vision of the NHS, as described in the Health and Social Care Bill, which aims to put patients and the public at the heart of the NHS, deliver improved outcomes for patients and increase integration between health and social care. We are working with a number of national charities to strengthen requirements in the Bill to ensure this vision becomes a reality. In this briefing we highlight the following concerns we have about the Bill and the changes we would like to see:

— Strengthened patient and public involvement in commissioning.
— Clarity around whether there will be additional funding for local HealthWatch to reflect additional functions they will have around supporting patient choice.
— Increased integration between health and social care.
— Stronger requirements for multi-disciplinary working.
— The importance of the NHS Commission Board and the governing board of GP consortia having expertise of older people’s health and care issues.
— Issues around competition and licensing of NHS providers.
— Giving local HealthWatch, local authority overview and scrutiny committees or local Health and WellBeing Boards the power to petition a commissioner in their local area for a service to be “designated” setting out clear reasons for their request.
— In the interim and depending on the outcome of Value Based Pricing, GP consortia should have the same duty to fund NICE recommended drug treatment that exists under the current system for PCTs.
— An obligation for GP consortia to regard NICE Quality Standards in a similar way to the NHS Commissioning Board.

3. STRENGTHENING PATIENT AND PUBLIC INVOLVEMENT IN COMMISSIONING

3.1 We have raised jointly with a number of other leading national charities the need to strengthen the patient and public involvement provisions in the Bill. Changes we would like to see include:

— A definition of public involvement in the Bill.
— A requirement for the NHS Commissioning Board and GP commissioning consortia to report on all their duties, including their duty on public involvement.
— Regulations to require scrutiny functions arrangements made by the local authority to be independent and led by elected representatives.
— The need for the governing board of GP consortia to include lay members.
— A requirement to involve Local HealthWatch in the development of GP consortia commissioning plans.

3.2 We recognise that the Bill seeks to move away from prescriptive legislation. However, we maintain that strengthening requirements in the Bill on public involvement is needed to deliver the government’s vision of the NHS of ‘no decision about me without me’ but with local flexibility about how public involvement is undertaken.

4. FUNDING OF LOCAL HEALTHWATCH

4.1 We believe it is not currently clear whether there will be extra funding for local HealthWatch to discharge their additional functions around providing advice and information to enable people to make choices about health and care services and its role within the Health and Wellbeing board. While there is additional funding available for the local authority to commission complaints advocacy, and it is possible for HealthWatch to take on this role, this funding is not designed for and will not cover the other functions taken on by HealthWatch. The additional functions of signposting and assistance around choice of services are particularly key for people with dementia, who may lack the capacity to make choices about their own care.

5. INTEGRATION OF HEALTH AND SOCIAL CARE

5.1 Multidisciplinary Commissioning

5.1.2 Good dementia services require effective joint working between health and social care. People with dementia and their carers come in contact with a wide range of professionals, such as nurses, allied health professionals, psychiatrists, and social care workers, and it is vital that they have a clear and explicit involvement in commissioning dementia care services.

5.1.3 With other leading charities we have highlighted concerns about the strength of provision for social care and health professionals who are not GPs to be involved in the commissioning process. In particular, we do not feel that section 140 in clause 22, which states:

“Each commissioning consortium must make arrangements with a view to securing that it obtains advice appropriate for enabling it effectively to discharge its functions from persons with professional expertise relating to the physical or mental health of individuals.”

provides a strong enough impetus for GP commissioning consortia to meaningfully involve other health and social care professionals in commissioning. While we acknowledge that one of the proposals the GP pathfinder consortia are testing is multi-disciplinary commissioning we would like to see this aspect of the Bill strengthened from the current requirement to ‘obtain advice’ to a ‘duty to involve a range of health and care professionals’ in commissioning. This change will help ensure that collaboration between professionals is at the heart of the Bill.

5.2 **Stronger involvement of local authority representatives on GP consortia**

5.2.1 Alzheimer’s Society recognises the important role Health and WellBeing Boards (HWBB) could play in encouraging greater integration between health and social care. Given the priority that has been attached to dementia, it is vital that the Health and WellBeing Strategies, to be developed by local authorities and GP commissioning consortia, will have a strong focus on dementia and have regard to existing dementia strategies that are being developed by PCTs and local authorities.

5.2.2 We remain concerned that with the abolition of PCTs the co-terminosity of boundaries between health and social care will be lost, and this will create barriers for joined working. Furthermore, there is a concern that where a GP commissioning consortia straddles two or more local authorities it will have two or more Joint Strategic Needs Assessments and Joint Health and WellBeing Strategies, which may establish different priorities.

5.2.3 In order to ensure that health and social care can become truly integrated, we would like to see plans being developed to help consortia tackle some of these issues before they arise, in particular caused by the loss of co-terminosity, and the swift dissemination of good practice.

6. **Membership of the NHS Commissioning Board and GP Consortia**

6.1 The Bill defines membership of the NHS Commissioning Board (Section 1). In light of the fact that older people, including people with dementia, are heavy users of health and care services, Alzheimer’s Society would like to see that a member of the Board includes someone with expertise in older people’s health and care issues.

6.2 The Bill is not prescriptive of membership of the GP commissioning consortia Board. We also believe that included on this Board should be a member with expertise in older people’s health issues so they are at the heart of commissioning decision-making.

7. **The Tariff**

7.1 A tariff sets the price that commissioners pay to providers for NHS services, eg a hip operation. We shared the concerns of many other organizations, including the King’s Fund and the British Medical Association (BMA) that if competition on price is encouraged through a maximum tariff, this may result in poorer quality services.

7.2 Therefore, we were pleased that the Secretary of State for Health ruled out competition on the basis of cost (reported in the *FT* newspaper on 3 March). Alzheimer’s Society agrees that quality should drive the commissioning of NHS services.

8. **Licensing of NHS Care Providers**

8.1 The Bill would establish powers for Monitor to license providers of NHS care (including NHS foundation trusts, social enterprises, and private and voluntary sector providers). It is important that the fee that the license holder pays to Monitor does not discourage voluntary providers from bidding for NHS services.

8.2 We support the provisions in the Bill for exemption regulations to ensure that the regulatory burden is not excessive, and believe that this provision may be particularly beneficial to voluntary sector providers. We are concerned that before making exemption regulations the Secretary of State must only “give notice” to Monitor, the NHS Commissioning Board, the Care Quality Commission and its HealthWatch England committee and that only the Secretary of State can approve exemptions. We believe the DH should consult widely on proposals for licensing arrangements, including exemption regulations, and that the above organisations should be fully consulted on which organisations should receive an exemption.
9. DESIGNATED SERVICES

9.1 A “designated service” is one which is deemed too important to fail or cease to be provided. In the Bill GP commissioning consortia, the NHS Commissioning Board or the Secretary of State can apply to Monitor for a service to be designated. Alzheimer’s Society believes that local HealthWatch, a local authority overview and scrutiny committee or local Health and WellBeing Board should have the power to petition a commissioner in their local area for a service to be designated setting out clear reasons for their request. The commissioner should be required to respond to the petition for designated status with an explanation as to whether they intend to proceed with an application to Monitor. This measure would seek to enhance the involvement of influential local bodies in the process of getting a service designated.

10. NICE

10.1 The bill provides little detail on the new role of the National Institute for Health and Clinical Excellence (NICE), including what weight the guidance and standards will have and how this will impact on the social care services which now fall within their wider remit. While we anticipate that the regulations will address many of these concerns, we feel that this may have a real impact on the care of people with dementia, for whom access to a range of high quality social care services are often essential to improving quality of life.

10.2 In particular, we were pleased with the NICE Dementia Quality Standard which was released last year, and we would like to see it strongly reflected in commissioning plans going forward. While the Bill places a duty to regard NICE Quality Standards on the Secretary of State and on the NHS Commissioning Board, this duty does not appear to be reflected for the GP commissioning consortia who will be carrying out the majority of the commissioning which affects people with dementia. We would like to see an obligation for GP Consortia to regard NICE Quality Standards in a similar way to the NHS Commissioning Board.

10.3 We also recommend that, in the interim and depending on the outcome of Value Based Pricing, GP consortia have the same duty to fund NICE recommended drug treatment that exists under the current system for PCTs. This is of particular significance to people with dementia following NICE’s new draft guidance (January 2011) extending access to drug treatments. We are also concerned around the transition between the funding of drugs recommended in the NICE Guidance and Value Based Pricing. It is possible that, unless carefully managed, the drugs recommended in one system or the other may take priority, and not actually deliver the best treatment for the patient at the best value. We will raise these concerns directly to NICE in the consultation on Value Based Pricing.

10.4 We are also concerned that NICE’s strongly medical orientation may cause difficulties when they are called to assess social care interventions. By their very nature, social care interventions serve needs which do not fit neatly into the medical model of the health system, and it will be hard to establish common criteria on which to make comparable judgements on the effectiveness of interventions. As social care interventions are essential to many people with dementia and if delivered in a timely and effective manner can reduce some of the burden on the health service, it is essential that these will are included in guidelines and Quality Standards. It is vital that NICE staff have expertise in social care interventions.

March 2011

Memorandum submitted by Tunstall (HS 109)

This briefing sets out the important role that telehealth and telecare technology and services can play in the delivery of health and social care services, its potential in helping to make the proposed reforms a reality and the issues that need addressing so that this can take place.

WHAT IS TELEHEALTHCARE?

Telehealthcare is the use of technology to support the remote delivery of care and reassurance to older people and those with long term needs. This is divided into two broad areas. Telehealth means the remote monitoring of a patient’s vital signs and their health and well-being through monitoring equipment located in their home. This enables the remote capture and relay of physiological measurements and wellbeing information for clinical review, allowing early and appropriate intervention by clinicians and enhanced self-care. Telecare is the remote monitoring of real time emergencies and lifestyle changes over time in order to manage the risks associated with independent living. This is done through a range of sensors in the home linked to a 24 hour response service.

WHY SHOULD TELEHEALTHCARE BE CONSIDERED IN THE HEALTH REFORMS?

Telehealthcare can play a key role in the delivery of the proposed health reforms in the Health and Social Care Bill and should be a central part of solutions intended to improve the efficiency and quality of care delivered. In particular, telehealthcare improves:

— Efficiency: Telehealth allows patients with long term conditions to be cared for and monitored from home, freeing up valuable NHS resources by reducing unplanned hospital admissions, bed
days and re-admission rates and reducing the number of unnecessary journeys made by care staff. For example, a partnership between Tunstall and NHS North Yorkshire and York has already led to a 40% reduction in non-elective hospital admissions in that area. Telehealth also assists early discharge and supports the reconfiguration of clinical services and patient pathways. Telecare delivers real cost savings for commissioners of social care through preventing or delaying the need for intensive home care packages, institutional care or hospitalisation. Efficient, integrated commissioning of telehealthcare also helps deliver improved outcomes in terms of efficiency savings and the QIPP agenda.

— **Quality:** By allowing patients to be cared for in an environment of their choice, telehealth allows clinicians to effectively manage a patient’s long term condition remotely, enhancing patient self-care and improving clinical outcomes. Telecare leads to earlier interventions when incidents occur and makes a real difference to a user’s quality of life.

— **Outcomes:** Telehealth collates real time information on a patient’s condition and helps to identify changes, leading to earlier and better-informed interventions and ultimately, better patient outcomes. It can also aid medication compliance and provide greater reassurance for family members. Telecare can play a vital role in reablement and prevent or delay the introduction of more intensive care packages for users of social care services.

— **Choice:** Telehealth improves a patient’s understanding of their condition, helping them to make appropriate and positive choices about their care. Telecare allows people to be cared for in the environment of their choice for longer, rather than having to move into traditional residential care settings.

— **Personalisation:** Telehealth helps clinicians provide tailored, personalised care designed specifically to fit the needs of the patient. Telecare is a highly-flexible, personalised care tool which can be adapted as users’ needs evolve.

— **Integrated working:** Technology can greatly assist in the integration between health and social care services, a key theme of the proposed reforms. Tunstall is already working with a number of local authorities and health trusts across Europe to deliver a single view of the patient so that all stakeholders are joined together more closely.

**WHAT ARE THE KEY ISSUES FOR TELEHEALTHCARE IN THE BILL?**

The following specific issues should be addressed during the scrutiny of the Bill at Committee Stage to ensure that telehealthcare can help deliver important aspects of the proposed reforms.

**Commissioning**

— Careful attention should be paid to the alignment of powers and responsibilities of the NHS Commissioning Board, Public Health England and GP consortia in Part 1, and the involvement of local authorities in Part 5 to ensure that there is effective and integrated commissioning across traditional service boundaries.

— Commissioners should have regard to the potential benefits of telehealthcare solutions which, if commissioned properly, can deliver improved shared outcomes across the NHS, social care and public health service. In this regard, we welcome the proposed duties on the Board to promote innovation and integrated working.

— Greater clarity is needed concerning the mechanisms by which consortia will report on and justify the efficiency of commissioning and how integrated working will be monitored, particularly in terms of commissioning services that deliver improved shared outcomes across health and social care.

**Choice of treatment**

— Tunstall welcomes the commitments to extending patient choice in the Bill, notably in Part 1, Clause 19 (new Clause 13F) which creates a duty on the Board to promote involvement of patients and carers in decisions about the provision of services to them and enables patients to make choices.

— These rights to choice should be strengthened by a commitment to providing information about all appropriate care settings and available technology solutions at the time a patient is offered a choice and a commitment to personalise treatment and services as appropriate.

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Improving healthcare outcomes

— The duties on the Board and for consortia to improve quality of services in Part 1 should be strengthened by provisions to ensure that commissioners are informed regularly by patient feedback through measures such as PROMS and have regard to the importance of the personalisation of services.

Integrated working

— In Part 5 greater regard should be given to the role that technology solutions can have in breaking down traditional boundaries and encouraging better integration of health and social care services. The health and wellbeing boards’ proposed powers to encourage integrated working should be extended to explicitly encourage joint commissioning.

About Tunstall

Tunstall Healthcare Group is the world’s leading telehealthcare provider. Operating in more than 30 countries and employing over 1,000 people, Tunstall supports 2.5 million people around the world. Tunstall provides telehealth and telecare technology and services that enable anyone requiring support and reassurance, such as older people or those with long term needs, to lead an independent life with dignity and reassurance.

March 2011

Memorandum submitted by John Kapp (HS 110)

I support this bill, which I think will massively improve patient care at less cost to the taxpayer if enacted. I specifically support the Bill’s provisions to increase competition by opening up the NHS market to Any Willing Provider. This issue has come under attack by the British Medical Association, other trade unions, and groups such as 38 degrees, which has just launched an online petition saying “don’t break up our health service and hand it to private companies, listen to the real experts, doctors and nurses”. These vested interests have had 63 years of a meal ticket for life, whose mission statement is: “a patient cured is a customer lost.”

My Background

I have been a patient representative in the NHS for the last 11 years. I was in the Sussex Cancer Patients Forum (2000–06) the Patient and Public Involvement Forum, Brighton and Hove (2006–08) and the Local Involvement Network (2008–date) the National Association for LINk Members (NALM) representing Sussex (2008–10) I have been a Conservative councillor (1995–09) and active member (1974–present).

Creation of SECTCo as Any Willing Provider

In May 2010 I founded the Social Enterprise Complementary Therapy Company (SECTCo, see www.sectco.org). It exists to provide the following NICE-recommended complementary treatments, to which patients have a statutory right under the NHS Constitution if their doctor says that it is clinically appropriate:

(a) The Mindfulness Based Cognitive Therapy MBCT eight week course for depression to CG23 (December 2004).
(b) Hypnotherapy for Irritable Bowel Syndrome (IBS) to CG61 (February 2008).
(c) Spinal Manipulation for low back pain to CG88 (May 2009).

Depression, IBS and low back pain are long term conditions suffered by some 10 million people in UK, so the scope for what we provide is huge. Polls show that three out of four patients want these complementary treatments free on the NHS, and that half the GPs recommend them to their patients, but the patients have to pay, which most cannot afford. They are provided free on the NHS, (so that the commissioners can tick the box that says “complies with NICE guidelines”) but in such small quantity that the waiting time is thousands of years. The cause of health inequalities is that the rich can afford these treatments, and improve their health thereby, and the poor cannot, so die nine years earlier, and suffer long term conditions 18 years earlier. (Marmot report figures.)

For example, the sole (monopoly) provider of mental health services in Sussex (Sussex Partnership Foundation Trust SPFT) provides one part time MBCT course facilitator (Robert Marx) to provide four MBCT course pa for up to 20 patients per course (80 places pa) This is for the whole of Sussex, with a population of 1.5 million, of whom 160,000 are on antidepressant medication. The waiting time for these depressed patients for a course with Robert is therefore 160,000/80 = 2,000 years.

SPFT is currently training 14 more facilitators, which will reduce the waiting time to around 100 years. Treatments are supposed to be provided within 18 weeks (1/3 year) To get the waiting time down to this will require 300 more facilitators.
SECTCo is set up as an Any Willing Provider who has 15 complementary therapists (including four MBCT facilitators) on our books offering these treatments to the NHS. However, the commissioners (NHS Brighton and Hove) have steadfastly refused to contract with us. We have written to all 150 GPs in the city, offering to provide MBCT courses to their patients against vouchers for our tariff price of £400. Two GPs (Drs Susie Rockwell and Charan Koka) have registered with SECTCo, but have not yet referred any patients to us. We believe that this is because the PCT told them not to, and said that they will not pay SECTCo for the vouchers if they do refer. We have said that we will treat patients on credit until the funding is sorted out.

**Scope for Any Willing Providers of NICE-recommended Treatments**

We believe that the scope for Any Willing Providers like SECTCo is enormous, because millions of patients with long term conditions could benefit from these treatments. SECTCo is willing to tender to win contracts for our services, but our attempt at tendering for the Occupational Health contract of the Brighton and Hove Council has fallen at the first fence. To receive tender documents we have to pass a Pre Qualification Questionnaire of 30 pages, requiring references from three previous contracts of a similar nature. As a start up, we have no previous contracts.

We request the drafters of the Bill to ensure that the playing field for tendering be a level one, that allows entry by Small and Medium Enterprises (SMEs) We welcome the statements to this effect by the prime minister on 11 February 2011, and in Cardiff, reported on 7 March 2011.

March 2011

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**Memorandum submitted by Wish (HS 111)**

**Wish**

1. Wish is the only national charity that works with women with mental health needs across both the mental health and criminal justice systems. It has been a voice for women’s mental health since 1987. We are a user-led organisation, providing long-term support to women throughout their journey between psychiatric hospital, prison and the community. Our members typically have compound issues, and need a combination of treatment and support to address childcare and custody of children, self-harm, experience of abuse, poverty, lack of educational qualifications or training, homelessness and substance misuse. Wish’s unique gender-specific and needs-based approach is effective in turning around the lives of women with multiple support needs, and providing continuity of support as they move between different statutory providers.

**Evidence for the Committee**

2. Our experience of working with women as they receive, or apply to receive, services from local authorities, the NHS and the criminal justice systems, has allowed us to identify issues and evidence relevant to the work of the Health and Social Care Bill Committee. As the Bill aims to devolve decision-making for health and social care commissioning, and bring in a wider range of health and social care providers, we wish to raise the issue of continuity of care and services for one of society’s most vulnerable groups of people.

3. Twenty years of working with thousands of women has shown us that they continue to receive inconsistent and inadequate provision for their mental health, resettlement and other service needs. Rather than following a needs-based model that is holistically designed to build continuity and relational security, women with mental health needs currently face unacceptable variation in the quality of services, the approach used and fractured treatment. This is exacerbated by the failure to effectively divert women with mental health needs, who commit petty and non-violent crimes, away from the criminal justice system and custodial sentences. Community mental health services are severely lacking and, as a consequence, many women only receive treatment when their condition reaches crisis point, or results in offending behaviour. At this point they are forced back into secure settings, which are often inimical to recovery and regaining control over their lives. The geographical dispersion of secure provision for women usually means that they are moved all over the country, disrupting family relationships, removing them from support networks and jeopardising their opportunity to have a say in the direction of their treatment and care.

4. The “revolving door” model of service-use, in which women switch between hospital, prison and the community, is further complicated by the fact that local boards and government departments address the needs of this group of women differently, using different standards of care and differently prioritised outcomes. Wish believes that there should be a co-ordinated approach. The reorganisation of the commissioning and provisioning structure provides the opportunity to implement oversight. Outcomes should be co-ordinated, and the importance of gender-specific approaches in this area reaffirmed, in line with government and independent policy recommendations outlined in papers including the Corston Report, *Into The Mainstream*, and Lord Bradley’s Review.

5. If a measure of co-ordination was brought about, with the premise of shifting the focus onto early intervention, continuity of support and community-based treatment, Wish believes that positive benefits would result, in line with the government commitment to the parity of mental health and physical health,
early intervention and restrained and effective uses of public funds. For example, the 2008 New Economics Foundation report and cost/benefit analysis, *Unlocking Value: How we all benefit from investing in alternatives to prison for women offenders* shows the potential savings from a community-based approach. The report found that for every pound invested in support—focused alternatives to prison, £14 worth of social value is generated to women and their children, victims, and society generally, over 10 years. Holistic, woman-centred community services, such as those offered by Wish, are also cheaper and more cost-effective than the cost of keeping a woman in a medium secure hospital (£165,000 a year) or in prison (£39,000 a year, excluding mental health care costs).

6. Evidence clearly illustrates that women in prisons and women in secure hospitals present a commonality of issues, needs, characteristics and experiences. Frequent movement between those institutions means that co-ordinating services and treatment across the two systems is vital for realising this value and improving the lives of some of the most vulnerable, and under-supported, groups in our society. Wish is promoting a co-ordinated, consistent and complete intervention approach through our new campaign, urging all stakeholders to harness joined-up thinking and ensure the best outcomes for women, service-providers, tax-payers, and wider society.

*March 2011*

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**Memorandum submitted by million+ (HS 112)**

**ABOUT MILLION+**

1. million+ is a university think-tank which provides evidence and analysis in respect of the impact of policy and funding regimes on universities, students, graduates and the services that universities and other higher education institutions provide for business, the NHS and the not-for-profit sectors.

**THE NHS AND SOCIAL CARE BILL AND THE ABOLITION OF THE STRATEGIC HEALTH AUTHORITIES**

**NHS workforce planning, education and professional development**

2. The abolition of the Strategic Health Authorities (SHAs) has significant implications for NHS workforce planning and for the future education, training and professional development of NHS non-medical staff—issues which have been the subject of very little parliamentary and public scrutiny to date. Currently, nursing, midwifery and allied health profession education in England is provided via a national standard contract between the SHAs and individual universities which run faculties or Departments that specialise in particular NHS professional education and training and have been approved by the relevant professional body. The SHAs are therefore currently the planning and awarding bodies for these education and training contracts in England.249

3. Funding for nursing, midwifery and allied health professional education (NMET) is one component of the “Multi-Professional Education and Training” (MPET) budget which is included in DoH funding of the SHAs. Other components provide funding for postgraduate medical and dental education (MADEL) and support for the practice teaching of medical students (SIFT). The current budget is around £4.5 billion. MPET funding is allocated for NHS workforce education and development for all areas other than for medical training and courses. The Higher Education Funding Council for England (Hefce) allocates student numbers to universities for medical training and courses as well as for dentistry, pharmacy and healthcare science.

4. At present MPET funding for nursing, midwifery and allied health profession education provides for:

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- pre-registration education;
- post-registration education; and
- continuing professional development.

Universities have significant revenue (staff) and capital investments in NMET/ MPET contracts and employ academic staff who are experienced practitioners in their field.

5. In addition to nursing and midwifery, MPET funding covers allied health professions such as radiographers, physiotherapists, podiatrists where similar arrangements in respect of registration apply. For example, radiographers must be registered to work in the NHS. For this, they need a degree in radiography from an education centre approved by the Health Professions Council (HPC). All qualifying radiography courses are at degree level and most are three-year courses and students are normally based in a university and in hospital departments for an equal amount of time. Students choose at the outset whether to study for diagnostic or therapeutic radiography degree courses.

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249 In Scotland, Wales and Northern Ireland, funding is allocated by the individual education funding bodies in the respective nations and devolved administrations for the same areas of professional education and training eg in Scotland MPET student numbers are allocated by the Scottish Funding Council.
Example: Nursing

To work in the NHS, nurses must hold a degree or diploma in nursing (a “pre-registration” programme), which leads to registration with the Nursing and Midwifery Council (NMC), enabling them to practice as a nurse. Degrees and diploma programmes comprise of 50% theory and 50% practice, with time split between the higher education institute (HEI), which runs the course, and practical placements in a variety of healthcare settings.

New entrants to the nursing profession from September 2013 in England will have to study for a degree. However, diploma courses will be phased out between September 2011 and early 2013. As a result, some universities in England will only offer the new degree programme from September 2011, while others will continue to offer the diploma and current degree programmes throughout 2011 and 2012. By September 2013, all nursing programmes will be degree-only.

Part-time pre-registration nursing programmes are provided by some universities and normally last for five or six years. They are available to staff working in the NHS, usually as an assistant or an associate practitioner with qualifications up to NVQ level 3 (or equivalent). Staff are employed by the NHS which provides support in terms of time-off to attend on a part-time basis.

RefoCusing MPET Commissioning and Budget Reductions

6. The DoH in England has signalled that the MPET budget will be cut by up to 15% over three years commencing in 2011–12. Universities in England have confirmed that the number of commissions is likely to decrease by around 10–15% and that they have been advised by SHAs that these cuts will be front ended with greatest reductions in year one (2011–12).

7. Within this overall reduction, indicative education commissions received by universities from SHAs for 2011–12 demonstrate considerable variation within each SHA region and within individual professions, with some areas (such as physiotherapy) likely to receive even larger cuts over the period. At present, there appears to be a wide level of variation in the number of students being commissioned. For example, in midwifery some universities are facing a 50% cut while others are being asked to substantially increase the number of new midwives that they are training. More recently, the Government has announced an intention to increase the number of Health Visitors.

8. The extent to which the DoH and BIS (the Department responsible for universities) have undertaken any assessment of the risks of reducing the MPET budget and abolishing the SHAs as commissioning bodies from April 2012, is unclear. Some universities receive approximately 25% of their total income from NHS-funded health professional courses. Uncertainty about the arrangements for the commissioning and award of these contracts from 2012–13 is creating a financial risk which will coincide with the introduction of the new tuition and funding regime for other undergraduate courses in England. If there is continued delay and uncertainty in future NHS planning and commissioning arrangements, universities may have no option but to consider making well-qualified and experienced staff redundant if there is no clarity and further anticipated reductions in student numbers.

9. This poses an obvious risk to future NHS education and training provision. If reductions in the MPET budget are front loaded and a new commissioning system which places greater emphasis on local decision making, is introduced in the short timescale envisaged in the NHS and Social Care Bill, there is every prospect of “a boom and bust” approach to healthcare education commissioning. There are therefore considerable concerns as a result of the proposal to abolish the Strategic Health Authorities and the failure of DoH and the Bill itself to assign clear responsibility for the future planning and commissioning of MPET and NMET education and training.

Health Education England: A Special Health Authority?

10. DoH has attempted to address some of these problems by issuing a consultation Paper, Developing the NHS workforce, on the future of education and training in England. However, the robustness and effectiveness of the arrangements currently proposed are open to question. In addition, there is a very significant concern that DoH has used the consultation paper and the NHS reforms to propose that the MPET budget for nursing, midwifery and the allied health professions should no longer fund post-registration and continuous professional development (CPD) provision and be restricted in the future to pre-registration programmes (to be paid for through a levy, the operational details of which are unclear).

11. The DoH’s proposal to exclude post-registration and CPD from the MPET/NMET budget from 2012–13 poses a further risk to the future viability and availability of this provision. Funding for the latter will not be ring-fenced and may understandably not prove to be a high priority for Foundation Trusts and GP consortia during a period of radical structural change and when as providers they will be required to deliver efficiency savings over a four year time-scale on a scale that, as the Health Select Committee have pointed out, has not been achieved in the history of the NHS or by any other healthcare system in the world.

12. Developing the NHS workforce proposes that a new body, Health Education England (HEE) will provide a multi-professional oversight of the new system. The paper envisages that Medical Education England (MEE), which currently covers medicine, dentistry, pharmacy and healthcare science, will be merged with the allied health professional advisory board and the nursing and midwifery professional
advocacy, bureaucracy and quality assurance requirements in both the NHS and in universities.

Efficiencies within the NHS and whether these arrangements are more or less likely to increase professional development of non-medical NHS staff are likely to contribute to the drive to achieve the Bill and the DoH’s proposals for the future award of contracts for the education, training and in clinically and academically qualified staff and teaching and research infrastructure.

It is difficult to see how the DoH’s proposals to replace the commissioning functions of the SHAs will deliver value for money either within the NHS or in higher education institutions, bearing in mind their investments in developing international higher education partnerships, training staff in their home countries. This expertise developed in England in the education and training of healthcare staff has been an area in which universities have been highly valued and these HE partnerships and contracts contribute to the UK’s foreign exchange earnings.

LocaL ProviDeraSSkiLLS NETwoRks

13. HEE would be established as a Special Health Authority and be answerable to the Secretary of State under the terms set out for Special Health Authorities in the NHS and Social Care Bill. As a Special Health Authority, HEE would have a three year life and further primary legislation would be required (probably in 2013–14) to ensure that HEE’s existence continued in 2014–15 and beyond. However, there is no specific reference to HEE in the Bill or in the explanatory note and the Bill is silent of responsibilities in relation to workforce planning and the future education, training and professional development of NHS staff.

14. The DoH Paper further proposes that Local Provider Skills Networks should be established without specifying the governance arrangements, geographic basis or number of the latter and their relationship with HEE. It is not clear how many of these networks should or would operate in the future. The transfer of the current planning and commissioning function of the ten Strategic Health Authorities to a plethora of local skills networks is a cause of further uncertainty in the future planning and commissioning of MPET/NMET provision.

15. As a legal entity HEE would be able to award contracts. However, if the Local Provider Skills Networks were also expected to commission and award contracts eg for NMET and allied health provision, they would have to be established as legal entities. This would be hugely costly and bureaucratic. In any case, it is difficult to see how this could be achieved prior to the abolition of the Strategic Health Authorities in April 2012. HEE itself will have to be established initially as a Shadow Special Health Authority and will be informed in the long run by the Centre for Workforce Intelligence—although the latter will not be functioning in time to inform commissions in 2012–13. Moreover, under DoH’s current proposals, HEE does not appear to have the power of direction over local skills networks to ensure that a more long term approach to workforce planning is able to influence local decisions in the future.

16. The Bill is silent on the responsibilities of providers (GP consortia and Foundation Trusts) to participate in local provider skills networks or co-operate (for example with HEE) to identify future workforce requirements. Notwithstanding the duties identified for the NHS Commissioning Board in respect of the effective and safe delivery of services and the duty to improve quality to which the Bill refers, it is difficult to see how the DoH intends to secure effective and transparent arrangements for the future education and training of NHS staff. For its part, the NHS Commissioning Board will have a specialist commissioning budget (currently set at £20 billion), 5,000 staff (half the size of the current DoH) and a £400 million staff and operational support budget and will have regional outposts. In principle, the Board could be given responsibility (and a commissioning budget) for the commissioning of NHS education and training. However, unless this funding was ring-fenced and a specific responsibility allocated to the Board, there would be no guarantee that this would be a priority.

17. As outlined, MPET funding currently includes NHS professional development and courses for those eg healthcare assistance who wish to enhance their skills. The DoH proposal to remove funding for these activities from the future MPET budget and restrict the latter to pre-registration training is at odds with the life-long learning agenda which the Coalition Government has said it values but also the quality agenda to which reference is made in the Bill. It is very unclear how well the DoH’s proposals will serve the future needs of the NHS in terms of continuous professional development and the skills training required to keep pace with developments in care and technology, improve patient care and add value in the drive to improve quality.

18. At present, the SHAs manage MPET budgets according to national, regional and local requirements in terms of workforce planning. Universities are contracted to provide courses and have to meet certain criteria. For their part, universities plan and manage the viability of course programmes, their staffing by appropriately clinically qualified and academic staff and associated clinical placements. They are also required to meet standards and regulations set by the relevant professional health bodies and they have to match these requirements with commissioned numbers. Staff teaching MPET courses are also frequently involved in near-market research with innovative and improved outcomes in terms of products, procedures and organisational efficiency gains in the NHS and health-related markets. The expertise of universities in England in the education and training of healthcare staff has been an area in which universities have developed international higher education partnerships, training staff in their home countries. This expertise is highly valued and these HE partnerships and contracts contribute to the UK’s foreign exchange earnings. It is difficult to see how the DoH’s proposals to replace the commissioning functions of the SHAs will deliver value for money either within the NHS or in higher education institutions, bearing in mind their investments in clinically and academically qualified staff and teaching and research infrastructure.

19. The Public Bill Committee may therefore also wish to consider the extent to which the provisions of the Bill and the DoH’s proposals for the future award of contracts for the education, training and professional development of non-medical NHS staff are likely to contribute to the drive to achieve efficiencies within the NHS and whether these arrangements are more or less likely to increase administration, bureaucracy and quality assurance requirements in both the NHS and in universities.
20. million + remains concerned that the new organisational framework envisaged in the NHS and Social Care Bill and the low level commissioning arrangements implied by the DoH White Paper will not promote effective commissioning arrangements in respect of future MPET/NMET education, training and the continuous professional development which are essential to improved patient care.

TRANSPARENCY AND TRANSITION

21. The NHS in England must have an agreed and transparent strategy for the future planning of non-medical workforce education and in particular, a mechanism for the allocation of funds for the education, training and professional development of these staff. It is essential that there is clarity in respect of funding arrangements during the transition period and also the funding arrangements that will be applied in the future. Any new arrangements must provide for an agreement about:

— the allocation of a tranche of funding for MPET/NMET in advance of the abolition of the SHAs and prior to the introduction of the new NHS organisational and funding framework; and
— the future allocation of MPET/NMET funding bearing in mind the requirements to make effective and efficient use of HE facilities and infrastructure and the need to avoid unnecessary bureaucracy and transaction costs within the NHS and higher education institutions.

22. Experience under the previous Government illustrates the merits of coherent and transparent funding arrangements. For example, in 2006-07 the DoH removed the requirement for SHAs to ring-fence the MPET budget (essentially to assist SHAs to reduce deficits). This decision was made with very little consultation and without any appreciation of the implications for universities which have their own business requirements to provide viable courses and meet the quality standards laid down by the professional health regulatory bodies including in respect of staff-student ratios. Transparency and ring-fencing of MPET/NMET funding in advance of and during the transition period and thereafter, are therefore crucial.

PARTNERSHIP APPROACH

23. There would be considerable merits in DoH adopting the partnership approach currently deployed in the devolved administrations in terms of the planning and allocation of MPET student numbers. This approach already operates in respect of medical training, dentistry and pharmacy in England and will continue under the reforms proposed by the NHS and Social Care Bill. The Scottish Funding Council (SFC) performs a similar role for medical education in Scotland. However, the SFC also manages the allocation of non-medical NHS education and training and associated numbers. These arrangements are proven, known to be workable and are administratively effective. They therefore offer a simpler and less bureaucratic system than currently operates for MPET/NMET funding in England.

24. If a similar approach in respect of the MPET budget was adopted following the transfer of responsibility from the SHAs in England, it would have the advantage of introducing a less bureaucratic system than at present while delivering transparency and an organisational framework for forward planning with HEE taking account of and mediating needs identified on a regional and local basis.

25. The adoption of a similar arrangement in England, in liaison with HEE would allow employer needs to be aggregated in the new NHS organisational structure and a partnership approach to be developed between employers and providers with Hefce taking on similar responsibilities to those already managed by the SFC in Scotland. Such an approach would:

— ensure that a partnership approach was developed between NHS employers and HE providers;
— provide for the professional bodies for MPET education and training to continue their role in maintaining quality and standards;
— ensure that best use was made of expensive university infrastructure; and
— avoid higher transaction costs among providers.

For this partnership approach to work effectively, there would need to be:

— an agreed mechanism to deliver an appropriate transfer of funds to MPET/NMET to ensure that funding was available in the transition period and prior to the implementation of any new arrangements; and
— an agreed and transparent mechanism for the future allocation of MPET/NMET funding ie post NHS re-organisation.

26. The low-level commissioning arrangements for the future award of MPET/NMET contracts implied in the NHS and Social Care Bill and in the DoH White Paper pose real risks to NHS workforce planning and the future education and professional development of non-medical staff. Moreover, the lack of clarity in terms of future responsibilities increases risks in respect of the viability of university-led MPET provision and the quality and scope of the education and training for NHS staff that will be available.

27. Currently, transitional funding and future commissioning arrangements lack transparency and the timescale for the abolition of the current commissioning bodies, the Strategic Health Authorities, is a cause of concern. It is also difficult to see how the proposed arrangements will be cost-effective, add value or improve the quality of patient care.
28. Future responsibility for NHS workforce planning and the funding and commissioning arrangements for the education and professional development of NHS medical and non-medical staff should be clearly identified in the NHS and Social Care Bill.

29. Bearing in mind the proposals tabled to date, the establishment of HEE as a Special Health Authority appears to be the best option. However, DoH must resolve the governance issues arising in respect of HEE and indicate the scale and scope of its remit and commit to appropriate funding for its staffing and operational requirements. Moreover, the Secretary of State must avoid creating arrangements in which local provider skills networks add another costly layer of bureaucracy. Future commissioning and funding arrangements must be transparent and DoH and BIS should recognise that this is particularly important for universities currently engaged in contracts related to nursing, midwifery and the professions allied to health since medical numbers will continue to be allocated by Hefce.

RECOMMENDATIONS

1. Health Education England (HEE) should be established without delay as a Special Health Authority with an independent Chair and a Board that includes expertise in the commissioning of NMET and allied health professions provision and not just medical education.

2. The establishment of HEE should be underwritten and accompanied by Ministerial commitments that:

   (i) HEE will be provided with:

       (a) an agreed budget which is sufficient to meet operational support and staffing costs; and

       (b) the authority to determine the number and geographic basis of local skills provider networks with the staffing arrangements and operational costs of the latter agreed and funded by HEE.

   (ii) MPET/NMET funding will continue to include pre-registration, post registration and continuous professional development funding. This is particularly important during a period of structural change and efficiency savings and would avoid the risk of post-registration and CPD training and education being “lost” during the transition period.

   (iii) A tranche of funding will be transferred to HEE for the 2012–13 financial year which as a minimum, is sufficient to maintain funding and commissioned numbers, allowing for inflation and any strategic workforce planning needs identified in the 2011–12 year.

   (iv) HEE will be the legal entity and will be required to work with Hefce to introduce from 2012–13 the same arrangements as currently apply to the allocation of medical education, pharmacy and dentistry, to the allocation of numbers associated with nursing, midwifery and the allied health professions. The arrangements for the allocation of medical and other numbers, have been proven to be administratively effective and their application to MPET/NMET numbers would provide a more efficient and less bureaucratic system for the NHS and for universities than that which currently operates or which might be required if local provider skills networks have to be established as legal entities.

3. HEE should have a duty to establish effective local skills provider networks or alternative organisational arrangements to ensure that HEE is informed by local workforce needs as well as by the Centre for Workforce Intelligence.

4. Quality assurance arrangements in respect of NHS educational provision should be provided through the professional bodies which would continue to be required to give course approval.

5. At a time of significant reform in both health and higher education, these recommendations are likely to ensure continuity in NHS workforce planning, education and training, offer real benefits in terms of transparency and administrative efficiency in the commissioning process, provide a mechanism for the latter to be informed by and responsive to local provider needs and provide arrangements to mediate these needs against nationally agreed workforce requirements.

   However, in order to avoid further uncertainty, the Secretary of State and Government Ministers from DoH and BIS should confirm their intention to implement these recommendations and the associated funding requirements as soon as possible during the Committee stage / the passage of the NHS and Social Care Bill through Parliament.

March 2011
Memorandum submitted by the General Medical Council (HS 113)

SUMMARY

1. The GMC is the independent regulator for doctors in the UK. Our purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. Our duties and powers are set out in the Medical Act 1983 (as amended).

2. In our memorandum on the Health and Social Care Bill we address issues related to Section 215, Abolition of the Office of the Health Professions Adjudicator. We also examine some of the implications that the proposed abolition of PCTs and SHAs will have on revalidation, and the regulation of medical education and training.

ABOLITION OF THE OFFICE OF THE HEALTH PROFESSIONS ADJUDICATOR (OHPA)

3. OHPA was established in law in January 2010. It was intended to ensure a clear separation between the investigation of fitness to practise cases by the GMC and the process of determining whether a professional’s fitness to practise is impaired.

4. OHPA had been preparing to assume operational responsibility for the adjudication of fitness to practise cases involving doctors from the GMC in April 2011. In due course it was anticipated that OHPA would assume the adjudication function of all the healthcare professional regulators.

5. In October 2010, following consultation, the Government confirmed that it did not consider the establishment of a new body to be the most proportionate approach to adjudication and does not intend to proceed with the transfer of adjudication to OHPA.

6. Our evidence on this issue sets out the changes which have already been made to the GMC’s adjudication function as well as our proposals to reinforce the autonomy of decision making at the adjudication stage and to streamline the procedure.

Recent changes to the GMC’s adjudication functions

7. In 2000, we commenced a fundamental review of our fitness to practise procedures. Following public consultation, the Council agreed to bring together our three separate procedures for conduct, performance and health. Amendments were made to the Medical Act 1983 and new procedural rules, the General Medical Council (Fitness to Practise) Rules 2004, were introduced.

8. The changes resulted in:
   (a) An approach which looks at all aspects of a doctor’s fitness to practise together (which might include issues relating to health, conduct or performance) based on the concept of impaired fitness to practise.
   (b) The introduction of a degree of separation between the investigation and adjudication stages.
   (c) The introduction of professional decision makers (case examiners) at the investigation stage.
   (d) A staged decision making process based on formal criteria and supported by extensive guidance allowing for thorough audit of case progression.

9. In addition, Council members have had no role in either the investigation of cases or in adjudicating since 2004. Council is our governing body and sets our strategy and priorities, ensuring that we are properly managed and that we fulfil our statutory and charitable purposes.

10. We have kept the operation of the Fitness to Practise Rules 2004 under review and further improvements have been implemented including moving to the civil standard of proof for hearings. Additionally, the infrastructure supporting the fitness to practise procedures has been significantly enhanced. This includes a more robust process for monitoring and supporting those doctors who are subject to undertakings and conditions and an electronic case management system.

11. In 2009, our approach to entering agreements with doctors (called undertakings) was extended. The aim was to increase the opportunity for remediation and rehabilitation of doctors whose fitness to practise was impaired in appropriate cases without the need for a fitness to practise panel hearing.

12. There is an active training and development programme for panellists and for staff. Regular training events are held for panellists to brief and update them on changes to legislation, case law and policy, with the aim of ensuring more consistent and robust decision making. Panellists are also subject to 360° assessment following every hearing. Staff undergo thorough induction training and have access to manuals which set out in detail the procedures governing the handling of cases.

Assessment of our fitness to practise procedures

13. Current data suggests that decisions made by the GMC’s fitness to practise panels are robust. Only a small proportion of cases are challenged before the courts, and, of those, only a very small proportion are successful.

250 Fitness to Practise Adjudication for Health Professionals: Assessing different mechanisms for delivery—Impact Assessment (Department of Health, August 2010)—Table 1 of the impact assessment.
14. In their 2009–10 Performance Review, the Council for Healthcare Regulatory Excellence (CHRE) reported positively on our performance stating:

“The GMC has continued to perform well, demonstrating excellence in several areas across its functions in a year of significant change. It is impressive that the GMC has maintained its commitment to continuous improvement, even in areas where it was already performing to a good standard, and to addressing challenges in medical regulation.”

The future of adjudication

15. Following proposals outlined in the 2007 White Paper, Trust, Assurance and Safety—the Regulation of the Health Professions in the 21st Century, we had been expecting to transfer our adjudication function to OHPA.

16. Following public consultation, the Government confirmed in late 2010 that it does not intend to proceed with the establishment of this new body.

17. The start-up costs associated with the establishment of OHPA and the increased ongoing costs associated with a separate organisation is clearly a key consideration. Costs would be incurred not only by the taxpayer, but also by doctors, who would be expected to pay for the additional running costs of the new organisation.

18. Figures contained in the impact assessment accompanying the consultation document suggest that the net benefit of strengthening and modernising the GMC’s systems and procedures instead of transferring adjudication to OHPA is in the region of £45–£59 million over a five-year period.

19. As a result we consider that ensuring greater separation between investigation and adjudication within the GMC, while delivering the key changes envisaged under OHPA, is the most proportionate way forward.

20. Following the Government’s announcement, we have been developing proposals to both reposition adjudication within the GMC to achieve greater separation and to modernise and streamline the hearing procedure to make our procedures more efficient and effective. In developing a new approach we have drawn on best practice from other jurisdictions, such as the Courts and the Tribunal Service. We have also taken into account the work undertaken by OHPA which stimulated a useful debate on the future of the adjudication function.

Proposals to reposition adjudication within the GMC

21. Our aim is to create a body that will be recognisable as operationally separate from the rest of the GMC’s work. This will strengthen public confidence in fitness to practise panel decisions by increasing the separation between our investigation role in bringing proceedings on the one hand from the function of adjudicating on those cases.

22. While the GMC has achieved a degree of separation to ensure fairness and impartiality of panels since the new procedures were introduced in 2004, further separation is possible.

23. To achieve this we propose to set up a body provisionally called the Medical Practitioners Tribunal Service (MPTS) to assume responsibility for the day-to-day management of adjudication and be accountable for the decisions made by panels, which we propose in future be called medical practitioner tribunals.

24. At present, fitness to practise panels make their decisions independently of the GMC and can and sometimes do make decisions that do not accord with our preferred outcome. We propose to strengthen the separation between our investigation and adjudication work by placing all aspects of operational management of adjudication under the control of the MPTS.

25. Our proposed governance structure for the MPTS includes the appointment of an independent Chair and two further members to act as the executive and new reporting arrangements to provide further assurance that individual tribunal decisions are arrived at independently. We are proposing to seek a right of appeal for the GMC against tribunal decisions so that, where we disagree with the outcome of a tribunal hearing, there is a fair and transparent procedure to challenge that decision. This will further signal the separation between our investigation work and the adjudication of cases.

Proposals to modernise and streamline the hearing procedure

26. We will also use the opportunity to modernise our procedures. In the last three years the number of referrals to fitness to practise panels has increased, as has the complexity and average length of a fitness to practise hearing.

27. Other jurisdictions, including the courts and Tribunals Service, have developed a more risk-based and cost-effective approach to hearings management which we can adopt, adapt and benefit from. This includes better use of new technologies and enhanced performance management and support for panellists.

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251 Performance review report 2009–10—Enhancing public protection through improved regulation (CHRE, July 2010).

252 Fitness to Practise Adjudication for Health Professionals: Assessing different mechanisms for delivery—Impact Assessment (Department of Health, August 2010).

253 During the period January to June 2008, the average number of sitting days per closed hearing each month was 5.46 days. This increased to 5.5 days in the same period in 2009. In 2010 it rose to 6.41 days.
28. Further changes to our procedures may also help to reduce the time a case takes to reach a hearing and the time each hearing takes. This will also reduce the stress for everyone involved. The proposals which we are considering include:

(a) more active and robust pre-hearing case management arrangements;
(b) the introduction of legally qualified chairs in some or all cases;
(c) a reduction in unnecessary review hearings where the parties agree the outcomes; and
(d) further streamlining the hearing procedure by removing the need to read out the allegations at the start of the hearing and greater use of written evidence.

Conclusions on the abolition of OHPA and the future of adjudication

29. We agree with the Government’s assessment that establishing a new body to be responsible for the management of adjudication in fitness to practise cases is not proportionate in light of the reforms which have already been delivered within the GMC and the costs of the new organisation.

30. However we also recognise that while the current adjudication function is effective, achieving further separation between investigation and adjudication is possible. Additionally there is an opportunity to modernise our procedures to make them simpler and faster.

31. Some of the proposals will require a significant shift in our current approach and will have some financial impact for the GMC in the short term. However, in the long term, these improvements will increase public confidence in the profession and deliver an improved service and better value for money without the significant ongoing costs associated with an independent body.

32. We are currently consulting on the principles of reform until June 2011 and further details can be found on our website: http://www.gmc-uk.org/ftpconsultation

The Abolition of PCTs and Implications for the Revalidation of Doctors

33. Revalidation is the process by which doctors will have to demonstrate to the GMC, normally every five years, that they are up to date and fit to practise and complying with the relevant professional standards. The purpose of revalidation is to assure patients, employers and other healthcare professionals that licensed doctors are up-to-date and are practising to the appropriate professional standards.

34. The Responsible Officer (RO) will be the link between the local healthcare organisation and the GMC and as such they are an essential component of implementing revalidation. The RO will usually be based in and employed by the organisation in which the doctor works, or with which the doctor is contracted to provide services.

35. ROs also have a wider remit to make sure doctors are practising safely and that patients are receiving the best possible care from them. For example, the RO regulations require that they monitor doctors’ conduct and performance by regularly reviewing patient outcomes. They are also charged with investigating and dealing with concerns about doctors (which may or may not include escalating cases to the GMC). Their wider responsibilities will help to ensure their organisation’s clinical governance and patient safety systems are as strong as possible.

36. To revalidate a doctor, the GMC will require assurance from the RO that the doctor is practising to the appropriate professional standards as set by the GMC and that there are no known concerns about the doctor’s fitness to practise. ROs will base their recommendations on the outcome of a doctor’s annual appraisals over the course of five years, combined with information drawn from local clinical governance systems, including patient and colleague feedback.

Implications of the Bill for revalidation

37. The Department of Health’s (England) Responsible Officer regulations came into force on 1 January 2011. All “designated bodies” that have a prescribed connections with doctors are now required to have a Responsible Officer in place. Designated bodies include primary care organisations.

38. The GMC expects revalidation to start in late 2012. Of course, this timetable will be dependent on NHS employers and other healthcare providers ensuring that they have the local systems in place to support the revalidation of their doctors.

39. The abolition of PCTs leaves a number of issues unclear, including where the performers list will be held, where the RO role in primary care will be based and how the role and functions of the PCT medical director will be exercised. This has implications for the revalidation of both GPs and locums.

40. Also, with the abolition of SHAs it is unclear how ROs will themselves be revalidated as it was anticipated that SHAs would provide an intermediate tier for the revalidation of Responsible Officers, clinical governance oversight and quality assurance. Furthermore, as ROs for trainees currently sit in deaneries within the SHAs, further clarity is needed as to where the RO for trainees will sit within the new system.
41. It is important that we continue to make progress towards the implementation of revalidation and this uncertainty is a cause for significant concern. These changes will have a direct impact on the successful implementation of revalidation given that it will restructure the revalidation routes for the vast majority of doctors at the time that revalidation is beginning to be rolled out.

42. The Department of Health (England) will be consulting on this issue in the summer of this year and we will be looking to work with the Department in order to resolve this issue.

**The Abolition of SHAs and Implications for Regulating Medical Education and Training**

43. The GMC sets standards for, and assures the quality of, all stages of medical education and training. This work underpins our objective to protect, promote and maintain the health and safety of the public.

44. We expect that further primary legislation will be introduced to Parliament at a later date which will lead to significant reform of medical education and training. In this memorandum we would however like to highlight the significant implications that the Health and Social Care Bill will have for medical education and training, particularly with regard to the abolition of SHAs.

45. The GMC works closely with the postgraduate medical deaneries within the SHAs. They are responsible to the GMC for quality management of placements and programmes, ensuring proper supervision and assessments and ensuring orderly recruitment, rotation and progression of trainees through their training programmes, often across a wide range of providers and units. Postgraduate Deans, on behalf of medical schools, are usually responsible for certifying that a provisionally registered doctor has met the educational outcomes that we set, so as to be eligible to apply for full registration. Postgraduate Deans have also played an important role in the remediation of trainees with fitness to practise problems, and have built up substantial expertise in this area, liaising closely with the GMC and other organisations.

46. Postgraduate deaneries carry out important functions. The proposal to abolish SHAs and the deaneries within them will therefore have wide reaching implications for the regulation of medical education and training.

47. The Government’s proposals for dealing with these issues are outlined in *Liberating the NHS: Developing the Healthcare Workforce*, including the transfer of the functions of SHAs to healthcare provider skills networks with a stronger multi-professional approach. It is also proposed that an organisation called Health Education England (HEE) will be created, which will focus on workforce issues that need to be managed nationally. HEE will take on the advisory role of Medical Education England and the professional advisory boards for education and training. Its functions will include championing the greater involvement of patients and local communities in planning and developing the workforce.

48. We welcome the proposed new duty on all NHS organisations to provide high quality training. To make that happen, however, there needs to be proper checks and balances within the new system. This should include an “education champion” at local level alongside a clear employer voice.

49. We also have some concerns about the speed of these changes, the potential instability during the transition to the proposed new system and the impact on quality management of medical education and training during this period.

50. During the transition, SHAs will have a role to develop coherent plans, building on existing arrangements where possible, and agreeing with healthcare providers the leadership and accountability arrangements.

51. The transition to this new system will be challenging, particularly given the timescale of putting in place new systems and processes by 2012 to take on functions of SHAs before they are abolished. This is a particular concern given that legislation to create HEE will not be introduced until a later date.

52. Careful thought and planning is therefore essential. We wish to emphasise the need to manage the transition in order to ensure that training programmes are not disrupted to the detriment of existing students and trainees, and that the knowledge of staff, especially within deaneries, is not lost. Stability and continuity of delivering safe, patient care and training programmes is a priority.

53. We also believe that the new arrangements need to recognise the pivotal role of the professional regulator in setting and assuring educational standards, and for there to be a clear line of accountability to the GMC from the new local skills networks.

54. The GMC will be responding to the Developing the Healthcare Workforce consultation by 31 March 2011. A copy of our submission can be obtained on request.

*March 2011*
Memorandum submitted by the Association of Directors of Public Health (HS 114)

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DPH) in the UK. It seeks to improve and protect the health of the population through DPH development, sharing good practice, and policy and advocacy programmes. www.adph.org.uk

ADPH has a strong track record of collaboration with other stakeholders in public health, including those working within the NHS, local authorities and other sectors. We have worked closely with colleagues in local authorities—particularly Directors of Adult Social Services (DASS) and Children’s Services (DCS)—and with IDeA (now LGID) developed work on effective joint working in local authorities between DPH, DASS and DCS (Leading Together Better).

ADPH submitted views during consultation on the White Paper Liberating the NHS and the associated consultation documents. In this submission we raise areas of concern that we believe require urgent consideration and clarification in relation to Parliament’s consideration of the Health and Social Care Bill.

We recognise that the Health and Social Care Bill and Public Health White Paper raise huge opportunities for public health and we welcome the increased formal role of Local Authorities in the health agenda. The integration of local Directors of Public Health into Local Authorities also opens the chance of real improvements in health and well-being. However, with such changes there are also risks. England needs an integrated system for delivery of public health outcomes, and we are concerned that there is a significant risk that the proposals could have adverse effect in:

— fragmentation of the public health workforce across a number of organisations;
— fragmentation of commissioning and finance responsibility for public health programmes; and
— fragmentation and loss of clarity on accountability, particularly in the area of health protection.

In this submission, we seek to highlight key issues that we believe will need to be addressed to mitigate these risks and to ensure:

— real improvements in health care services and outcomes;
— improving health and the reduction of health inequalities; and
— strengthened health protection and resilience.

We welcome the opportunity to work with Ministers and the Department of Health to achieve transformational change that will improve outcomes in the three public health domains of health improvement, health protection, and health care service planning and commissioning.

1. Overview—Public Health and Local Government Organisations

The Health and Social Care Bill represents a major restructuring, not just of health care services, but also of local authority responsibilities in relation to public health, health improvement and health protection and the coordination of health and social care. Recognising this fundamental change and the opportunities—and risks—that it presents for improving the health of the public, ADPH along with eight organisations representing public health specialists and local government have joined to discuss the Bill. All involved recognise the important role that local authorities have to play in improving the health of the public and are keen to develop effective working relationships—and in doing so are calling for:

— urgent clarification on funding arrangements for public health;
— safely managed transition arrangements which avoid the loss of vital expertise;
— a clearer picture of what functions go where, minimal direction from the centre and early resolution of very complex resource issues; and
— most importantly that no action should be taken that threatens or undermines the good work that already takes place across the country on integrated health and social care delivery.

2. Protecting and Promoting the Health of the Local Population

We believe that local authorities should be responsible for protecting and improving the health of their populations at all times, including during outbreaks and emergency situations. Public Health England should support local authorities in doing this, and local authorities should be required to use the skills and expertise of public health specialists to deliver health and wellbeing for their local population.

255 The Local Government Group, Royal College of Physicians, Public Health Medicine Committee of the British Medical Association, Royal Society for Public Health, Royal College of Nursing, Chartered Institute of Environmental Health, Association of Directors of Public Health, Faculty of Public Health and the UK Public Health Association.
However, we are very concerned that neither the Health and Social Care Bill (nor the Public Health White Paper) articulate these responsibilities clearly. This puts the public at serious risk, particularly in emergency or epidemic situations. We believe that the following responsibilities are so important that they should be defined in primary legislation:

— Local authorities should be responsible for protecting and improving the health of their populations at all times, including during outbreaks and emergency situations.
— Public Health England should support local authorities in discharging this responsibility.
— Local authorities should be required to use the skills and expertise of public health specialists to deliver health and wellbeing for their local population.

3. PUBLIC HEALTH ENGLAND

Public Health England should:

— Be able to offer independent scientific evidence-based advice to national and local government, the NHS and the public on all matters relating to the maintenance, improvement and protection of health.
— Provide effective, expert and adequately-resourced specialist PH capacity to support the work of the Director of Public Health and their teams.
— Be able to provide independent scientific evidence-based advice and guidance to the devolved nations where they are unable to access this locally.
— Be able to generate revenue from external consultancy and academic research funding.

ADPH is concerned that it is unlikely that these aims can be achieved if Public Health England becomes a fully-integrated part of the Department of Health. We would suggest that consideration be given to establishing Public Health England out-with the civil service—for example as a NHS Special Health Authority or as an Executive Agency of the Department of Health. This could offer a more practical and acceptable way forward, and would:

— facilitate the employment of public health staff by Public Health England;
— enable pooling of scarce and specialist capacity;
— enable the continuance of external income streams that currently support national health protection activity; and
— facilitate the separation of science from policy and therefore re-enforce the independence of Directors of Public Health and health protection for the populations’ health and protection.

We are also concerned that there must be clear lines of accountability, communication and access between Public Health England, GP consortia, NHS and Directors of Public Health working within local authorities.

4. ROLE OF THE DIRECTOR OF PUBLIC HEALTH

Directors of Public Health are the frontline leaders of public health input into the three domains of health improvement, health protection, and health care service planning and commissioning. Directors of Public Health must be enabled—through primary legislation—to provide oversight and influence across all these determinants of health within local authorities, the NHS and primary care, and other appropriate sectors and agencies in order to secure the improving health of their population.

— Directors of Public Health will need clearly defined responsibilities and powers which can be summarised as follows.
— The professional status and enablement to express an independent view in order to provide advocacy for the health of the population. This is analogous to the requirement for local authorities to appoint a suitably qualified officer responsible for the proper administration of its financial affairs in section 151 of the Local Government Act 1972.
— A requirement to produce an independent, public annual report on the health and health needs of the population (as provided for in the draft Bill); and authority to comment publicly in a professional capacity on matters pertinent to the health of the local population.
— The authority to influence all the levers that impact on health and well-being and to act as a statutory and principal advisor (across the three public health domains) to the Health and Well Being Board.
— Corporate/Strategic Director status—the ability to act at corporate/strategic level within the Local Authority structure (as a full voting member of the corporate leadership team and reporting or accountable to the CEO or equivalent), with direct access to the local authority Cabinet and councillors; have credibility to engage externally; influence across all Local Authority functions and tiers; to work alongside other Directors; develop and promote corporate policy; and contribute to whole organisational decisions.
We are concerned that whilst the Health and Social Care Bill makes reference to the duties to be discharged by an individual in the post of Director of Public Health, it does not seek to regulate appointments to these posts, as currently happens. This removes an important area of public protection.

ADPH is very concerned that, as currently drafted, the Health and Social Care Bill (and the Public Health White Paper):

— would allow someone with no relevant training or qualification to be appointed as a Director of Public Health;
— do not require that the Director of Public Health should have direct access to the cabinet, councillors or to the CEO;
— do not provide clarity over the relationship between the Director of Public Health and Public Health England; and appear to be unclear as to whether the appointment of Directors of Public Health within local authorities are to be made jointly with the Secretary of State for Health or with Public Health England; and
— could allow for a Director of Public Health to have their employment terminated without the approval either of PHE or of the Secretary of State for Health.

ADPH therefore strongly believes that:

— A Director of Public Health should be an individual trained, accredited, and registered in specialist public health.
— The Director of Public Health should be a statutory appointment, working at corporate/strategic director (top team) level as a full voting member of the corporate leadership team with direct access to the local authority Cabinet and councillors— influencing and working alongside other Local Authority Executive Directors and normally reporting or accountable to the CEO or equivalent.
— The Director of Public Health should be recognised as the principal adviser on all health matters to the local authority, its elected members and officers, and including the Health & Well Being Board, on the full range of local authority functions and their impact on the health of the local population as stated in Annex A of the White Paper Healthy Lives, Healthy People.
— The professional status of the Director of Public Health and ability to express an independent view in order to advocate for health improvement and reducing health inequalities within their local population and act for the protection of the local population—and the independent DPH annual report—must be protected.
— Directors of Public Health should:
  — be appointed jointly by the local authority and Public Health England, through a statutory appointments process which mirrors the existing Advisory Appointments Committee process for Directors of Public Health and Consultants/Specialists in Public Health—and which is accredited by the Faculty of Public Health (as is currently the case).
  — have a formal contractual relationship and role—which could be honorary—with Public Health England.
  — have their employment terminated only with approval of both the local authority and the Secretary of State for Health.

5. Health and Well Being Boards

ADPH is concerned that the Bill does not grant sufficient powers to Health and Well Being Boards:

— The powers granted to Health and Well Being Boards are weak and there is a risk that health and social care integration may be more difficult to achieve.
— The Boards have not been granted sufficient powers to meet the expectation that they will join up commissioning between the NHS and local authorities. The interface between GP consortia and local authorities will be critical in ensuring that services meet the full range of local population health needs, however while Consortia must consult Boards in drawing up their commissioning plans, there is no requirement for Consortia to have regard to the views of the Board.

ADPH believes that local commissioning plans should be subject to scrutiny and comment by the Health and Well Being Board—and to greatest effect would also be signed off by the Board.

The Director of Public Health should act as a principal advisor to the Health and Well Being Board for public health advice across the three public health domains of health improvement, health protection, and health care service planning and commissioning.

It is important that in two tier authorities the existing health and well-being partnerships continue to work together for the health and well-being of the local population. We believe that District Authorities should have specific roles and duties for the improvement and protection of health.
Health and Social Care Bill

6. GP CONSORTIA AND COMMISSIONING

We are concerned that the Health and Social Care Bill:

— lacks clarity over who will be responsible for providing ‘local system leadership’ and planning services across GP consortia boundaries following the abolition of strategic health authorities (SHAs) and primary care trusts (PCTs);

— includes few requirements on the governance of consortia. As recently highlighted by the Health Select Committee, it is essential that consortia include a wide range of health professionals and involve the public in their work. While the Bill includes a limited duty on consortia to involve the public, it does not specify a need for them to include other health professionals; and

— does not require GP consortia to promote integration between health and social care—an omission that will be exacerbated by the potential lack of co-terminosity between consortia and local authorities.

— does not appear to place a duty on GP consortia to promote and protect the health of their local health population. This lack of clarity over the role of GP consortia in promoting and protecting population-wide health could result in the NHS not giving it sufficient priority with consequent risks to health outcomes.

Specialists working in health services public health possess skills that are highly specialised, not held within the General Practice or health service management communities and not widely available from commercial suppliers. The essential role of this group in the commissioning of health services by Commissioning consortia (and the NHS Commissioning Board) has not been grasped in the proposals in the Bill. The current position is that the Bill requires commissioners to take advice only from those with “professional expertise relating to the physical or mental health of individuals”.

The requirement for commissioners to take advice should be extended to ensure that commissioners receive support from those with skills and expertise in health services public health.

GP Consortia should be required to work through and with Directors of Public Health to ensure Consortia decision-making is underpinned by expert, professional public health advice.

GP Consortia (and the National Commissioning Board) should be responsible for improving inequalities of health outcome rather than just inequalities of access to health services.

In order to promote coherent response to emergencies, GP Consortia should assume similar responsibilities as category 1 responders under Civil Contingency Act that have previously applied to Primary Care Trusts.

Commissioners should be required to demonstrate the use of a strategy covering high quality, universal services, targeted services for communities of interest at greater risk especially deprived communities and tailored services for people with multiple and complex needs. This should be underpinned by evidence base, public health intelligence and needs assessments.

7. PROVIDER ORGANISATIONS

To fully realise the transformational change envisioned in the Health and Social Care Bill, we believe there is a need to extend public health influence within provider organisations. We believe that there are huge benefits that derive from having a public health lead working within Trusts.

We would welcome measures that would enable and encourage provider trusts to work with local authorities in improving the health of the population.

For example, we have in the past expressed concerns over the accumulation of excessive financial reserves in Foundation Trusts, and suggested that above a capped level of reserves, an annual proportion of the reserves could be spent on initiatives agreed locally as providing health gain for the population.

In 2010 ADPH surveyed its members on progress with the introduction of Transforming Community Services, and results from this survey highlighted that:

— Care must be taken that in any re-organisation the impact on public health services should be assessed—this is particularly true for emergency planning and response.

— Where possible there should be a named public health lead in community services.

— Public health expertise should be readily available to provider services where no public health lead is in place.

8. REGULATORY ORGANISATIONS

In strengthening the role of the Care Quality Commission, and developing the role of Monitor, we would wish to see clear lines of public health input into both organisations, and specifically:

— public health expertise and input at a high level within the Care Quality Commission to ensure a strong population perspective in quality regulation; and
9. **HEALTH INEQUALITIES**

We welcome that the Bill includes new duties on the Secretary of State, NHS Commissioning Board and GP consortia to have regard to the need to reduce health inequalities. However these duties are narrowly drawn, only applying to the role of the NHS in providing services to patients. The duties do not reflect the broader role of the NHS in promoting public health as a provider, commissioner and major employer. There are also no equivalent duties on the Secretary of State or local authorities in respect of their roles in promoting public health.

ADPH is concerned that the duties are unlikely to be sufficient to ensure that tackling health inequalities is prioritised in the health system.

The NHS Atlas of Variation published last year, showed significant geographical differences in care. We are concerned that the proposed new system should not result in service fragmentation, which would have detrimental impacts on the very areas the Bill’s reforms seek to improve: the quality of services, education and training, patient choice, efficiency and equity. It also has the potential to exacerbate any existing postcode lottery in health services.

*March 2011*

Memorandum submitted by Professor Martin McKee (CBE MD FRCP FFPH FMedSci), Louise Hurst (MSc MFPH), Robert W Aldridge (MSc MBBS MEng), Professor Rosalind Raine (MB PhD FFPH), Jennifer S Mindell (MB PhD FFPH FRCP), Ingrid Wolfe (MB MSc MFPH), and Professor Walter W Holland (CBE MD FRCP FFPH) (HS 115)

1. In an article published by *The Lancet* (Annex 1) we set out reasoned arguments for an alternative model for Public Health in England that overcomes some of the problems with the current proposals in the Health Social Care Bill, namely:

   - the stripping of public health professionals of their “independent voice” to advocate for the health of the population based on evidence;
   - unnecessary fragmentation of the public health workforce between the Department of Health and local authority;
   - possible risks to the “ring-fenced” budget;
   - securing adequate technical support to Directors of Public Health; and
   - practical difficulties for the maintenance of the substantial trading activities of the health protection agency.

   In the article we outline recent successes of public health and key principles that should underpin a new public health service.

2. Our practical proposals suggest the establishment of a new body, which would still be called “Public Health England” that would build on existing capacity and absorb the entire existing NHS public health workforce. This body would ideally be established within the NHS as a special health authority, although it might be an arm’s length body of the Department of Health. It would be organised at a local, subnational and national level.

*Our model would:*

   - secure the independence of public health advice, which is crucial to build public trust. For example, it has taken many years for public health professionals to regain public trust following the bovine spongiform encephalopathy affair. The importance of public trust has also been well illustrated by the difficulty the last government experienced in convincing parents of the safety of the measles–mumps–rubella vaccine, a challenge that the new government must now take on;
   - provide clear lines of accountability with a board of Public Health England, similar to the model proposed for the NHS National Commissioning Board;
   - provide national support for cross-governmental working to tackle the wider determinants of health as outlined in the Marmot review;
   - ensure that Public Health England would hold a truly secured ring-fenced budget, reducing the risk of asset stripping;
   - enable teams to be deployed at a local level to provide strategic leadership for public health. Local teams would work across the domains of public health with the local structures proposed in the

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256 http://www.rightcare.nhs.uk/atlas/
Health and Social Care Bill

Health and Social Care Bill, including Health and Wellbeing Boards and Commissioning Consortia. Flexible deployment of staff will make it possible to secure critical mass of public health expertise to work with local authorities;

— provide comparable competitions for medical staff with their clinical counterparts, avoiding the potential damage that could be caused by 2-tier pathway; and

— enable the Health Protection Agency to continue its trading and research activities, that would be compromised by the present proposals, so threatening key elements of its work.

3. We attach the article \textit{(not printed)} that this submission summarises in Annex 1 as further evidence for consideration by the Public Bill Committee on the Health and Social Care Bill 2010–11.

\textit{March 2011}

\textbf{Memorandum submitted by City of London Corporation (HS 116)}

\textbf{General Background}

1. The City of London Corporation provides local authority functions for the City. The square mile of the City of London has unique demographics with a residential population of some 9,000 but around 320,000 commuters arriving in the City every week day to work.

\textbf{Specific Issues Raised by the Bill}

2. Under the Bill the City Corporation will assume responsibilities for public health in the City. This will present a particular challenge for the City Corporation in that its obligations will extend to the 320,000 workers commuting into the City each day as well as the 9,000 residents. Clearly if the requirement under the Bill is “to improve the health of the people in its area” the City will need to deliver appropriate services to both residents and workers and thus the expectation in the Bill is that City’s responsibilities will be greatly extended. The scope of such responsibilities, in relations to City workers, will go well beyond so called “local workplace health initiatives”. Thus the funding arrangements under the Bill will need to recognise the City’s increased obligations to a broader category of people.

3. The need to accommodate the City’s unique demographic is already recognised through its designation as a “special authority” in the Local Government Finance Act 1988 where special provision was made to take account of the City’s unique circumstances. During the discussions leading up to the 1988 Act, the Department of Environment, the department responsible, recorded that special provision was needed “because the City has a very small resident adult population, ... which would constitute its tax base under the new system, but provides services for a daytime population of over a million. Its total expenditure is therefore exceptionally high in proportion to its resident population.”

4. The position remains essentially unchanged quarter of a century later with the City’s local authority funding arrangements still separately calculated to reflect the fact that the City of London is a business district with a unique local business franchise and a small resident population.

5. The Bill’s measures should permit local flexibility to ensure that funding is available so that public health services can be commissioned that are appropriate for both workers and residents. The Liverpool Street Walk in Centre has collected anecdotal evidence which suggests that sexual health (in particular the morning after pill), is a key issue for City workers. It would make sense therefore for contraceptive services to be commissioned for both residents and workers. By way of further example, drug and alcohol issues are most likely to be recognised in the workplace (because of the impact on the ability to work) and those employees will, some evidence indicates, seek immediate help close to work. The proximity of such services close to the workplace also reduces disruption future treatment may cause to the working day. As a third example, it is very likely that, through the responsibilities created under the Bill, the City will have to actively tackle smoking among City workers. A recent study, commissioned by NHS City and Hackney to look at smoking prevalence amongst City workers revealed that 54% smoked which is significantly higher than the national average of 22%. In the City 37% smoke because of stress and 22% to help with keeping alert.

6. The Bill suggests that conditions may be applied limiting the use of the ring-fenced public health grant. To ensure that differing local needs can be fully met these should be widely drawn so as to allow local health provision to be as flexible as possible. A condition could, for example, stipulate “value for money” but should not set out details of precise services that may be offered within the scope of the grant.

\textit{March 2011}
Memorandum submitted by Turning Point (HS 117)

1. ABOUT TURNING POINT

1.1 Turning Point is a leading health and social care organisation. We work in over 200 locations, providing specialist and integrated services that meet the needs of individuals, families and communities across England and Wales. We have also developed Connected Care, Turning Point’s model of community-led commissioning, which is currently working in 10 areas of England to integrate health, housing and social care.

1.2 We are a social enterprise and reinvest our surplus to provide the best services in the right locations for people with a range of complex needs. Turning Point is responding to the committee’s inquiry on behalf of our 2,000 members of staff and the 100,000 individuals who access Turning Point services every year.

2. SUMMARY

2.1 This submission focuses on three key aspects of the Health and Social Care Bill:

— arrangements for GP Consortia—focusing on provisions for consortia to seek advice when commissioning services;
— public engagement and community involvement; and
— integration and the extent to which it is promoted by the Bill.

2.2 We make a number of key recommendations to the government:

— to ensure that consortia receive firm guidance on the nature of the advice that they must seek in order to effectively commission services, as well as the extent to which they must seek this advice, to ensure that they are sufficiently guided and advised on the commissioning of services of which they have little specialist knowledge—particularly for those with the most complex needs;
— to widen the duty imposed upon consortia (clause 22 section 14O) to seek professional advice, to include a requirement to seek advice from those with expertise in social enterprise and not-for-profit organisations’ delivery of health and social care services;
— to strengthen the duty upon consortia to promote patient choice and involvement by removing the phrase “have regard to the need to” from these provisions (clause 22 section 14N);
— to ensure that the duty to involve is not just applied to consortia’s current “patients and carers”. but to every member of the local population, including those not registered with a GP practice;
— to amend section 13J of clause 19 and clause 179 of the Bill to strengthen the NHS Commissioning Board and the Health and Wellbeing Boards’ duty towards integration, replacing “encouraging”/ “encourage” with “pursuing”/“pursue”;
— to replicate this duty for GP consortia, to ensure that integration is pursued at a local level; and
— to promote a common definition of commissioning to ensure that in every area it is centred in local need, namely: “the means by which you understand the needs of an individual and/or a community such that you can build a platform for procurement.”

3. GP CONSOR rIA: ADVICE AND COLLABORATION

3.1 While Turning Point appreciates the expertise that GPs can bring to the commissioning of local services, we are also aware of the need for those with more specialised knowledge to contribute to such important decision-making processes.

3.2 Turning Point believes that commissioning should be a collaborative process, drawing on the knowledge and expertise of professionals from across the spectrum of health and social care, and from the public, not-for-profit and private sectors.

3.3 Research by Turning Point has fuelled our concerns that the generalist position of most GPs may undermine their ability to effectively commission certain services. In one survey of our service users, around 50% did not think that their GPs understood all of their care needs. They attributed this to a number of reasons:

— “My GP does not spend enough time with me” (27%);
— “My GP doesn’t listen to my needs” (13%);
— “My GP is not aware of real problems—they are too removed from my life” (27%);
— “My GP is not aware of services that can help me” (18%); and
— “My GP is not interested in my needs” (15%).

3.4 In September 2010, ICM surveyed 250 GPs on behalf of Turning Point. This indicated that they share our concerns:

— 38% foresaw consortia needing a lot of support in order to effectively commission mental health services;
40% thought they would need a lot of support to effectively commission learning disability services;
32% thought they would need a lot of support to effectively commission substance misuse services; and
in relation to all three types of service, 98–99% of respondents thought that some level of support would be required.

3.5 Clause 22 of the Bill lays out the consortia’s duties, one of which (section 14O) requires them to “make arrangements with a view to securing that it obtains advice appropriate for enabling it effectively to discharge its functions from persons with professional expertise relating to the physical or mental health of individuals”.

3.6 While this is a move in the right direction, we urge the government to ensure that consortia are issued with firm guidance on the nature of the advice that consortia must seek, and the extent to which they must do so.

3.7 We are also concerned that the Bill only imposes a duty to seek clinical advice. GP consortia will be commissioning services not just for their registered patients, but also for hard-to-reach individuals whose needs they may not be aware of; some of whom will not even be registered with a GP practice. They are therefore likely to require guidance from a far wider range of professionals than those confined to the clinical arena, including on non-clinical issues such as public engagement.

3.8 Social enterprises like Turning Point have much to offer to the provision of health and social care, as recognised by the government in its commitment to diversify the provision of such services. Our Crisis model for mental health delivers significant cost-savings to the health service, including a 70% reduction in admissions to acute mental health wards.

3.9 Worryingly, a survey of GPs by ICM for Turning Point found that:
— only 9% felt that consortia would be very likely to commission services from social enterprises;
— 46% felt that they would be very likely to commission services from Foundation Trusts; and
— 84% felt that they would be very likely to commission services from GP provider arms.

3.10 In order to effectively meet their responsibility to empower patients to make choices about the services they access, consortia need to develop a better understanding of the role that social enterprises and charities can play in delivering primary, secondary and integrated care.

3.11 As such, we urge the government to widen the duty imposed upon consortia to seek advice from relevant professionals, to include those with professional expertise in social enterprise and not-for-profit organisations' delivery of health and social care services.

3.12 Summary of recommendations:
— For the government to ensure that consortia receive firm guidance on the nature of the advice that they must seek in order to effectively commission services, as well as the extent to which they must seek this advice, to ensure that they are sufficiently guided and advised on the commissioning of services of which they have little specialist knowledge—particularly for those with the most complex needs.
— For the government to widen the duty imposed upon consortia (clause 22 section 14O) to seek professional advice, to include a requirement to seek advice from those with expertise in social enterprise and not-for-profit organisations’ delivery of health and social care services.

4. PUBLIC ENGAGEMENT

4.1 Turning Point strongly welcomes the government’s desire to better involve patients and the public in the provision of health and social care. We have long advocated for communities to be placed at the heart of the design and delivery of health and social care services, as demonstrated by our “Connected Care” model of community-led commissioning.

4.2 Connected Care emerged from research carried out by Turning Point in conjunction with the Institute for Public Policy Research in 2004, which found that people with complex needs were frequently falling between the gaps between services. The report called for the voice of the community to become central to the design and delivery of connected services.

4.3 Connected Care uses community engagement to narrow the gap between local need and commissioner priorities, training local people to audit the community—contacting its most hard-to-reach members—to uncover their experiences of local services. The results of this audit are then used to reconfigure service provision, designing and delivering new services that effectively address the needs of local people.

4.4 Demonstrating the value of public engagement in commissioning, an independent cost-benefit analysis by the LSE found that our Connected Care project in Basildon delivered to the government a return of £4.44 for every £1 invested.
4.5 In the government’s response to the White Paper consultation, Turning Point’s consultation response was directly quoted and it was stated that the Bill would “place a duty on GP consortia and the NHS Commissioning Board to ensure that people who may receive a service are involved in its planning and development, and to promote and extend public and patient involvement and choice”.

4.6 In contrast, the Bill itself merely requires consortia to “have regard to the need to . . . promote the involvement of patients and their carers in decisions about the provision of health services to them” (clause 22 section 14N(c)). We believe that this represents a considerable weakening of the government’s position on public engagement.

4.7 The wording of this clause means that the consortia do not have a duty to promote involvement, but merely a duty to “have regard to the need to” promote involvement. As demonstrated by a debate by the Health Bill Committee on 25 February, the quoted term is one of considerable ambiguity—such that the Rt Hon Simon Burns was required to offer a legal interpretation.

4.8 We urge the government to demonstrate their previously-stated commitment to public engagement in the provision of health and social care by rewording section 14N—removing “have regard to the need to”—so that the promotion of patient involvement and choice become duties in themselves.

4.9 We also recommend that the government consider the implications of limiting the provisions to the involvement of “patients and their carers”. Every member of the community deserves to be involved in the design and delivery of their local health and social care services, regardless of whether they are, at that time, a patient or a carer.

4.10 Many of the people who Turning Point support are not registered with a GP practice or, as outlined above, feel they lack understanding of their needs and thus avoid visiting them, instead seeking help elsewhere. It is vital that these people—many of whom have a complex (and expensive) mix of needs—are taken account of and involved in the commissioning of their local services.

4.11 The recognition of Joint Strategic Needs Assessments (JSNAs) within the Bill’s provisions is welcome. It is vital, however, that JSNAs are strengthened and draw on and report on local people’s lived experiences and perceptions of services. This is best achieved by directly involving local people in gathering the evidence required, and is the only way that services can be designed around a full understanding of the local population.

4.12 While a JSNA based on a true understanding of local need has the potential to improve the quality of commissioning, standards across the country are likely to remain inconsistent—with some bearing more resemblance to purchasing—until there is a commonly understood, universally accepted definition of commissioning. Turning Point therefore proposes the following definition:

“Commissioning is the means by which you understand the needs of an individual and/or a community such that you can build a platform for procurement.”

4.13 Summary of recommendations:
— for the government to strengthen the duty upon consortia to promote patient choice and involvement by removing the phrase “have regard to the need to” from these provisions (clause 22 section 14N);
— for the government to ensure that the duty to involve is not just applied to consortia’s current “patients and carers”, but to every member of the local population, including those not registered with a GP practice; and
— for the government to promote a common definition of commissioning to ensure that in every area it is centred in local need, namely: “the means by which you understand the needs of an individual and/or a community such that you can build a platform for procurement.”

5. Integration

5.1 Turning Point welcomed the White Paper’s emphasis on integration as an untapped resource to greater efficiency savings. Many of the people who we support would benefit greatly from better integration of health, social care, and other related services (such as housing, employment and debt advice).

5.2 Integration has great potential to deliver significant cost savings to the government, while simultaneously improving the lived experience of people with complex needs and reducing the risk of them falling down the gaps between different services.

5.3 Many people find current service provision confusing, repetitive and frustrating. Integrated services enable people to access a whole package of support for a variety of needs, rather than dealing with each problem individually.

5.4 Integrated, early intervention can have enormous economic and societal benefits. The New Economics Foundation has estimated that, if the government invested £190 billion on a range of preventable problems (all of which involve multiple services at present), such as teenage births, crime and neglect, the total saving over a 10 year period would be £460 billion. This amounts to a net return of £269 billion.²⁵⁷

5.5 Turning Point are concerned that the Bill's provisions on integration are far too weak to make a significant difference to the way in which services are designed, commissioned and delivered.

5.6 GP consortia are excluded from any duty to promote or pursue the integration of services, while the NHS Commissioning Board and Health and Wellbeing Boards are required only to “encourage” integrated working (clauses 19(13J) and 179).

5.7 We contend that this wording is too weak, and that, if integration is to be effective, the responsibility to pursue it needs to be at a local level—with GP consortia. While Health and Wellbeing Boards will be responsible for encouraging integration in their localities, it is not yet clear how much power they will have to hold consortia to account for their commissioning arrangements.

5.8 We recommend that the government:
— Amend section 13J of clause 19 and clause 179 of the Bill to strengthen the NHS Commissioning Board and the Health and Wellbeing Boards’ duty towards integration, replacing “encouraging” / “encourage” with “pursuing” / “pursue”.
— Replicate this duty for GP consortia, to ensure that integration is pursued at a local level.

6. Conclusion
6.1 Turning Point welcomes many aspects of the Bill, but urges the government to strengthen the provisions for public engagement and the integration of services in health, social care and beyond.

6.2 While the government’s evident faith in GPs is positive, we are concerned that it has overestimated their ability to commission many specialist services without additional support, as well as their understanding of different types of provider. We hope that consortia guidance makes it clear that they must seek advice from specialists with not only clinical knowledge, but experience in engaging with local communities and in the role of social enterprises and not-for-profit organisations in delivering public services.

6.3 We would welcome any opportunity to engage further with the government over this highly significant piece of legislation.

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In addition we request that a power be inserted for the Secretary of State to produce regulations stating such other persons as s/he considers appropriate, to bring additional local expertise to the Health and Wellbeing Boards. This would allow the inclusion of such housing and other local experts, such as the Chief Executive of a local housing provider partner (ALMO or large scale voluntary transfer association) or a representative from any local housing provider fora.

4. Reason for amendment

4.1 The Health and Wellbeing Board will sit at the level of a unitary authority or, in two tier authority areas, at the county level. As such, the effectiveness of housing as a contributor to individual and community wellbeing has the potential to be missed from the expertise of the Board. The Bill allows for such other persons or representatives as the authority thinks appropriate, which in some areas may include Directors of Housing in district/borough authorities. However, making the inclusion of housing discretionary to each local area will result in differentials in the level of inclusion of housing expertise and risks missing a key social determinant to the health and well being of communities.

4.2 The varied and patchy inclusion of housing as a partner for evidence and delivery can be seen in the evaluation of Joint Strategic Needs Assessments. Guidance advised health and social care to include housing bodies and their knowledge and understanding of local communities, but the actual level of inclusion proved varied and in many cases, extremely low. This was evidenced in a national evaluation by IDeA in 2009, and again in a regional evaluation by NHC.

4.3 The current financial pressure on services, and the drive to transform public services to improve quality and choice, and increase individual and community involvement and control will require a more comprehensive and inclusive approach of all partners providing services in a local area, and that should start with needs assessment and understanding of communities’ and individuals’ aspirations. Involvement of housing will enable health and social care partners to widen their “reach” into local communities and find new ways of addressing key health and social care agendas (such as prevention, more effective re-ablement etc). CIH’s report from 2009 gives examples of where and how such strategic integration is beginning, and the benefits it achieves.

5. Part 5 section 176 relates to the duty of local authorities and GP commissioning consortia to prepare a Joint Strategic Needs Assessment and develop joint health and wellbeing strategies based on the most recent assessment. This and the strategy should then inform the way the partners meet local needs.

The amendment we request would:

— ensure involvement of housing partners in the assessment of needs and,

— strengthen the role of the assessment and strategy in shaping local services.

Section 176 states that the commissioning consortia or responsible local authority “may consult any person it thinks appropriate”.

We request an amendment to read “must consult such persons as stated within current or future guidance”, to reinforce the inclusion of key local partners such as housing partners in the development of the JSNA, given their connection to and awareness of the needs of local communities reflect consideration of the guidance that currently exists.

6. Reason for amendment

6.1 The JSNA will be the primary process for identifying needs and will provide a transparent, evidence based rationale on which to base all local commissioning plans and decisions around investment and disinvestment. Guidance is quite clear that community partners, including housing, are amongst those best able to provide data and intelligence on the needs of communities especially those at risk of exclusion from health programmes, yet the research referenced above shows that the involvement of housing partners in JSNA has been limited. This provides the opportunity to reinforce the inclusion of wider partners to encapsulate the social determinants of health as well as medical/clinical assessments.

7. Section 179 provides for a duty on the Health and Wellbeing Boards to encourage integrated working

1. A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

This should be amended to read 2encourage persons who arrange for the provision of any health or social care services in that area, or who arrange for the provision of services that support health and wellbeing, to work in an integrated manner.”

A power should be given for the Secretary of State to issue regulations or guidance on the extended range of services, which should include housing and related support services.

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259 NHC/ Integrated Living Network (2009), JSNA and Housing: a review of Northern approaches.
260 CIH/NHS Housing LIN (2009), Housing, health and care.
8. Reason for amendment

8.1 Decent housing and housing related support services have been recognised as supporting health and social care policy and practice and in providing considerable benefits, including financial savings, for both sectors. It is important that services which support the delivery of health and social care outcomes are also included in a local integrated approach. Integrated working across health, social care and housing is promoted widely in government publications such as *No Health without mental health* and *A Vision for adult social care*. A failure to reinforce this in the Bill could result in a risk that opportunities may be lost to maximise the impact of joint working across housing, health and social care.

*March 2011*

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**Memorandum submitted by Professor Roderick Martin (HS 119)**

**The Future Organisation of the NHS**

1. The Health and Social Welfare Bill’s proposals for the future organisation of the NHS are characteristic of “permanently failing organisations” (to use the US sociologists Meyer and Zucker’s term): incompatible objectives; lack of clarity on roles and responsibilities; organisational complexity; and multiple, overlapping responsibilities.

2. **Incompatible objectives**

   Conflict between quality and competition. Responsibility for quality is rests with the Care Quality Commission, responsibility for stimulating competition rests with the Monitor. The Bill simply provides that the two should cooperate with each other: no mechanism is suggested for resolving the inevitable conflict.

   Conflict between competition and continuity of service. The Bill proposes measures to facilitate supplier entry and exit. How can exit be eased without disrupting continuity of service? Health care continuity is more difficult to ensure than car company after sales service.

3. **Lack of clarity**

   Two areas are uncertain: the relationship between the Department of Health and the independent NHS Board; and the precise role of the Secretary of State. It is difficult to see how the Department can transfer such a large element of its responsibilities to an independent body. Secondly, the Secretary of State will be accountable for the service, but not responsible for its day-to-day management; instead, the Secretary of State will present a mandate for the NHS for the forthcoming year, with authority to revise the mandate only in “exceptional circumstances”. Ministers have not been very good at adhering to self-denying ordinances, especially when possible justifications for intervention are provided by “accountability”, exceptional circumstances and budgetary responsibilities.

4. **Organisational complexity**

   GP practices will be tied to the decisions of the group commissioning consortiums, and which will be monitored by Healthwatch Committees, for quality, and the Monitor, for value for money and competition. The organisational chart published in the Commons Research summary of the Bill indicates the complex “dotted line” relationships in the new structure; such dotted lines are easier to draw than to operate.

5. **Overlapping responsibilities**

   Responsibility for assessment of quality will rest with the Secretary of State, the independent Commissioning Board, Healthwatch England, regional bodies, and local representative bodies including local government representatives—not to mention the GP and the actual patient. The possibility for consensus is small.

6. The stated overriding purpose of the reform is to align clinical and financial responsibility, to create incentives to ensure commissioning decisions provide value for money and improved quality of care through efficient prescribing and referral patterns (Impact Assessment Para A4). The relation between patient quality of care, much less patient preference, and efficient prescribing and referral patterns is not clear. Given the overall financial context, and the role of Monitor, the incentive for GPs to prioritise value for money will be difficult to resist.

7. The Monitor institutionalises the Government’s commitment to competition as the driver for improving quality, mainly through innovation, and reducing costs. The Impact Assessment “Provision-provider liberalisation, economic regulation, and joint licensing” states: “There is very clear evidence from across services and countries that competition produces superior outcomes to centralised management and monopoly provision. Competition is more effective where markets are highly contestable and contestability requires that organisations are able to expand/enter the market and contract/exit particular markets in response to consumer preferences” (Para B10). The Assessment recognises that market failures exist—due to externalities, natural monopolies, and imperfect information and uncertainty—but does not discuss their
The British Acupuncture Council (BAcC) is the largest body for the regulation of traditional acupuncture in the UK. With over 3,000 members and a track record of delivering robust self-regulation (recognised in the Secretary of State’s announcement on herbal medicine on 16 February 2011), the BAcC believes that it has a significant and expanding contribution to make to national healthcare delivery. BAcC members offer over three million patient treatments a year and wish to expand this service work within the NHS. The inclusion of acupuncture in the NICE guidelines on the treatment of low back pain is a demonstration of how BAcC members can significantly benefit the nation’s health.

The BAcC hopes that the explicit provisions in the Bill promoting research will extend to encouraging the funding of studies which compare the cost effectiveness of acupuncture treatment alongside conventional care. Where these have been conducted already, as, for example, in Ratcliffe J, Thomas KJ, MacPherson H, Brazier J. A randomised controlled trial of acupuncture care for lower back pain: cost effectiveness analysis. British Medical Journal, 2006; 333: 626-628, acupuncture treatment has been shown to significantly reduce the overall cost of care. The large-scale GREAT trials in Germany demonstrated similar outcomes and have encouraged the use of acupuncture in mainstream provision.

The BAcC believes that the bill offers opportunities for GP consortia to allocate funds specifically for services which their patients request, such as acupuncture. The BAcC believes that one of the great advantages in placing the commissioning arrangements closer to patient needs is that small providers will now have a much greater opportunity to become an “any willing provider”. The BAcC hopes that the commissioning arrangements will permitting individual acupuncturists and consortia of acupuncture to compete effectively without undue burden.

The BAcC has welcomed the extension of regulatory arrangements for herbal and traditional Chinese medicine practitioners. The BAcC remains committed to the statutory regulation of acupuncture alongside herbal medicine and traditional TCM in order to minimise potential public confusion caused by splitting these closely intertwined strands. However, it believes that the extension of the function of the CHRE into the accreditation of voluntary self-regulation presents an opportunity to generate innovative forms of regulation and would welcome the chance to participate in the process of developing these systems.

The BAcC particularly welcomes the emphasis on outcomes in the Bill, with effectiveness, safety and quality for patients being highlighted. The BAcC has an exemplary record in promoting safe practice in its field, and has always demonstrated high levels of patient satisfaction with the services provided by its members. Like many small bodies with a predominance of self-employed or small group members, however, it has proved difficult to find the funding necessary to demonstrate by well conducted research the cost-effectiveness of acupuncture.

The BAcC hopes that the explicit provisions in the Bill promoting research will extend to encouraging the funding of studies which compare the cost effectiveness of acupuncture treatment alongside conventional care. Where these have been conducted already, as, for example, in Ratcliffe J, Thomas KJ, MacPherson H, Brazier J. A randomised controlled trial of acupuncture care for lower back pain: cost effectiveness analysis. British Medical Journal, 2006; 333: 626-628, acupuncture treatment has been shown to significantly reduce the overall cost of care. The large-scale GREAT trials in Germany demonstrated similar outcomes and have encouraged the use of acupuncture in mainstream provision.

The BAcC is mindful that the extended consultation time, -integral to best traditional acupuncture practice—is now considered in conventional medicine to contribute significant reductions in the provision of care (and therefore costs) for chronically ill, repeat patients. The BAcC would be happy to work in partnership with statutory bodies to enable research into this or other aspects of its work.
7. In particular the BAcC believes that the period of transition presents an ideal opportunity to set aside or earmark funding for a small number of innovative pilot projects or studies involving the use of complementary therapies. A relatively small investment at this stage could generate results which could be rolled out on a national scale if they clearly demonstrate that a number of complementary therapies can offer a high level of patient satisfaction, cost effectively.

8. The BAcC welcomes the focus on patient needs and choice throughout the Bill, and does so from a perspective which recognises that the service offered by its members is often beyond the means of those who could most benefit from the intervention—the NHS patient. It hopes that the provisions of the Bill will allow easier access to these treatments to this group.

9. The BAcC also hopes that the commissioning consortia allow flexibility to individual GPs in making choices about what they want to fund within their practices. There have been examples within the current structure where choices have been delegated to PCTs, which have then issued blanket refusals to any funding within their areas.

10. The BAcC is also encouraged by the creation of the Health and Wellbeing Boards which appear to offer possibilities for ensuring that local communities have a direct say in the integrated services which are proposed for them. Through its Regional Group network, it is developing a network of traditional acupuncturists who would be able to offer acupuncture provision on a scale which warrants consideration by commissioners seeking cost effective provision within their area.

11. In conclusion, the BAcC is a model of self-regulatory excellence in the healthcare sector. It believes that the current healthcare reforms, while they target problems of a major and infrastructural nature, nonetheless offer exciting possibilities to extend and improve care.

12. It has long been the aspiration of the BAcC to have its members contributing to a “free at point of delivery” system, and the reforms proposed in the Health and Social Care Bill bring that aspiration a little closer to realisation.

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Memorandum submitted by Dr Penelope Jarrett GP (HS 121)

MY UNDERSTANDING OF THE PROPOSED REFORMS

This huge piece of legislation (288 clauses) changes all parts of the NHS—reforms so big that they will be “visible from space” (according to David Nicholson, NHS Chief Executive). At the same time, there are White Papers proposing major changes to the Public Health Service, and to the training of doctors.

— PCTs and Strategic Health Authorities to be abolished.
— New commissioning consortia of GPs.
— New NHS Commissioning Board; working only on an annual mandate (so not opportunity for long term planning) to commission GPs as providers, and to judge commissioners.
— All hospitals to achieve Foundation Trusts status, with no obligation to observe national pay and conditions, and removal of the cap in private earnings.
— Establishment of Monitor, a new economic and licensing regulator, with a duty to promote competition; and powers to investigate commissioner and providers, and to fine or impose change on them.
— New Health Education England, new “local skills networks” for training.
— New Health and Wellbeing Boards in each Local Authority.
— Replacement of Local Involvement Networks (LINks, themselves only three years old and just getting established) with local HealthWatch, with unclear lines of accountability, and no specification to ensure the bodies are representative of the local population. It is unclear if they can investigate services.
— Hospital procedures will be paid for on a local or a national tariff (as brought in by the Labour Government under so-called “payment by results”—actually a payment for activity).
— There are number of clauses requiring information to be shared or disclosed, including clinical information which could compromise patient confidentiality.
— A greater role for the Care Quality Commission.

The Government is committed to patient choice, any willing provider policies, competitive tendering, and the Secretary of State will have the power to create regulations to ensure that these happen.
THE BILL IS UNNECESSARY

Andrew Lansley and David Cameron have said that the Bill is necessary because outcomes in the NHS are not as good as in some other countries. This is true of the outcome they picked out (death rates after a heart attack are lower in France than in any other European Country), but you can pick out many figures in international comparisons, and easily find others in which the UK performs better than France. In fact, on trends since 1979, the UK rate of death after a heart attack will fall below the French rate by 2012 (Organisation of Economic Co-operation and Development (OECD) reports).

Overall, life expectancy at birth in the UK in 2007 was 79.5 years, similar to most European Countries and slightly above the OECD average of 79.1 years. European countries have health care systems which are called insurance based, but they are all compulsory and to a great extent underwritten by Governments, which makes them effectively funded by taxation. The OECD country which has the most developed market and least socialised system is the United States. It stands out from the other countries in having a below average life expectancy of 78.1 years, and spending over $9,000 per capita to achieve this in 2007 while most other OECD countries spent $2,000-4,000 per capita. The UK spent about $3,000 per capita.

In the years of increased funding there have been significant improvements in health outcomes in the UK. Most clinicians would agree that these improvements have come about due to evidence based policies as promulgated by NICE, some aspects of QOF, waiting time targets, and funding for networks of stroke, cardiac and cancer care which enabled coordinated evidence based pathways to be put in place. All of these are threatened by the bill.

Patients have recognised the difference: according to the British Household Survey, patient satisfaction levels soared from a low of 35% (quite or very satisfied) in 1997 to an all time high of 64% in 2009 (the latest reported survey ). Politicians have commented how the NHS was not an issue during the election campaign of 2010, because people were generally happy (personal communication).

Despite the increased funding put in by the previous government, we still lag behind the OECD average, because expenditure has risen in other countries too.

No-one would argue that the NHS is perfect. However, there are many existing examples of good practice and successful projects, some of which have been touted by the reformers as arguments for the reforms. It must be remembered that these projects have all taken place under the present legislative framework. Passage of the Bill is not necessary.

THE REFORMS WILL BE EXPENSIVE

In the context of the current economic recession, it has already been recognised that health expenditure would be a problem. NHS chief executive David Nicholson’s 2008–09 annual report says the health service should expect to have to make “unprecedented” efficiency savings of £15 billion to £20 billion between 2011 and 2014. He writes: “This is so that we can deal with changing demographics, the implementation of the [NHS next stage review strategic health authority] regional visions and cost pressures in the system.” This has become known as “The Nicholson Challenge”. It means that although the Coalition have promised not to cut NHS spending in real terms, because there will be more older people, and healthcare inflation is more than consumer or retail inflation, £20 billion has to be saved over the next three years, from a budget of about £300 billion.

The DH estimates that the proposed reforms will cost £1.3 billion to implement. Independent academics have estimated it could easily cost as much as £3 billion. This is on top of the £20 billion of the Nicholson Challenge.

The Health Select Committee has recently estimated that the transaction costs of the NHS have gone up from 5% of total NHS expenditure to 14% over the last 20 years in which the internal market has been operating.

There is absolutely no evidence that the changes will save money, and plenty of evidence to the contrary.

THE REFORMS ARE RISKY

The whole process is very risky: changing all the structures at once means that there will be no safety net if one of them fails. Indeed, in the market the expectation is that some consortia and hospitals WILL fail. The presumption is that other consortia or hospitals (or private providers) will take over the failing bodies—or they will close. Where will patient choice be in all this? Or indeed, any patient rights?

There are very many unanswered questions about how the proposed new bodies will be constituted, exactly which body will have which duty, and where lines of accountability will lie. I am speaking of financial accountability, clinical accountability (and clinical governance) and data sharing (confidentiality, IT systems, Caldicott Guardians and data protection). Indeed, it rather looks to staff on the ground as if the people writing the Bill were unaware of the many and complex functions and responsibilities that are carried out in the modern health service, as so many functions seem to be without a home in the proposed structures.

This is going to be difficult for staff and patients alike. When there are problems, and there always are problems in healthcare delivery, it is likely that no-one will be accountable.
The process of GP commissioning carries inherent conflicts of interest, since GPs will be commissioning services which overlap with the services that they themselves provide. For example, a diabetic may be cared for at the GP surgery, or may be referred to hospital. This is even before one considers the problems when GPs set up companies to provide services such as physiotherapy, or minor injuries (which is already happening); or if GPs are rewarded for saving money on prescribing or referral budgets.

The Reforms will be Ineffective.

The proposed changes have not been tested nor piloted. There is some evidence that fundholding in the 1990s allowed GPs to make some savings by lowering the demand for clinical services, but this was at the cost of higher managerial and transaction costs, and a substantial drop in patient satisfaction (Zack Cooper). There is evidence from health economists to show that competition on price reduces quality. This happens in other markets too: we do not generally go to the Poundshop if we want good quality goods. The Government have backed off a little, and said that there would only be two tariffs for hospital procedures (a local and a national tariff). However, it has been estimated that 70% of NHS activity is not covered by the tariff system (Leys), hence would be subject to this drive to minimum quality.

The Government’s vision is “to modernise the NHS so that it is built around patients, led by health professionals and focused on delivering world-class healthcare outcomes”. This sounds fine, but there is no evidence that the proposed changes will achieve this. The BMA commissioned Ipsos MORI to do a survey in January 2011. 1,645 doctors participated in this. A majority thought that enactment of the Bill would lead to increased competition (88%), which will lead to fragmentation of services (89%), reduce the quality of patient care (65%) and will damage NHS values (66%). They also thought that the reforms would increase health inequalities (66%). These concerns, and many others, were also articulated at the BMA Special Representative Meeting on 15th March. Over 400 doctors, representing medical staff throughout the UK, voted for motions criticising every aspect of the Bill, and agreeing to campaign against it.

So, it comes down to whom you believe: Lansley says it will work, the majority of doctors, including myself, say it will not.

March 2011

Memorandum submitted by Michael O’Riordan (HS 122)

Preparedness for Nuclear Emergencies

1. The complex radiological response in Japan to the nuclear accident at Fukushima and the uneven media coverage in the UK should cause the Government to reconsider how best to prepare for the possibility of nuclear emergencies or radiation accidents that might arise in or affect this country.

2. When the radioactive cloud from Chernobyl reached the UK during the Mayday weekend in 1986, the scientific response was anchored by the National Radiological Protection Board (NRPB), a public body at arm’s length from Government. It conducted measurements, assessed the risks, advised Ministers, informed the press, and dealt with questions from many members of the public. In the aftermath of the Chernobyl accident, the NRPB contributed much to the improvement of nuclear emergency schemes throughout Europe.

3. The NRPB had belatedly been created by Parliament in 1970 mainly to remedy the organisational deficiencies revealed by the national response to the Windscale nuclear accident some thirteen years earlier, when responsibility for radiation safety had been divided between the Ministry of Health, the Medical Research Council, and the Atomic Energy Authority.

4. The statutory functions of the NRPB were to conduct research and provide advice to Government Departments and others on the protection of the community from the hazards of ionising and non-ionising radiations including the standards of protection to be achieved in normal and emergency circumstances. It was also empowered to provide and charge for technical services.

5. In scientific and managerial terms, members of NRPB staff were well equipped to deal with radiation protection generally and nuclear emergencies in particular. A succession of strong boards and directors guaranteed the independence and integrity of the organisation and took it to international pre-eminence in its field. In the last year of its existence, the statutory functions of the NRPB cost the exchequer less than £7 million because of the considerable income from commercial services.

6. When the NRPB was abolished by statute in 2005, its functions were transferred to the Health Protection Agency (HPA) in a consolidation of disparate bodies sponsored by the Department of Health. It became a minor component of a much larger entity with some loss of identity and impact. Now the Government proposes to abolish the HPA and transfer its functions to an even bigger body, Public Health England, probably as a Directorate within the Department of Health. Under the terms of the Bill, provision is being made for the devolved administrations also to exercise radiation protection functions.
7. Complicating matters further is likely to be the activation of a Scientific Advisory Group for Emergencies (SAGE) by the Government in the event of a nuclear accident. Such a group, supported by scientists previously in the NRPB, has been advising the Government on the implications of the Fukushima accident for British citizens in Japan. The origins of the SAGE concept can be traced back to the handling of the BSE crisis.

8. The proposed intricate set of arrangements is likely to cause delay and confusion in the urgent wake of a nuclear accident. What is needed is an expert authority dedicated to radiological protection whose members have absorbed and rehearsed the scientific skills needed to deal with such an event. They would be able to assess radiological conditions quickly and confidently and devise the best means of minimising the exposure of workers and the public to radiation and radioactive substances. And in the medium term, they would be able to advise on the best remedial actions in the areas affected by the accident.

9. In short, it would seem prudent to re-examine the relevant proposals in the Bill and reconsider the merits of a discrete and effective organisation modelled on the NRPB.


March 2011

Memorandum submitted by George C A Talbot (HS 123)

SUMMARY
The NHS is essentially socialist and I challenge Government’s claim it needs capitalist autonomy and competition to increase efficiency to meet rising demand. The PM adds he wants the NHS to be the best in Europe. But the NHS is not demand led and performs above average on most measures despite below average funding. It has suffered from historically low funding and ceaseless ideological reorganisations. Recently these have aped capitalism. Thus payment by results is ill suited to professionals and has increased costs to little benefit. And the purchaser-provider split has added over ten billion pounds per year and not been shown to benefit patient care.

Government faces an economic crisis but my informed opinion is it is wrongly blaming previous Labour governments and idealising Conservative ones and has no credible recovery strategy. I regret being unable to trust it. I fear it seeks to apply the same principles that have manifestly failed business globally to the NHS although they are even less appropriate. I reject these reforms that have appeared almost out of the blue. Free market competition is poorly suited to providing a people with efficient health care.

I worry about recurrent emphasis on the need to achieve internal savings of 4%/year during this Parliament. Any established organisation should seek savings year on year but this large amount could prove counterproductive. It appears an emotional reaction to the huge budget deficits needed to sustain the economy rather than a reasoned response to the state and cost of the NHS. I am sure conventional management with the power to discipline could further improve efficiency and urge Government to reintegrate Foundation Trusts into the NHS to restore a fully cooperative service.

If the Coalition wants to make its mark, it should develop reforms to the economic system to assist people to live in harmony with themselves and the planet.

1. During the 1970s, I studied depth psychology to try to understand the roots of mental illness and myself. Soon I was moved to apply this to children in trouble. In the early 80s, I combined my approach with an earlier interest in macroeconomics to criticise the Thatcher government’s economic policies. I feared they would cause troubles similar to those earlier in the century. Since then I have explored the religious and secular values adopted by society. Below I oppose the Health and Social Care Bill because it would replace the rational and cooperative values that formerly sustained the NHS with the primitive self-interest and competition of capitalism.

2. By nature the NHS is an essentially socialist facility. I regret Government ignores the benefits of direct management respectful of subsidiarity to ensure decisions are made at the lowest practical level and of emulation to ensure less efficient units can learn from more efficient others. NHS responsibilities are not just patient care. They include the well being, training and disciplining of staff, and preserving and enhancing its assets. Numberless hard choice must be made in real time and after deliberation to ensure as good care and treatment as possible are offered to those seeking help in England without prejudicing the present or the future. It is very large, has limited resources and unlimited demand. This and the personalities of those who choose to work in it mean it is not like most capitalist businesses or even those running privatised utilities under a regulator.

3. Great harm has been done to the NHS over the years by politicians claiming it can meet the need for treatment. Need is unlimited and this has never been possible. This claim overworks NHS staff and threatens its assets. And it distracts attention from deciding how the available resources can best be used. As the NHS is funded nationally, it must have a strong decentralised management that can make and enforce crucial
decisions from top to bottom. GPs are important but cannot meet patients’ needs simply by commissioning. GP commissioning: insights from medical groups in the United State suggests it is hard to sustain in the US; Nuffield Trust, January 2011.

4. Section 34.6 of ref 1 says:

An independent NHS Commissioning Board will take over responsibility for running the NHS, in accordance with a mandate set by the Secretary of State. The Board will hold consortia to account for the health outcomes they achieve and for their stewardship of NHS funds. In addition, it will itself undertake commissioning of primary care services (including GP services) and some specialised services.

5. Monitor is central to Government’s reforms that liken it to Ofcom and Ofgen despite no longer calling it the Independent Regulator of NHS Foundation Trusts. Although charts show data flowing into it as befits its name, section 6.1 of ref 2 says:

Clause 52 of the Bill stipulates its principal overarching duty: to exercise its functions so as to protect and promote the interests of people who use health care services, by promoting competition where appropriate and through regulation where necessary. Right!

6. These two quotes reveal Government’s faith in competition between autonomous providers managed by Government appointed commissioners from the centre. This mirrors nominally independent capitalist companies run by directors appointed by shareholders. But they usually have decentralised managements!

7. I find this extraordinary given the dire state of the economies of many advanced nations. Since 1980, I have carefully followed macroeconomic policy and know the Coalition is wrong to blame Brown’s pragmatic policy and to idealise those of Thatcher and Major. And I doubt its claim that eliminating the budget deficit will ensure recovery.

8. I fear Government is in denial about the failure of the deregulated global economic system and is applying the same arrangements to the NHS to strengthen its denial. If so, this would explain why it is immune to the severe criticisms its proposals have received. They have little to do with the NHS and much to do with retaining faith in a long cherished ideal that is in deep trouble.

9. A two page report from the Commonwealth Fund ranks health care for seven nations under twelve headings in 2010 and compares their spending on health from 1980 to 2007. It shows the NHS nearly best despite low funding.

10. The most comprehensive comparison of health care I have found is the OECD’s Health Care at a Glance 2009. Its web pages and PowerPoint slides compare the health care in many nations around the world on dozens of measures. These take time to interpret but confirm the Commonwealth Fund’s conclusion: The NHS performs relatively well.

11. Many agree that the purchaser-provider spilt was introduced to allow competition into the NHS. I add despite its socialist nature. Wendy Savage provided a neat summary of its effects in a letter to the Guardian, 20 January. I quote it in full.

(a) Colossal waste in NHS commissioning costs.

(b) We are glad to see the president of the Royal College of Surgeons speaking out against the cuts that are taking place all over the country (Report, 17 January). The health select committee said in March 2010: “Whatever the benefits of the purchaser-provider split, it has led to an increase in transaction costs, notably management and administration costs . . . If reliable figures for the costs of commissioning prove that it is uneconomic and if it does not begin to improve soon, after 20 years of costly failure, the purchaser-provider split may need to be abolished.”

(c) What is needed is an end to the purchaser-provider spilt that underlies the market, following the example of Scotland and Wales, where the NHS has not fallen apart. It is ludicrous to stop surgeons from operating because PCTs want to save money. The marginal cost of surgery is minimal; what costs money is running the hospital, heat, light, and staff salaries. And what costs even more money is the tendering, contracting, marketing etc, which does not benefit patients and could be scrapped, while retaining evidence-based treatments that work and help patients.

(d) The new health select committee says that “more effective commissioning is key to delivery of efficiency gains” and is critical of the “surprise proposal” to abolish PCTs (Report, 18 January). However, it does not follow up on the request to examine the cost of commissioning. DoH officials have said this was 14% of the NHS budget, but this was the cost of administration in 2002, and they are not revealing what it is now. What we do know is that administrative costs in the NHS were 5% of the budget before the 1984 Griffiths reorganisation (which brought in managers not administrators), rose to 10% in the early 90s and are probably 18% now. The cost of the market must be at least £10bn, but no one wants to discuss this colossal waste of money that has not been shown to improve patient care.

(e) Wendy Savage: Co-chair, Keep our NHS Public.
(f) Note well the distinction that Savage draws between the marginal cost of an operation and the price (needed to fully fund the facility providing it). None now supposes free markets create optimally efficient economies. See the cautionary note in Annex 1.

12. In ref 2, the Health Select Committee refers 28 times to the Nicholson Challenge; “also expressed as the need to make £15 to 20 billion in efficiency savings”, Summary. The Committee is clearly worried that Government’s reforms will fragment the NHS yet it accepts the purchaser-provider split. How interesting! Is this another example of the group think an IEO report says prevented the IMF from seeing the Crunch coming?

13. Government quotes statistics showing the NHS unfavourable saying, for example, France has had much lower rates of heart disease. But this is because of how they record deaths and the gap has almost closed. See John Appleby Does poor health justify NHS reform? He qualifies the cancer figures in his final paragraph.

14. I admit NHS figures for cancer are poor. For expert opinions see S. Michael Crawford, BMJ 341. UK cancer survival statistics reflect clinical realities in the NHS, 11 August, hear More or Less, 21 January from 5:45 or for the full report from 0:44, and watch the nine minute interview of Michel Coleman on EJC News Focus, February 2011. I conclude that the low historic funding has limited NHS spending on consultants and drugs. This does not justify major reforms. Note, although GP gatekeepers reduce unnecessary referrals, they delay diagnosis and worsen outcomes.

15. In conclusion, I urge reflection on public services provided by capitalist companies subject to competition and choice and external regulation with socialist ones where structured, thoughtful management preserves local freedoms with respect for subsidiarity and enhances efficiency with cooperative endeavours and emulation.

16. Capitalism fails when the marginal cost of an extra unit is low and costs of the capital required are high. Power generation and telephones are classic examples where at best, competition is managed illegally to avoid destitution or a monopoly. Why have national monopolies been broken up and forced to compete under regulators? This occurred after governments had deregulated the economic system but its full effects had not been felt. As a student of human nature, I know our base nature seeks freedom when it feels secure. But although many feel better when restraints are dismantled, eventually security is lost. The global economy is now in this stage. I urge Government not to take the NHS further down this road as it is poorly suited to capitalism. Rather, it should try to create a more cooperative economic system that would assist persons and peoples to live in harmony with each other and the planet. Perhaps it could usefully try some of its ideas out on public services!


Annex 1

For the Common Good—Herman E. Daly & John B. Cobb; Beacon Press, Boston, 1994

Chapter 2: Misplaced Concreteness: The Market

From Some Market Grammar: The Equi-Marginal Principle of Maximization, page 49

Economists do not spend all of their time celebrating the virtues of the market. Much effort has gone into specifying both the conditions under which markets work as advertised and the conditions that give rise to “market failure.” If we focus on market limitations and failures throughout this book, it is not because we are antimarket. Much to the contrary, we are eager to identify and correct those conditions that lead to market failure as a way of enhancing the market as our basic institution for allocating scarce resources among alternative uses. Three broad categories of problems with the market have been identified by economists:

(i) the tendency for competition to be self-eliminating,

(ii) the corrosiveness of self-interest on the moral context of community that is presupposed by the market, and

(iii) the existence of public goods and externalities.
Of these types of problems, the first two are cases of the market eroding its own requirements, which we treat in *The Market’s Tendency to Erode Its Own Requirements*. The third is considered under *Public Goods and Externalities* below.

March 2011

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Memorandum submitted by Julie Partridge (HS 124)

I am writing to express my concerns over the White Paper—*Liberating the NHS*

I am writing in a private capacity because I have a number of concerns regarding the White Paper, *Liberating the NHS*. I am not an expert but I am a patient and a taxpayer and I believe the changes are going to do irreparable harm to the NHS.

My summary is as below:

1. GPs should be allowed to concentrate on upping their game rather than being employed as financial advisors to the NHS.
2. There is a conflict between the Department for Work and Pensions and The Department of Health where one Department—the Department of Work and Pensions does not trust the other Dept—Dept for Health to make a decision on their patients ability to work, but who are strangely going to be trusted to control the NHS budget.
3. The Public Health White Paper was drafted by the food and alcohol industry—conflict of interest leading back to Andrew Lansley.
4. There are a significant number of conflicts of interest with regards to private companies profiting from the tax payer which ought to trigger amendments and or judicial reviews in the interest of patients and tax payers.
5. Price Competition, cherry picking and the “level playing field” which is fixed in favour of private health companies where it will cost more to treat patient using private health care providers.
6. “You and your GP will decide where you will get treated.”—this is an untruth, it is not possible unless the consortium of which the GP is a compulsory member has a contract with a particular hospital, the patient will not be able to go there from their GP.
7. I am not a consumer; I am either a patient or a taxpayer, sometimes both but not a consumer. If you want to make me a consumer then there has to be an NI opt out clause. Also, changes are not in the interest of the tax payer who happen to fund the NHS.
8. The real government prescription.

1. As a patient I have been alarmed to read some of the facts that have been released by both the Conservative Party and The Liberal Democrats to garner support for these reforms. One of them being that 23% of cancer patients are only diagnosed when they turn up at hospital as emergencies. This means that either patients were not registered with a GP or that a significant number of GPs are failing to diagnosis cancer. My brother has lung cancer and he went to his GP many times with persistent chest infections and a cough that he could not shake off. His GP just kept giving him antibiotics. Finally he was sent for an x-ray which revealed a shadow on his lung. He has been informed that his cancer cannot be cured but he is having radiation and chemotherapy to prolong his life. As he is an ex-smoker, I would have expected red flags to have been set off and the GP to have sent him immediately for an x-ray where there might have been chance of a cure. I feel my brothers GP let him down.

In like manner it was recently announced that one in four patients die from rare cancers because GPs fail to diagnose them in time. The Dept of Health were quick to make assurances that GPs will up their game but quite frankly assurances are not good enough. GPs are not financial advisors, and they should concentrate on providing care so that they can up their game, rather than be forced to take over dismantling the NHS on behalf of the Coalition. The reality is that GPs are neither trained nor skilled in planning and providing health services for the whole population; their duty is to care for the patient. They know this, but have no choice now but to allow their practices to join consortium or find themselves taken over by the private sector. But they also know the new consortium will over time be run by shareholders for profit and in time so will all the services.

2. I would like to know why the NHS is being dismantled by the Department of Health in favour of GP commissioning but the Department for Work and Pension rejects their expert opinion? If the white paper goes through (if that is the right phrase) won’t the Department for Work and Pension be mandated by parliament when Atos Healthcare retests everyone on sickness benefits and apply similar tests to those currently claiming Disability Living Allowance, to accept the view of GPs, consultants or other experts with an in depth knowledge of their patient’s condition? It would seem extremely perverse otherwise—the same health professionals who are not trusted to make a decision on their patients ability to work, are strangely going to be trusted to control the NHS budget.
3. I am concerned at the lack of joined up thinking with regard to the public health white paper. Andrew Lansley announced on 13 March 2011 that the NHS will not be able to meet the demands of people with long-term conditions such as diabetes and asthma unless it changes. He says there will be a 252% increase in the number of people over 65 with one or more such conditions by 2050. Lansley says the NHS must work smarter to keep people out of hospital in the first place which also saves money. He is absolutely right—this should be the way forward, it won't happen though because the planned overhaul of the NHS won’t be transferring power to GPs.

Dr Mark Porter, the chairman of the British Medical Association’s hospital consultants committee has already warned that the reforms means the NHS will be a “tattered safety net” for patients with complex illnesses, such as diabetes and obesity because private healthcare firms will “cherry-pick” patients who are easy to treat”. The Secretary of State is in effect abolishing his duty to provide and secure comprehensive services for the whole population, while the mechanisms which enabled that to happen would also be repealed. The white paper provides for the abolition of the statutory cornerstone of the NHS (and therefore of the NHS itself), namely, the secretary of state’s duty to provide a universal health system. The new consortium would therefore have no duty to provide and secure comprehensive care as they would no longer have responsibility to all patients and residents in a defined area. Instead, local authorities may end up becoming providers of last resort when patients are denied or cannot get care. Therefore Lansley can significantly reduce the forecasted numbers of people living with asthma and diabetes into their sixties, let’s hope he sees this as a negative.

My real concern is with the recent announcement that people who live in deprived areas are 2.5 times more likely to die from cardiovascular disease than in wealthiest counterparts. Dept of Health figures show that adult obesity levels vary, with 15% of the population in wealthier parts of London being obese compared with 30% in Stockton on Tees and Hartlepool in Cleveland. Nation wide, only 50% of us eat enough fruit and vegetables. Yet, the Public Health White Paper was drafted by groups dominated by food and alcohol industry members. Lansley’s decision to “improve” public health through voluntary agreements with the food and alcohol industry is like putting Hitler in charge of our immigration policy. We have the fattest children in Europe, where it has been predicted that this will be the first generation to die before their parents. Soft touch policies with regard to corporate responsibility, means that Lansley has abdicated ministerial responsibility and placed corporate interests above our children’s health and well being. I am constantly surprised that more questions haven’t been raised regarding the link between Lansley being funded by advertising companies that had contracts with companies such as Mars when he was in opposition, and the voluntary agreements that now form public health policy.

4. In my view there are a significant number of conflicts of interest within the white paper.

Andrew Lansley has been forced to give public assurances that GPs would not be allowed to profit from his reforms. The denial followed leaked documents that showed under Lansley’s reforms, GPs could refer patients to private health companies in which they had a financial interest. Documents leaked to the Guardian reveal one private health firm, IHP, in discussion with three GP consortiums actually proposed to GPs that he could set up a company that would turn under spends in their annual budget—in effect, savings on patient spending—into profits. This company, which aims to list on the stock market in three to five years, would treat patients at 95% of the cost of the NHS. This putative saving, amounting to £40 per patient, would be booked as earnings.

American Healthcare providers are lining up to make millions if not billions of money directly at the English taxpayers expense, by again, exploiting the loophole where they can form a Consortia and then send their patients to companies where they have a financial interest. Frank Dobson in a parliamentary session asked Andrew Lansley if the American health corporations, who have been indicted in the United States for defrauding US taxpayers, doctors, patients and, sometimes, all three were to be ruled out of any outfits obtaining contracts to run consortia he said “I can’t say”. Well if he can’t, who can? Or is it more of a case that he won’t say? Andrew Lansley needs to be reminded that it is the tax payer who funds the NHS and not the Conservative Party. To safeguard our interests, an amendment must be added to the white paper that states that any private company, who has been found guilty of fraud within the UK or otherwise, should not be allowed to run GP Consortia.

It is naive to the point of being dangerous to assume that we can rely on Andrew Lansley’s promise alone that GPs or their consortia will not profit from the reforms especially when they make their commissioning decisions in private. Further it is disgraceful that loopholes have been written into a white paper where Lansley considers a one line reference with regards to conflicts of interest to be good enough to protect the interests of the tax payer. Therefore I further propose that the white paper should be amended to state that private companies running a consortium are disqualified from awarding contracts either to their own companies, or other companies that they have a financial interest in. If Consortia are discovered to be turning under spends into profit, or sending patients to their own private health companies, then they should be taxed at 100% and prosecuted for fraud. This is what it is called when the tax payer will be paying for transferring power to GPs.

My real question is though, what questions are being asked regarding, the conflict of interest between Andrew Lansley, outsourcing companies and the White Paper? An outsourcing company that hopes to make millions of tax funded pounds from the shake up of the NHS has been revealed to be secretly providing the
government with apparently independent GPs to help ministers sell their reforms to patients and staff. Internal emails obtained by SpinWatch show that the arrangement was agreed just before Andrew Lansley, launched his bill last month to scrap primary care trusts and hand £80 billion of the NHS budget to private health companies.

Tribal, the outsourcing firm with £150 million worth of government contracts supplied a list of friendly GPs to Bill Morgan, Lansley’s special adviser. Morgan is a former lobbyist for private health companies and Tribal confirms that it was in discussions with some of the GPs on the list about future lucrative contracts.

The Government refuses to disclose Tribal’s list of tame GPs who stand to profit from the reforms. A health department spokesman said: “There is, and will be, absolutely no preferential treatment for the independent sector.” Well if that is true, then there would be no problem releasing the list for public scrutiny would there? This is a time of austerity. Why is £3 billion of tax payer’s money, being wasted on dismantling the NHS, when no one seems to want them with the exception of Private Healthcare Firms, who are the main beneficiaries? I believe a judicial review should be held regarding the influence companies such as Tribal and Care UK had in drawing up the “reforms”, when it is public knowledge that CareUK in particular funded Lansley when in opposition. This would ensure that the public would trust that the reforms are being made for patients, and not business interests alone.

5. David Cameron claimed during Prime Minister Question Time, that the Coalition have strengthened the White Paper, “First of all, we have ruled out price competition in the NHS and also the issued raised by the Liberal Democrats which is, we must avoid cherry-picking by the private sector in the NHS.” This is risible, you cannot rule out price competitions within the any willing provider model, when the right to fair and equal treatment will no longer be for patients but for the benefit of investors, who will use competition policy and trade law to demand a right of entry and a right to ensure that their services can continue to operate profitably. In like manner, you cannot avoid cherry picking of services when there is a free market free for all, or that is “any willing provider”. Even with the Lansley amendment which is not workable, private providers will still be able to “cherry pick”, for example by picking up profitable training contracts. Further, the commercial sector, unlike NHS public services, has market freedoms that the public sector does not—the freedom to levy charges and restrict care, and to downgrade or deregulate staff terms and conditions. The commercial sector’s first duty is to shareholders and risks must be managed either by reducing staff wages and terms, cherry picking profitable patients and treatments, or by ensuring that it is not faced with the enormous costs of unpredictable care.

The NHS will no longer work co-operatively for patients but become a commercial business driven by competition. There is already enough evidence to prove, because of The Labour Party “reforms” where they handed taxpayers’ funds to multinational companies, and remodelled the service along the lines of US healthcare, that there is a proven threat to the equity, value and quality of care by involving profit led companies in providing healthcare under NHS contracts. Independent Sector Treatment Centres cherry picked the less complex patients. Out of hours arrangements have caused unnecessary suffering, even deaths. The quality of work done in private treatment centres with NHS contracts has been criticised by NHS surgeons and has had to be repaired by the NHS. This is not good for the patient, is not a good return on tax payer’s money and gives the lie to the claim that providers will deliver care at NHS standards and within the price the NHS is willing to pay.

Even the so called level playing field with regard to any willing provider, unfairly favours private health companies over the NHS. NHS Hospitals and community services are being forced into competition with private healthcare companies at a time when they are also having to make £20 billion “efficiency savings”, but just to ensure that profits are sufficient to tempt private health companies (as if they needed it) into the market place Lansley advocates that private healthcare providers should receive a 14% premium above the fees paid to NHS providers. This is not a level playing field in any sense of the word; it looks like it might actually break competition rules, and that it would cost more to provide NHS services via private health companies than if NHS Hospitals and community services did so. Hardly a good return for tax payer’s money. The Government’s market strategy is neither supported by evidence nor consistent with the World Health Organisation policy, which rejects unregulated commercialism. It is likely to lead to service fragmentation, increasing inequities within and between populations, and higher costs. These will undermine the ability of the NHS to provide for the whole population.

6. One great deception that is being promoted is saying to patients, “You and your GP will decide where you will get treated.” Or put another way “there will be no decisions about me without me” That is simply not true. Unless the consortium of which the GP is a compulsory member has a contract with a particular hospital, the patient will not be able to go there from their GP. The patient is not at the centre of the reforms because any decisions regarding whether or not to fund treatment, is done in private. Concerns have already been expressed that complex illnesses will not be funded by Consortia because of their profit margin. Any “choice” the patient will have regarding being treated in our new model NHS, will be based on whether or not they have a top up insurance policy. Even then where “care” takes place will depend on the type of top up insurance policy the patient has purchased. This is after all a US model of healthcare. Should the patient have the misfortune not to have top up insurance because (a) they cannot afford one, or (b) they have the foolish belief that they do not need private health insurance because they are an NHS patient in a NHS Consortia, then they will have to go on a waiting list, where there is every possibility they will have never have the care that they have already paid for, via a National Insurance Stamp.
The Government are using family doctors to sweeten the pill by presenting the changes as being GP-led; they tell us that as Primary Care Trusts are abolished they will be replaced by GP consortiums, led and operated by. This is a horrible and grotesque fiction. GP practices already have to compete for commercial contracts; soon these contracts will specify what services they can and can’t provide and determine which patients they can accept. The conflict between shareholders’ demands and patients’ needs will be ever evident to patients and public in day to day practice and services provided.

These reforms are driven by pure market ideology, without a shred of evidence that they will benefit the English population as a whole. On the contrary, all the evidence shows that if you create a US healthcare system the result will be denial of care and exorbitant costs for the taxpayer and the patient as private sector providers hold the Government to ransom. Consortiums are to be granted extraordinary new powers: the power to deny care, to close and erase NHS services and to introduce charges, top up fees and sell private health insurance. The private sector providers too will have extraordinary new rights. The right to fair and equal treatment will no longer be for patients but for the benefit of investors, who will use competition policy and trade law to demand a right of entry and a right to ensure that their services can continue to operate profitably.

7. I am absolutely incensed by the inference throughout the White Paper that I am a consumer. I am neither, I have no choice when it comes to the NHS, tax is deducted at source. I am a patient, a taxpayer, sometimes even both, but not a consumer. If you want to make me one, you have to give people an opt out clause, otherwise if I am not using the NHS, then to use a market based approach then I am paying for someone else’s bills. Therefore as long as I am forced to fund the NHS then I would expect a good return on my investment. The reforms aren’t it. Lansley keeps telling us that under Labour NHS spending rose to European levels but it was so tied up in red tape it was unable to deliver European levels of quality health care. What he is not saying is that the red tape was caused by the market, where the huge investment into the NHS by Labour was diverted not into direct patient care but marketing, billing, invoicing, chief executive-level salaries, profits, shareholders’ returns and bank dividends. Budgetary controls that made the NHS the most cost-efficient health system in the world were dismantled in the rush to market. It will not be any better under “any willing provider”, costs will go up and health inequalities will widen.

In a speech on 14 October 2008, Dr Margaret Chan, WHO Director General, said:

“Some of the greatest waste and inefficiency occurs when health is treated as a commercial commodity, to be bought and sold, assuming that market forces will somehow self-adjust to iron out any problems. This seldom happens. What you see instead is unnecessary tests and procedures, more and longer hospital stays, higher costs, and the exclusion of people who cannot pay.”

There is no systematic scientific evidence that market competition, even if achievable, will reduce costs while retaining quality and universal access; it is axiomatic in health economics that a perfectly competitive health care market is unattainable and that therefore market competition cannot be relied on to lead to cost efficiency. Scientific evaluation of the impact of competition on solidarity (cost-sharing across a whole population) is very poor, and therefore the risks for universality are unwarranted.

We are assured that the reforms are going to save £5 billion but The Health Service Journal calculates that the new model could cost £1.2 billion more than the current one. York University has estimated that the internal market has increased admin and management costs from a pre market NHS of 6% to 14% of the NHS budget—and yet incredibly the Coalition are proposing in a time of austerity to extend this market.

On top of this it has been estimated that the process of restructuring alone will cost between £2–£3 billion, so what is the rationale behind the reforms and where are the savings that are supposed to found by these reforms?

If Labour’s market based approach with regards to health did not significantly improve outcomes or decrease health inequalities what makes Andrew Lansley think that his reforms will fare any better? If you create a US healthcare system that is what you will get and the result will be denial of care and exorbitant costs for the tax payer as private sector providers hold the government to ransom. As a tax payer, this doesn’t sound like an awfully good return for my investment. The reforms aren’t it. Lansley keeps telling us that under Labour NHS spending rose to European levels but it was so tied up in red tape it was unable to deliver European levels of quality health care. What he is not saying is that the red tape was caused by the market, where the huge investment into the NHS by Labour was diverted not into direct patient care but marketing, billing, invoicing, chief executive-level salaries, profits, shareholders’ returns and bank dividends. Budgetary controls that made the NHS the most cost-efficient health system in the world were dismantled in the rush to market. It will not be any better under “any willing provider”, costs will go up and health inequalities will widen.

If Labour’s market based approach with regards to health did not significantly improve outcomes or decrease health inequalities what makes Andrew Lansley think that his reforms will fare any better? If you create a US healthcare system that is what you will get and the result will be denial of care and exorbitant costs for the tax payer as private sector providers hold the government to ransom. As a tax payer, this doesn’t sound like an awfully good return for my investment. David Cameron says change is not an option, well actually David it is when I am paying for it and private companies will profit from my money, at no benefit to me what so ever.

I am fundamentally against these reforms because there is no benefit to the patient, or the tax payer what so ever. In fact it is the worse of both worlds where tax payers are funding private providers to make an obscene amount of profit out of us, when we already know that it will lead to poorer quality health outcomes and further health inequalities. It is pure market ideology and without a shred of evidence. On the contrary, all the evidence shows that if you create a US healthcare system that is what you will get and the result will be denial of care and exorbitant costs for the tax payer and the patient as private sector providers hold the government to ransom. For the first time in the history of the NHS we are seeing the emergence of commercial corporations’ influence over GP services where, as in the US, primary care providers will be orientated towards business interests.

9. The Governments real NHS prescription is:

More waste—£5 billion drained from patient care.
More waiting—Cuts and closure as competition bites.
Less Care—clinical decisions undermined by business motives.
Less Fair—paying patients jump queue for NHS services.

March 2011

Memorandum submitted by Wendy Barker (HS 125)

1. ABOUT ME

I am Wendy Barker. In February 2008 I was diagnosed with ovarian cancer. I wish to share with you my experience of being diagnosed with what is the fourth most common cause of cancer death in women. There are nearly 7,000 women diagnosed like me each year in the UK, and I’m very sad to say 4,400 deaths, primarily because women are diagnosed too late.

2. I was showing all the classic signs of the illness for at least a year prior to diagnosis. I felt tired all the time, had bloated stomach, and lower abdominal and back pains. I kept attending my GP telling him that I felt unwell but wasn’t getting any better my GP conducted lots of blood tests but still couldn’t find anything wrong. Towards the end of November 2007 I felt so bad I knew I would have to go back to see the GP again yet dreaded attending as they hadn’t been very sympathetic, making it feel as though they thought I was imagining my illness. I was due a smear test in December 2007 so decided to wait for the results of that test first to rule it out. On 8 February 2008 I finally decided the pain was so bad that I needed to return to my GP I felt around my belly so that I could tell the doctor exactly were the pain was and found a lump in my lower abdomen I made an appointment that same day and by the 27 March was in hospital having a total hysterectomy. I would like the Bill Committee to consider my evidence and fears that whilst the Bill commits to saving lives from cancer, the proposed structure of the Bill is such that for people like me, being diagnosed and living with a cancer other than breast, lung or bowel, there is a very real danger that survival rates, which for ovarian cancer are already woefully low, will worsen. For me, it took all my determination and effort, over the course of a year, to get an accurate diagnosis. I was very lucky in that the cancer was detected when it was still at an early stage, but my experience in relation to my GP leaves me to question whether they are indeed the correct people to be making detailed decisions about my care. It is those who are experts in their field who should be making decisions, along with the patients—people like me, about what is in my best interest.

3. I recently attended a meeting of the All Party Parliamentary Group on Ovarian Cancer, and subsequently have been in correspondence with my own MP. From this interaction, I am deeply concerned that MPs, somewhat like the GPs are in the dark when it comes to the realities of what this Bill will mean for people like me, being diagnosed and living with a cancer other than breast, lung or bowel, there is a very real danger that survival rates, which for ovarian cancer are already woefully low, will worsen. For me, it took all my determination and effort, over the course of a year, to get an accurate diagnosis. I was very lucky in that the cancer was detected when it was still at an early stage, but my experience in relation to my GP leaves me to question whether they are indeed the correct people to be making detailed decisions about my care. It is those who are experts in their field who should be making decisions, along with the patients—people like me, about what is in my best interest.

4. MORE DETAIL—ABOUT MY DIAGNOSIS

I was one of the lucky women in that it was the lowest categorised ovarian cancers, which was treatable by operation alone. My symptoms had been ongoing for a year; imagine my relief that it wasn’t one of the more aggressive types. Had I known in advance of the symptoms associated with ovarian cancer I could have requested a blood test CA125 and had an internal scan to diagnose my cancer earlier. I do appreciate that ovarian cancer can be a challenging disease to diagnose, and that for a GP it must be difficult to pick out those women like me, who do have something seriously wrong. But this is precisely why I have concerns over the power, and budgets being given to GPs in the Bill, without the need to consult with experts, who know full well, what best practice should look like.

5. OVARIAN CANCER IS BEING OVERLOOKED

Ovarian cancer, I am told is one of the “less common cancers”, though given it is the fourth most common cause of cancer death in women, I find it very hard to understand why it does not appear to be more of a priority, especially given the fact that so many women are diagnosed once the disease has already spread, and experienced considerable delays. I look at the evidence that is now available, from charities, from international studies and comparisons, and from the Department of Health work itself, and it upsets me to think that despite this wealth of robust evidence, still no action is being taken. I urge the Bill Committee to consider the following steps which would ensure that attention is given appropriately to where progress can be made:

(a) Only outcome measures for breast, lung and bowel cancer have been included, but I would like to see ovarian cancer similarly tracked and monitored, or cancer as a whole. That way much more attention will be paid at a local and national level to the things that can be done to improve awareness and access to diagnostic tests. I was bitterly disappointed to see that despite the
evidence, ovarian cancer was not included in the recent investment in awareness raising. There is progress waiting to be made, and that is what concerns me, that those opportunities will not be taken up and in the meantime, more women will die.

(b) That specialist expertise must be involved in the decision making around commissioning. GPs cannot be expected to know what is best for ovarian cancer, and the thousands of other diseases they see. Ideally I would like to see a national standard, that they have to follow.

6. I do welcome the new increased access to diagnostic tests for GPs, but unless women and GPs know to consider ovarian cancer as a possibility, then it will not impact significantly on improving early diagnosis. My own experience was that it took all of my determination over the period of nearly a year, to get a correct diagnosis. I also welcome the news about the Cancer Drugs Fund, but once again, given there have been no new life extending treatments in over a generation for ovarian cancer, it will in the short term remain largely irrelevant to women like me.

7. My personal fear is that progress that has begun to be made recently for women with ovarian cancer, will go backwards, given the focus on breast, lung and bowel cancers. I know this is not the intention, but I want you to be aware of the real risk of this happening. I would like to see ovarian cancer included in the awareness initiatives as a matter of urgency, so that women like me in your constituency have a chance to be diagnosed and treated as quickly as possible. It seems as though we are being told we do not matter, and have to wait, because the government is choosing not to act now on the data of which it is fully aware.

March 2011

APPENDIX 1

RESPONSE TO MY MP

I would like to thank you for your letter dated 7 February 2011, and the effort that you took to explain how you feel the Government is aiming to save many more lives of those affected by cancer. Indeed I applaud the steps that you outline, and similarly hope that the lives of many more patients particularly those with breast, lung and bowel cancer can be saved.

However 60% of cancer deaths are from cancers other than breast, lung and bowel cancer. Women such as myself who have ovarian cancer are, it appears, being left out of any such initiatives and this is despite a wealth of compelling evidence for action:

— Ovarian cancer is the fourth most common cause of cancer death amongst women, after breast, lung and bowel.

— Survival rates for ovarian cancer are, and remain low. Five year survival is 36% in contrast to 80% for breast cancer, and one and five year survival rates are amongst the lowest in Europe, indicating a significant problem with early diagnosis as shown in the recent release from the International Cancer Benchmarking Partnership Study. It is known that the lives of at least 400 women are being lost unnecessarily to ovarian cancer each year in the UK, representing the difference between the UK’s and the average European survival rate.

— Awareness of the symptoms of ovarian cancer has been shown to be woefully low. Just 4% are very confident at recognising a symptom (Target Ovarian Cancer Pathfinder Study using the Ovarian Cancer Awareness Measure (a validated tool). This contrasts widely with breast cancer.

— The recent National Cancer Intelligence Network Report on routes to diagnosis showed that only a quarter of ovarian cancer diagnoses were through the urgent two week referral, and some 29% were as a result of emergency presentations at accident and emergency units.

Memorandum submitted by the Urology Trade Association (HS 126)

EXECUTIVE SUMMARY

— Given the impact which urology products have on a patient’s clinical health, wellbeing and ability to lead socially independent lives, it is vital that patients who require ongoing continence management can access the most appropriate choice of clinically effective urology products that suit their individual needs.

— National policy arrangements such as Part IX of the Drug Tariff provide essential protection on choice for patients, ensuring that patients can access a full range of clinically effective products on NHS prescription, while also ensuring that the NHS is guaranteed a fair price; these supply arrangements should be maintained once the new commissioning arrangements are in place.

— Steps should be taken to ensure that all those who are to be involved in commissioning decisions are aware of the principles of these national supply arrangements and the protections they provide for patients. The UTA believes there is a role for the NHS Commissioning Board to ensure that these principles are upheld by GP commissioning consortia.
INTRODUCTION

1. The Urology Trade Association (UTA) is the leading urology membership organisation representing 95% of urology product manufacturers and suppliers, who supply the urology appliance market. Due to the nature of their business, UTA member companies deal extensively with PCT commissioners, as well as NHS procurement agencies. Through this experience and work, the UTA has, as a trade association, become increasingly concerned about the use of initiatives by a number of PCTs and Collaborative Commercial Hubs which restrict patient and prescriber choice in access to and the selection of stoma and urology appliances.

2. The UTA believes that the Government’s proposals to reform commissioning could potentially address some of these issues. However, there is still considerable uncertainty about how the revised system will work, and it is possible that the existing problems could be exacerbated under the new arrangements.

3. This submission aims to highlight the UTA’s key concerns that need to be addressed and to make recommendations as to how the new system can ensure adequate and equitable access to urology products for patients.

BACKGROUND—PART IX OF THE DRUG TARIFF

4. There are an estimated half a million people across the UK who rely on a daily basis on prescribed urology products to maintain their quality of life and independence, manage underlying clinical conditions and prevent repeated medical consultations.

5. The supply of urology products and medical devices is determined by The new arrangements under Part IX of the Drug Tariff for the provision of stoma and urology appliances—and related services—in primary care. These regulations were published by the Department of Health in 2009 following an extensive review and over three years of consultation with industry, patients and health bodies, developing Regulations that keep the interests of patients at heart, ensuring that they can choose products and services that are right for them.

6. The Part IX Regulations list the stoma and urology products that are approved as clinically effective and value for money by the Secretary of State for Health and should be made available to people through the NHS. It is also a tariff and lists the price that the NHS should be charged for each product. Products are assessed for safety, quality of clinical health outcomes and value for money.

7. The Review into Part IX of the Drug Tariff concluded that functional equivalent products should not be recommended to patients in place of a particular preferred device. The review thus concluded that the Drug Tariff is the preferred mechanism to improve patient care, maintain local choice, and provide services and products at a fair and balanced cost to the NHS and industry. The new Regulations also stipulate that patients are entitled to ask for any product listed on Part IX of the Drug Tariff on prescription.

8. An important safeguard of these arrangements for patients is that they prohibit a postcode lottery for stoma and urology appliances. All prescribing clinicians should be able to choose any clinically appropriate product that is listed on the Drug Tariff. This is essential protection for patients given the invasive nature of urology products and the particular self care, mobility and dexterity needs that very often accompany conditions that require continence management. Inappropriate product use in primary care settings, however minor product differences may appear to non-clinicians, can cause serious discomfort and increased exposure to infections and can impede a patient’s ability to live a relatively independent life.

9. The Drug Tariff is also an aid for commissioners since it provides a comprehensive list of products that have already been assessed and approved as clinically effective and cost effective at a national level. The Drug Tariff sets a pre-defined price for each listed product which is set at a balanced and fair price to both the NHS and industry. These prices and any mechanism to alter the price in line with inflation, for example, were agreed as part of the review into Part IX.

10. Most importantly, by setting a pre-defined price, the Drug Tariff safeguards against industry exploiting different commissioning and procurement procedures across the country to drive up prices and profits. The Drug Tariff is a useful tool for commissioners and policy makers to streamline procurement within NHS bodies and ensure price transparency.

PATIENT CHOICE AND THE DRUG TARIFF

11. In September 2010, the Royal College of Physicians published a National Audit of Continence Care, which examined the quality of continence services in England, Wales and Northern Ireland. The report identified a number of significant weaknesses in the care and choices offered to patients with continence needs. Among the criticisms was that there was unacceptable variation in the choice of type, quality and quantity of continence supplies made available to patients.

12. With the reforms outlined in the NHS White Paper, and as PCTs are replaced with GP commissioning consortia and a National Commissioning Board, there will be even greater scope for local variation in provision. It is argued that this will enable GP consortia to respond more effectively to the needs of local populations but it also risks development of postcode lotteries and variation of care across the country.
13. The UTA is aware of an increasing number of PCTs and PCT Hubs that are seeking to supply and prescribe urology devices through alternative local arrangements that bypass the provisions set out by national policy through Part IX of the Drug Tariff. These local arrangements often only prescribe and supply from a restricted list of urology products, severely reducing patient choice.

14. This is reinforced by the introduction of formularies which provide clinicians with a restricted list of products that can be supplied to patients on NHS prescription. In many cases formularies do not make clear that all products on the Drug Tariff should be available to patients, and the bureaucracy involved for clinicians to prescribe off-formulary products is extremely prohibitive. Even when this caveat is in place, it still relies exponentially on patients being fully informed about their rights and the principles of national policy and additionally on determined clinicians to navigate through knowingly complex administrative processes.

15. The UTA is additionally concerned by the selection criteria that are used to identify which products are placed on Formulary. Arrangements also need to ensure that incentives are aligned with a focus on prevention to ensure that patients can choose products and services that reduce the incidence of infection, re-admissions and additional care needs. Where formularies operate, patients are often required to trial first line products before access to an off-formulary product is made available. Due to the invasive nature of many continence products, any difficulties experienced can result in the need for emergency hospital treatment or even the need for surgery to treat avoidable infections or replace unsuitable products. Less than optimal prescription can cause significant clinical repercussion as well as cost implications.

16. These local developments are contradictory to national policy as laid out in The New Part IX arrangements which stipulate that patients can demand on NHS prescription any urology product and appliance that has been approved at a national level. In practical terms, rather than enabling patients and clinicians, formularies limit the choice that patients and prescribers have when managing clinical conditions. The very principle of the Drug Tariff is to provide prescribers and commissioners with a list of approved products that have been evaluated on the basis of robust clinical evidence, patient safety and value for money. By giving GPs freedom to prescribe within these nationally set parameters, the Government can ensure that GP consortia and prescribers uphold the ideals of patient choice and equality while exercising their professional clinical judgement.

**Role of the NHS Commissioning Board**

18. With the reforms proposed by the Health Bill, it will be imperative to ensure that commissioning consortia abide by relevant national policies. As noted above, a number of PCTs are seeking to implement restrictive prescription and supply mechanisms at a local level that restrict patient choice and access to products. The National Audit of Continence has also found unacceptable levels of variation between PCTs.

19. It is hoped that the transfer of functions over to GP commissioning consortia and a greater ability to control services at the local level will drive forward improvement in these areas of care. However, with the already fractured nature of continence care, there is a risk that this will fragment even further, especially if GP consortia maintain the restrictive formulary policies that are already in place.

20. It will be essential that clinicians are fully aware of the principles of public policy about choice and access to products. Robust monitoring arrangements will need to be put in place by the Department of Health, the NHS Commissioning Board and/or Healthwatch to prevent further variation and ensure that national policies operate as intended.

21. The UTA has noted with interest that the NHS Commissioning Board will safeguard the core values of the NHS to ensure a fair and comprehensive system across the country, to promote the NHS constitution, and to champion the interests of patients. We understand that, as part of this, the Board will provide a national framework for local commissioning. The UTA believes that, properly enforced, the national Drug Tariff ensures that patients have access to the full range of approved products, while ensuring consistency, quality and value for money for the NHS, and prevents a postcode lottery in the availability of products and services. The Drug Tariff can therefore be a useful tool for commissioners to ensure these principles are upheld.

22. There is a role for the NHS Commissioning Board to ensure that patients who experience difficulties in accessing the right products and services can notify the national authorities of a failure to abide by national policy. We are interested in further detail about what steps the NHS Commissioning Board will be able to take in order to promote patient choice and enforce national policy principles, such as The new arrangements under Part IX of the Drug Tariff for the provision of stoma and urology appliances—and related services—in primary care.
23. The UTA would also welcome further details about the new provisions contained in Clause 43 of the Bill on pharmaceutical services expenditure. In particular, the UTA is seeking clarification about how remuneration and reimbursement will be dealt with by the NHS Commissioning Board. Further clarity is needed on whether the clause intends to provide for the re-introduction of the Global Sum with remuneration held centrally by the NHS Commissioning Board but reimbursement devolved to GP consortia.

SPECIALIST COMMISSIONING

24. Among the conclusions of The National Audit of Continence Care, published by the Royal College of Physicians in September 2010, it was found that there was often no designated lead for continence services in each PCT. This was identified as a principal cause of some of the weaknesses in continence commissioning and the unacceptable variation in care across the UK.

25. As GPs do not have specialist urology training, there is a need to ensure that patients can access specialist urology services and that the right care pathways are put in place to ensure early referral. An important part of this process is to ensure that patients can access the most appropriate product to match clinical and wellbeing needs at the earliest consultation stage.

26. It will be essential for GP commissioners to ensure that relevantly skilled staff are available to meet the needs of their population and involved in the commissioning process for their specialist clinical area. Where this is not possible, the GP consortium should be encouraged to bring in specialist advice or consultation. This specialist advice could come from other GP consortia, from clinical specialists, from user groups and representatives or from the independent sector. The knowledge of the independent sector, which in urology also provides services to patients through the opportunity to have Appliance Use Reviews, should not be disregarded and could be called on to provide training and advice on specific products where appropriate.

27. The UTA believes that there is also a role for the NHS Commissioning Board to ensure that GP consortia receive training on commissioning specialist products and services and that prescribing clinicians also receive suitable training and support. This could help to tackle the current problem that often prescribers do not know enough about the full range of products that are available off-formulary to make informed choices for their patients. There is a wealth of experience in the private and third sectors which could help inform this training.

CONCLUSION

28. The UTA recognises that the proposals laid out in the Health Bill offer an excellent opportunity to address some long standing issues within the NHS and we hope that these can be addressed. We are, however, concerned that the reforms should not operate at the local level so as to restrict access to the full range of products that should be available nationally. Mechanisms that already exist to guard against this occurring, such as the Drug Tariff, should be maintained, as these national arrangements provide essential protection to patients and the NHS. With reforms ongoing, the Department of Health should take a lead in guiding GP consortia to follow the principles of national policy.

March 2011

Memorandum submitted by Save the NHS Now (Ealing) (HS 127)

1. ORGANISATION

— The Secretary of State for Health will cease to be responsible for the operation of the NHS and devolve all responsibility to the NHS Commissioning Board. Yet the NHS is of supreme national importance. It is publicly funded. Health policy and priorities are of huge national concern. The Government minister for Health must remain responsible and accountable to the nation.

— As far as we are aware the NHS Commissioning Board will have no patient or clinical representation and its proceedings will take place in private. This must be rectified. It should have patient and clinical representation and its proceedings be open to the public.

— We are very concerned about Monitor’s role of enforcing commercial competition. Its prime duty must be to maintain and extend a co-operative healthcare system in the UK.

— Regional planning will be deleted by removing the strategic Health Authority. This could lead to a “post code lottery” in patient care, workforce availability and it poses a threat to UK wide medical training. Something must be put in place to rectify this problem.

— GP Consortia. We are very concerned that the Bill states these will meet in private, with press and public excluded and no requirement to publish board papers. Only one public meeting per year is required. There should be places for elected members of the public, hospital and mental health clinicians. All meetings should be in public and minutes published.

— This Consortia structure unless amended makes the promise of patient involvement a lie.
— We, like the RCGP are concerned that there is an ethical conflict between GPs being required to economically manage a diminishing budget in the Consortia and doing their best for their patients. This needs to be addressed. A commitment in the bill is needed that GPs will still be able to provide the treatment for patients they feel most appropriate.

— The likely reality will be that the GPs will only have token involvement in the Consortia. They have neither the time nor the training. They will hand the commissioning job to private consultants or others leading to higher administration costs than the PCT system, not less.

2. Any Willing Provider. It seems there has been a “back track” on this and it could be possible in some cases that the Consortia can designate “a prime provider”. This needs to be firmed up. Similarly regarding the assurance stated by Sir David Nicholson that there’s “no question” of introducing competition on price, we remain unconvinced. The market approach that colours this Bill will privatisate, destabilise and fragment NHS services destroying the co-operative and unified service we now enjoy.

— We would want the NHS to be the preferred provider of services

— We agree with the RCGP that the phrase should be changed to “enough excellent providers” and the ability given to Consortia to make the decisions needed for local communities.

3. Foundation Trusts. We are very concerned that this status will be forced on hospitals. The limits on money FTs can earn from private medicine are to be scrapped leading to a likely increase in this sector due to diminishing budgets. Not good for NHS patients! It is still likely simpler services will be “cherry picked” by the private sector leaving FTs with the difficult work. If they cannot balance books they may well fail. It has also been stated FTs will be removed from the NHS/Treasury balance sheet and made independent social enterprises putting NHS terms, pay and staff conditions in doubt for health workers.

4. We remain concerned about many other issues such as:

— Treatments already being excluded from the NHS as spending cuts are sought.

— Responsibility for public health currently shouldered by PCTs to be passed to local Councils at a time when they are reeling from massive budget cuts.

— We understand the PCTs have 100+ other important functions than patient care commissioning and we have no clear idea to where these responsibilities will move.

There is probably much more in the 367 page document we are not yet aware of.

We hope you will consider these points and also see attached information from Medical Practitioners.

We would also point out that apart from private sector providers and management consultancies this bill has received virtually nothing but criticism from any think-tank, medical or academic professional body.

March 2011

Memorandum submitted by The Bed Bug Foundation (HS 128)

1. We write with reference to the Health and Social Care Bill that is currently being discussed. Following your request for relevant experience and expertise, we feel that we could positively contribute to developments and as such would like to be included as a representative for public health pests, specifically with the increasing populations of Bed Bugs.

2. The Bed Bug Foundation was set up during the second half of 2010 in response to the increasing levels of infestations seen across the United Kingdom and the lack of understanding and comprehension from members of the public. The Foundation received charity status towards the end of 2010 as an independent provider of education and awareness documents for the management of Bed Bugs to the general public and both the accommodation and pest management industry.

3. This is a global issues and the recent media interest in America, especially New York has demonstrated the need from all responsible parties, to understand how this pest has affected various nations. Australia had a reported 4,500% increase in Bed Bug infestations between 1999 and 2006. The total cost of these infestations is estimated at around AU$ 100,000,000.00

4. Studies completed in London between 2002 and 2007 found a 26% year on year increase for Bed Bug related matters. We are currently embarking to update these statistics; however we know that these figures will have dramatically increased. Initial predications on cost are anecdotal, but it will certainly be hundreds of thousands of pounds, potentially millions.

5. In the past, articles have largely focused on the direct health impact both from the bite and the potential of Bed Bugs to spread infectious diseases, which we know is (currently) nil. However, the indirect impact of Bed Bugs, both in terms of the mental health and also the environmental impact through the unwarranted use and overuse of insecticides, has not been explored.
6. The Foundation has an increasing number of comments from those who have been suffering with long- 
term Bed Bug infestations. Unfortunately these infestations have been inadequately treated over the past 
few month or even years, many “professionals” mis-identifying the infestations as Varied Carpet Beetle 
(*Anthrenus verbasci*) or even juvenile cockroaches (*oriental* or *germanica*).

7. This is not just causing added frustration to those individuals who have the infestations, the amount 
of time we have heard “they returned after eight to 10 weeks” is frightening and the cost of destroyed 
furniture must far outweigh the actual cost of effective treatments.

8. Stress, in relation to pest infestations, was recognised by the World Health Organisation (WHO) in 
2008 as a significant detrimental effect on human health. While that report was not directly associated with 
Bed Bugs, sleep deprived stress as a result from Bed Bugs is increasing and this is leading to anxiety, 
depression and long-term psychological mental health impact.

9. The unknown cost (at this time) is potentially far more serious. For example the Foundation has one 
report where an individual is receiving long-term social support, through NHS carers, and has depression. 
In a further two cases people have actually lost their jobs, through sleep deprivation, leading to lack of 
performance.

10. One was caught asleep at work as they felt this was the safest place to sleep. They are all currently 
receiving social care support and most of this could have been avoided if their GPs had recognised the 
situations and if adequate treatments had been carried out.

11. If you can’t consider these points as related to Bed Bugs—would you sleep in a bed that you knew 
contained insects that could suck on your blood while you slept? This is not the same as mosquitoes, it is 
not uncommon to have over 50 Bed Bugs in a small infestation and this is a significant loss of blood, let 
alone sleep.

12. Unable to leave this situation, the only course of action (for those we spoke with) was to find 
alternative ways to sleep—including on a plastic chair for one individual. He is now also claiming long-term 
sick as he is unable to work.

13. The Foundation is also starting to collect information on the environmental impact through the 
unwarranted or overuse of insecticides. Cases where properties have been sprayed, with a biocide, three 
times in a week are not uncommon and this could have an impact on their longer-term use.

14. The net result of this is that these individuals are taking matters into their own hands and applying 
a variety of concoctions (around their bed) to aid control, which cannot be beneficial for their health and 
of course could contribute to resistance with the Bed Bugs themselves, compounding the issues.

15. The Foundation has been asked to contribute to two workshops with the Royal Environmental 
Health Institute of Scotland and this is a very positive step. REHIS is putting its actions where its mouth is 
and making people aware of this problem, providing information to those who may be at risk and local 
authorities are enforcing landlords and sources of infestations, to clean up their properties. They have the 
support of the Scottish Parliament and this needs to be reflected for England and Wales.

16. It is very important that if we want to eradicate Bed Bugs, we have support from legislation and 
possibly enforcement officers. It is the primary route by which long-term control will be gained (as it was 
in the 1930’s) and also where qualifications and competence from the pest management industry could be 
implemented. Bed Bugs are not the same as other pests whereby if enough pesticide is applied then control 
will be gained, if anything it is the complete reverse.

17. The Foundation has three primary aims: Awareness, Communication and Education.

(a) Raise Awareness.
   — Improve social and professional understanding of this exposure pest.
   — Necessity to prevent and monitor potential activity.
   — Provide information on biology, lifecycle, etc.

(b) Increase communications.
   — Press releases
   — Interactive videos, news feeds and technical updates.
   — Mobile applications/podcasts.
   — Web Seminar sessions.

(c) Deliver education.
   — Integrated Pest Management.
   — Code of Practice.
   — Online/blended/Practical learning——Pest Management Professionals (PMPs).
   — Continued Professional Development (CPD).
18. The first draft for the European Code of Practice (ECoP) for the Management of Bed Bugs was released during March 2011 by the Bed Bug Foundation. The ECoP will cover the most effective measures currently known, which may be employed to:

- Control active infestations.
- Minimise the spread of active infestations.
- Minimise the risk of future infestations.
- Protect vulnerable parties who provide or purchase Bed Bug services or use Bed Bug products.
- Provide a reference document on which other, more focused, procedures can be based.

19. **Foundation Structure**

Day to day operation are delivered through Oliver Madge, as Chief Operating Officer. Oliver has been involved with the Pest Management industry for over 20 years, his most recent posting being as CEO of the British Pest Control Association, which included Executive Board member of the European Pest Management Association (CEPA).

20. The board of trustees guide the general direction of the Foundation and ensure that it operates within the boundaries of the charity commission and holds a balanced and considerate independent point of view.

21. The Senate working party is constructed of acknowledged research fellows, often connected with universities, who specialise in greater understanding of Bed Bugs. This group is headed up by Dr Stephen Dogged, Department of Medical Entomology at Westmead Hospital, NSW, Australia.

22. We trust this is all the information currently required and we thank you for your time in considering this representative request.

*March 2011*

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**Memorandum submitted by Monitor (HS 129)**

1. **INTRODUCTION**

1.1 This written memorandum addresses points raised by the Committee in Monitor’s oral evidence session that we wish to respond to in greater detail in order to assist the Committee in its consideration of the Health and Social Care Bill. It does not address all of the elements of Monitor’s proposed new role.

1.2 Monitor welcomes the Health and Social Care Bill. We support the Government’s plans to continue the reforms to the NHS and as part of these to make Monitor the economic regulator for health and adult social care. We believe it is valuable to have a sector regulator which is independent of direct political influence, accountable to parliament, can build specialist skills and ensures that there is transparency over its actions.

1.3 Monitor does not support competition for its own sake. We consider that competition is a means to an end and that end is to improve care for patients and value for money for taxpayers. There is a growing body of evidence to show that competition under fixed prices can drive improvements in health sector quality and productivity. In Monitor’s view, choice and the implied competition that goes with it should also be key components of creating a patient-centred and patient-led NHS. Competition between providers alongside patient choice can drive up quality, innovation and patient outcomes while reducing costs, simply, for example, because better quality hospitals attract more patients, forcing those which underperform to improve. This is especially important in the context of NHS productivity having fallen every year for the past decade.

1.4 The Health and Social Care Bill is very clear that Monitor’s primary role will be to protect and promote the interests of service users, either by promoting competition where appropriate or regulating where necessary. It will be this principle that guides our approach as a regulator.

1.5 Monitor also welcomes the intention outlined in the Bill that all NHS Trusts will become foundation trusts and that they will be given more freedoms. We believe that the process of achieving foundation trust status improves the quality of governance and financial management at a trust, to the benefit of patients and tax payers. We also believe that operational decisions are better made locally—close to the patient and by the people who actually deliver the services—rather than in Whitehall. We will continue to set high standards which trusts will need to meet in order to achieve foundation trust status.

1.6 Monitor is delighted that, on many aspects of the proposals, the Government has listened to our earlier concerns and has addressed these.

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Monitor

2. Accountability

2.1 Monitor’s accountability is clearly set out in the Bill in schedule 7. It outlines that:

2.2 Monitor is and will remain an independent non-departmental public body. What we can and cannot do will be set out by Parliament in legislation.

2.3 We will continue to be accountable to Parliament and subject to parliamentary scrutiny: as Accounting Officer, Monitor’s Chief Executive can be called to account in Parliament for the stewardship of the resources within the organisation’s control; Select Committees can call us in and hold us to account; we will still be required to account to central Government for our use of resources, to lay our annual accounts and annual report before Parliament; and MPs and Peers can table questions about us.

2.4 The Secretary of State will appoint (and can remove) the Chair and non-executive members of Monitor’s Board.

2.5 Monitor will be under a specific duty to ensure that its regulatory activities are transparent, proportionate, consistent, targeted only at cases where action is needed and not in conflict with our remaining role over foundation trusts.

2.6 We will also be accountable to those we will regulate, who will be able to appeal, for example, to the Competition Commission or to go to the courts if they feel that we are not operating fairly.

Foundation Trusts

3. The Foundation Trust Pipeline (Part 4 of the Bill)

3.1 In Monitor’s view, it is helpful to have the deadline for all trusts to become foundation trusts set in legislation, as it sends a signal to the system that an all foundation trust sector is definitely the goal. The requirement for becoming a foundation trust is that the organisation must be able to demonstrate that it is financially robust and that it has strong governance. All providers of NHS care should be able to meet these tests.

3.2 There are currently 136 foundation trusts (as at 1 March 2011). There are c. 97 NHS trusts, ambulance trusts and community trusts still to become foundation trusts.

3.3 The Government is finalising its plans for the remaining trusts to come through the pipeline and has established a Provider Development Agency (PDA) to support NHS trusts that will struggle to achieve foundation trust status. This is something Monitor supports and has been calling for for some time.

3.4 There are some organisations that are either in difficulty at the moment or that have longer term structural problems which are making it difficult for them to produce viable business plans. Those organisations will have to be dealt with by the PDA on a case by case basis and the Department of Health has plans in place to support them.

3.5 Monitor carries out a robust and challenging process to assess trusts applying for NHS foundation trust status and we will continue to set high standards in our assessment process as we play our part in meeting the April 2014 deadline for all remaining trusts to become foundation trusts. The Government has said that it has no intention of asking Monitor to lower its assessment bar and this is something we are equally clear about. It is not in the interests of patients and the public for trusts that are not well run and financially strong to be granted the independence and autonomy that comes with foundation trust status.

3.6 April 2014 is a challenging deadline. However, providing there is a steady flow of applicants, which are well prepared by the time they enter Monitor’s assessment process, we believe that the deadline is achievable.

4. Changes Following the Failings at Mid Staffordshire NHS Foundation Trust

4.1 Following the failings at Mid Staffordshire, Monitor commissioned an independent review to consider how the way we operate and work with others could be improved. We have made changes to the way we work as a result. For example:

— We have enhanced the way we assess quality governance in applicants to ensure that boards have robust arrangements in place to identify and manage risks to quality. This is particularly important in an environment of tighter public finances. These arrangements are tested by Monitor during the assessment process.

— We work very closely with the Care Quality Commission (CQC) and we won’t authorise a trust where the CQC has major concerns or is carrying out an investigation. We also share information about concerns in existing foundation trusts and coordinate any necessary action.

— We have strengthened our assessment process. We now take a broader view of performance and seek a wider range of information and intelligence on the quality of care, with the CQC’s judgements being the key element.
— We have worked with the CQC and the Department of Health to define a “quality bar” for authorisation. The bar incorporates CQC registration standards, the Secretary of State gateway threshold and Monitor’s governance risk rating.263

— We now take full account of “soft intelligence” such as trends in patient complaints, which feed into Monitor’s assessment and compliance work.

— Monitor is now contacted regularly by other stakeholders, such as voluntary organisations, patient groups, individual patients, coroners and clinicians who have concerns about a foundation trust. Stakeholders are encouraged to contact Monitor if they have concerns that a foundation trust is breaching its terms of Authorisation.

— Monitor seeks to work in partnership with SHAs and PCTs. Commissioners are encouraged to contact us if they have significant concerns about the performance of a foundation trust that they have not been able to resolve locally.

4.2 Monitor believes that these actions, specifically the greater focus on quality and closer working with the CQC, have strengthened our assessment process. The Bill explicitly requires (Clause 264) Monitor and the CQC to co-operate in operating their separate regimes, so this robust relationship will continue in the future.

4.3 Patients and their relations were failed at Mid Staffordshire NHS Foundation Trust by the Trust and by the system as a whole. Absolutely every effort must be made to ensure this never happens again. As a result of the failings at Mid Staffordshire, we have both refined our assessment process and improved the way we work with other parts of the healthcare system to ensure that information is shared effectively and concerns are identified and acted upon. The system as a whole has also moved to place a much greater focus on quality and quality indicators/outcomes.

4.4 Monitor is very clear in its message to both foundation trusts and applicant trusts that while financial stability gives a platform for improvements in all aspects of performance, efficiency must not be achieved at the expense of quality.

4.5 Monitor is participating fully in the Public Inquiry into events at Mid Staffordshire NHS Foundation Trust. We have submitted a statement that will be published in due course and a number of past and present Monitor employees are in the process of providing further statements and will also be called as witnesses. We welcome the Public Inquiry and the additional focus it is giving to what went wrong at this Trust. We will study the Inquiry report and any recommendations carefully once they are published, and where there are new lessons to learn we will work closely with all the relevant parties, including the Trust and the CQC, to act on these.

5. Protecting Taxpayers’ Interests

5.1 At the moment, £24 billion of taxpayers’ money is invested in foundation trusts in the form of public dividend capital and loans. Overseeing this investment is an important role which Monitor has carried out for foundation trusts to date. This has ensured that foundation trusts have genuine freedom from central government control, with a rules-based approach to oversight of taxpayers’ investment which has been free from the risk, or even the perception of a risk, of political interference.

5.2 The Department of Health Command Paper outlined that the Department of Health will establish an operationally independent banking function which will take over the management of taxpayers’ investment stake in foundation trusts. (This will be enabled by clause 148 of the Bill.) This means that:

— In future, the public dividend capital foundation trusts currently receive (via the Department of Health’s Foundation Trust Financing Facility and finance directorate) will be replaced by loans from the new operationally independent banking function;

— The banking function will monitor the public investment in foundation trusts and exert control over foundation trusts through the use of regulations similar to bank covenants in relation to debt.

5.3 Monitor is pleased that the government has recognised that the important job of protecting taxpayers’ interests should be undertaken through an operationally independent banking function. Transferring financial oversight of foundation trusts to the Department of Health without ensuring the operational independence of the function would have been contrary to the overall vision of a devolved healthcare system with less top-down control. It is important that the Secretary of State is not able to direct the operation of the banking function in order to ensure that foundation trusts are free from political influence in the future.

5.4 In the long term, Monitor believes that a separate, statutorily independent body should be established to carry out the ongoing role of protecting taxpayers’ investments in order to ensure there can be no question of political influence.

### Competition

#### 6. Ensuring a Level Playing Field

6.1 In protecting patients’ interests Monitor will need to determine if the “playing field” amongst alternative providers is level. A level playing field is important to ensure that all providers are incentivised to improve and to innovate, and that markets are efficient. A lack of a level playing field between providers of healthcare could result in resources not being allocated to the most efficient provider. This in turn could result in higher costs and/or poorer choice and service quality to the detriment of patients and tax payers.

6.2 Ensuring a level playing field is not straightforward. While there are some quantifiable distortions which work in favour of NHS organisations, for example in the areas of tax, the cost of capital and pensions, there are others which work in favour of the private sector, such as the fact that NHS organisations tend to treat more complex cases and NHS organisations have responsibility for professional training of clinical staff.

6.3 It will be important for the economic regulator to gain a complete picture before reaching any conclusions as to whether the playing field is distorted, and if so what remedial action it should seek. The first step will be to build on the Department of Health’s Impact Assessment by carrying out a thorough and complete analysis of the current situation. This analysis will be conducted transparently and consulted upon before any decisions are taken in this area.

6.4 In the event that there are distortions that need to be addressed we would need to consider all of the potential options available. We would again consult broadly on the most appropriate mechanism to address these issues. Examples of potential solutions include introducing more differential pricing to take account of the complexity of cases. Until the analysis and options appraisal is complete, we will not be able to reach any conclusions.

#### 7. “Cherry Picking”

7.1 There is some concern that the Health and Social Care Bill will enable private providers to “cherry pick” routine and less complex healthcare services and interventions that are cheaper to provide and more profitable. The concern is that this would leave the NHS to deal with the higher-cost, more complex and long-term conditions with insufficient funds, causing the destabilisation of local hospitals.

7.2 This is an area the economic regulator will have to look at very carefully. However, the Bill does provide for good checks and balances. For example, especially in rural areas, it is likely that many key services will be protected by designation. This means that if the cost of running the services were to outweigh the income, an application could be made to Monitor for extra funds to pay for the additional costs.

7.3 Furthermore, Monitor’s view is that the current system needs to change so that the complexity of the service should be reflected in the price charged, with all providers being rewarded on a cost-reflective basis. Cherry-picking should not be an issue if NHS prices are designed to reflect complexity of treatment so that appropriate payments are made for both simple and complex services.

#### 8. Competition vs Co-operation

8.1 Monitor will have in due course to work out detailed policy in this area, but our starting point is that competition and co-operation are not mutually exclusive—increased competition does not and should not have to come at the expense of beneficial collaboration and integration of services. We believe that the two can co-exist as they do elsewhere and that the aim should be to increase co-operation where this will increase the efficiency or quality of healthcare, whilst not allowing behaviours that are clearly not to the benefit of patients, such as arrangements that might exclude a service provider purely on the basis of its ownership.

8.2 Similarly, too much integration (such as one player buying up many other players in a particular geographical area) runs the risk that patients do not have access to the best care. It will be critical, therefore, that while partnerships fostering innovation and clinical integration must be facilitated, the patient’s ability to choose must also be protected wherever this is appropriate.

8.3 In our view, Monitor must seek to achieve a healthy combination of competition and collaboration through its approach. Allowing patients to choose the best care package for themselves, in consultation with their doctor, will also no doubt drive some further integration. We see nothing in the Health and Social Care Bill that will stop this. GPs should be able to work with clinicians from hospitals, and hospitals should be able to work with other hospitals, to plan ways in which patient care can be improved provided this is done in ways that do not seek to exclude other qualified providers from participating in the provision of care to service users as well.
9. EU Competition Law and the NHS

9.1 It is Monitor’s understanding that the Health and Social Care Bill does not change the way in which UK competition law (and, therefore, EU competition law, since this is reflected in UK competition law) applies to healthcare providers. What it does is to give Monitor the same powers as the OFT already has in relation to publicly and privately funded health care. This means that Monitor will be able to investigate infringements of UK and EU competition law in the healthcare sector in the same way as the OFT can investigate such infringements.

9.2 Commissioners will remain subject to Department of Health specified competition and procurement rules (which follow European procurement law) as they are today. Also as today, but for all providers not just foundation trusts, Monitor will police adherence to these rules. It is noteworthy in this regard that the “Any Willing Provider” policy is helpful in that it provides a way for commissioners to satisfy UK and therefore EU public procurement requirements without the costs that would be associated with a competitive tendering process.

10. Comparing the NHS to Privatised Industries such as Water, Gas or Electricity

10.1 Monitor does not believe that the NHS can or should be run in the same way as privatised industries such as water, gas or electricity. Healthcare is a distinct system with a number of particularities which the economic regulator will need to take into full consideration.

10.2 However, this is not to say that there will be no lessons from the experience of applying the principles of economic regulation to other sectors that may have some relevance to health. For example, ensuring the continuity of supply of essential services is something common to health and other sectors. We know that markets can fail and even without competitive markets, providers can fail. We believe it is valuable that the sector regulator oversees providers and any market mechanisms to ensure that the interests of patients and taxpayers are protected based on a set of transparent and objective rules which ensure, amongst other things, that in the event of some sort of failure, essential services are protected. The experience of other regulators may contribute to us working out how to do this.

Continuity of Service

11. Designating Essential Services

11.1 The Health and Social Care Bill (clauses 114 to 119) provides for a continuity of service regime to be developed. While commissioners will remain primarily responsible for ensuring the continuity of service provision, Monitor will be given powers to protect “essential” services designated for additional regulation.

11.2 Where providers find themselves in difficulty, there should be robust measures to ensure that, above all else, the interests of patients are protected and the continuity of essential services is maintained.

11.3 Monitor has for some time been concerned that the existing failure arrangements in health are not satisfactory. Failure cannot always be avoided. Indeed, it can be important that if a provider fails, for example as a result of mis-management, it is possible for it to exit the market whilst ensuring that essential services are maintained. Without failure, poor management or poor clinical care can continue unaddressed. It is very important that inadequate or inefficient management teams can be removed from the system if a provider fails. However, it is also important to recognise that failure and the exit of a provider does not have to mean the physical disappearance of facilities or the redundancy of staff, especially where they are designated services.

11.4 In Monitor’s view, the proposed arrangements for special administration and the creation of a risk pool are important features of the proposed failure regime which ensure that certain designated services will continue to be delivered to patients in the event of failure. Under clause 69, GP consortia, the NHS Commissioning Board and the Secretary of State for Health will all be able to request that a service is accorded designated status. Local commissioners, providers, MPs and other locally elected representatives of the public, and members of the public themselves will be able to engage in discussions about local service delivery and participate in the decision about which services to designate for additional regulation. Monitor will offer guidance and support throughout this process and will make the final decision based on the local recommendation.

11.5 Designation will be available to NHS-funded services, whether they are provided by NHS bodies, private providers or those in the voluntary sector.

11.6 In the event that there is a financial failure of a provider of designated services a health special administrator will be appointed. This builds on the practice that has been established in other sectors to ensure that services that are essential to a community can be delivered at the same time as financial restructuring and recovery. Services will be designated for a regulatory period defined by Monitor. During that period the provider will not be able to reduce, significantly reconfigure or cease provision of those services without the prior approval of both local commissioners and Monitor.
11.7 The Bill sets out that providers and commissioners of designated services will be required to take part in risk-pooling arrangements to ensure that Monitor can step in and keep essential services running if a provider becomes financially unsustainable. The purpose of the risk pool will be both to ensure the continuity of services in the short term and to provide funds to restructure an organisation to ensure the provision of those essential services in the long term.

11.8 In line with best practice seen in similar continuity of service schemes operated in other sectors, Monitor will have power to ensure that the providers which represent the greatest risk bear a greater share of the costs.

11.9 However, risk pool funding will only be accessible once a provider has been put into special administration by Monitor and management control has passed to the special administrator. This is to ensure that funding is not used to subsidise under-performing providers. We support the move to a clear and effective failure regime and a continuity of service regime for designated services.

March 2011

Memorandum submitted by All Party Parliamentary Group on Eye Health and Visual Impairment (HS 130)

We and our fellow Officers of the All Party Parliamentary Group on Eye Health and Visual Impairment are writing to the Committee with a few key observations around the Bill, the previous NHS White Paper consultations and the current Public Health White Paper. These observations are informed by the dialogue that Officers of the APPG have with organisations dealing with vision, eye health, prevention of sight loss and providing support to people living with sight loss.

We submitted evidence to the consultations on the NHS White Paper and received a very helpful response from the Secretary of State, which we attach with our submission for the Committee’s information.

SUMMARY

Outcomes Framework

We welcome the principle of a clear outcomes framework. However, we believe that quality measures for prevention should be explored further.

Primary ophthalmic services and the NHS Commissioning Board

We welcome the decision to retain General Ophthalmic Services as a national service with the National Commissioning Board rather than devolving responsibility from PCTs to GP Commissioning consortia.

Commissioning for Patients

The White Paper was one of the first government papers to include references to commissioning community eye care services from optical practices. We welcome this recognition of the effective role the community optical sector can play in delivering eye care services and in reducing costs for the NHS and social services.

Public Health Service

We welcome plans to create a Public Health Service in England. It is important to ensure that eye health is better represented in Joint Strategic Needs Assessments and we hope that the increased co-operation between health and social care will facilitate this.

Eye health—a key public health issue

We are concerned that Public Health White Paper makes no reference to eye health as a public health issue. Nor does it mention primary care eye health professionals as a group that needs to be closely involved in safeguarding the sight of the population.

Social care

We welcome the Government’s focus on breaking down barriers between health and social care funding to encourage preventative action. We look forward to the proposals by the Dilnot Commission and the Social Care White Paper in the autumn.

NICE Guidance

We are concerned about the impact of the decision to move away from NICE guidance being mandatory. There is an obvious risk that patients across England and Wales will be faced with a postcode lottery in relation to access to new health technologies.
Health and Social Care Bill

NHS information revolution and patient choice

It is essential for any health information that is being provided to sighted patients to be available to blind and partially sighted people in their preferred format. It is not sufficient to just produce large print versions or rely on web browsers to allow access.

Transition

We are particularly concerned about the transition period to the new arrangements. Eye health services and support services for people with sight loss are often overlooked and this might well be the case with GP commissioners whose main focus will be on the historically larger areas of PCT spending.

Our Detailed Comments

Outcome framework

The eye health and vision community has welcomed the principle of a clear outcomes framework. For eye care, the key outcomes should focus on vision correction, prevention of avoidable blindness and timely support for people with visual impairment or blindness. For community eye care, appropriate subordinate measures would include the percentage of the population receiving sight tests, and percentages of patients receiving timely referral and care for glaucoma, diabetic retinopathy, wet age-related macular degeneration and cataract.

These measures are amenable to simple clinical assessment and/or Patient Reported Outcome Measures, and the sector would welcome the opportunity to work with government to develop the relevant sections of the Outcomes Framework.

For outcome measures to work effectively, they must be feasible and it is important that they are not complex and expensive to operate. A simple system based on the collection of patient experiences, reporting adverse outcomes and tracking indicators of the nation’s health improvement is required.

The five domains don’t appear to address public health issues around keeping people well and preventing ill health. For example, there is considerable evidence to show a link between poor vision and falls in older people—optometrists can play a lead role in addressing this as a front line provider. Quality measures for prevention should be explored further.

Primary ophthalmic services and the NHS Commissioning Board

We welcome the decision to retain General Ophthalmic Services as a national service with the National Commissioning Board rather than devolving responsibility from PCTs to GP Commissioning consortia. We are pleased to see GP consortia will continue to develop Local Enhanced Services (LES) in eye care, for example, glaucoma referral refinement schemes, stable diabetic and glaucoma monitoring as well as emergency/acute eye care referral. This would allow resource to be better focussed to meet patient need and reduce the burden on the Hospital Eye Service. Similar services may need to be developed to cope with the increasing number of patients, with an ageing population, who will require continued monitoring and treatment for wet age-related macular degeneration and other retinal diseases.

Commissioning for Patients

The White Paper was one of the first government papers to include references to commissioning community eye care services from optical practices. We welcome this recognition of the effective role the community optical sector can play in delivering eye care services and in reducing costs for the NHS and social services.

Throughout the country there are examples of excellent practice of joint working between the NHS and Local Optical Committees (LOCs) representing local NHS eye care contractors and practitioners. The Optical Confederation would be happy to prepare some best practice guidance based on this evidence for both GP Consortia and LOCs to support engagement between the two.

The sector welcomes the commitment to improving health inequalities. Outreach services must be developed in areas of relative deprivation if world class eye services are to be achieved.

Public Health Service

We welcome plans to create a Public Health Service in England that recognises the importance of health and wellbeing, the prevention of ill health and the need to tackle health inequalities holistically, taking into account the impact of a wide range of policies (social care, transport, environment, welfare, etc) rather than focusing exclusively on health.

We welcome the plan to increase further the number of Directors of Public Health who are appointed jointly by the NHS (and in future the Public Health Service) and Local Authorities. We are keen to see eye health better represented in Joint Strategic Needs Assessments and hope that the increased co-operation between health and social care will facilitate this. Only a thorough analysis of the eye health and support
Health and Social Care Bill

needs of their local population will allow providers to identify those most at risk of unnecessary sight loss (the elderly, minority ethnic populations, people with learning disabilities as well as those on low incomes) and take targeted action to minimise their risk.

Generally, GP consortia and individual GPs can only be expected to respond to health needs that have been identified in JSNAs or public health strategies. Eye health is rarely receives specific mention in JSNAs (or in any of the current performance frameworks or policy documents). This needs to change to ensure that this significant health need of the population is no longer neglected.

Eye health—a key public health issue

We are, however, concerned that Public Health White Paper makes no reference to eye health as a public health issue. Nor does it mention primary care eye health professionals as a group that needs to be closely involved in safeguarding the sight of the population. This is a concerning omission given the Government’s support for the UK Vision Strategy.

We strongly believe that the forthcoming public health outcomes framework needs to make specific reference to eye health under domains three (health improvement and the promotion of healthy lifestyles), and five (healthy life expectancy).

Without concerted efforts to prevent avoidable sight loss the number of people suffering ill health and a lack of wellbeing due to visual impairment is likely to double in the next 40 years from the current 1.8 million to almost 4 million in 2050. Only preventative action through primary prevention, improved case finding, access to treatment and appropriate support for blind and partially sighted people will help reduce the burden of disease associated with eye disease and visual impairment that has been estimated to have cost the NHS and wider society £22 billion in 2008.264

Social care

We welcome the Government’s focus on breaking down barriers between health and social care funding to encourage preventative action. We look forward to the proposals by the Dilnot Commission and the Social Care White Paper in the autumn.

We will be particularly keen to see how any new arrangements will facilitate a more preventative approach to supporting people in the community as tightening eligibility criteria for social care support have tended to focus resources on those with needs deemed to be critical or substantial and away from those with perceived “low level” needs, such as people with sight loss. As the needs of those with sight loss tend to be underestimated by those who have no sensory training or expertise, a focus on multi-agency collaboration and prevention is warmly welcomed.

NICE

We believe that the importance of sight loss prevention should be recognised in the context of tackling health inequalities. Unless eye health is recognised as a major public health issue there is a very real risk that it will get lost among other major health priorities such as heart disease, stroke and dementia. Conditions such as age-related macular degeneration have been shown to have a similar impact on quality of life as coronary artery disease and stroke.

The cost of eye disease and sight loss to the economy runs into billions of pounds. When as much as 50% of all sight loss is preventable, early detection and access to treatment should be a priority area as it is an important way of saving significant health and social care costs.

We are concerned that the pressure on NICE to produce 150 Quality Standards within five years could result in the re-writing of existing guidelines without a proper chance to review evidence and points made during consultation. More significantly, in areas where no NICE clinical guidelines exist, development of Quality Standards should be prioritised.

In addition, we would like to raise the issue of access to information in relation to all Quality Standards. The reasonable adjustment duty within the Equality Act, 2010 emphasises the obligation on service providers to provide information in accessible formats. At present, every Quality Standard contains a standard paragraph that encourages service providers to make information accessible. We believe that this paragraph needs to be strengthened to remind service providers of their legal obligations.

NHS information revolution and patient choice

It is essential for any health information that is being provided to sighted patients to be available to blind and partially sighted people in their preferred format. It is not sufficient to just produce large print versions or rely on web browsers to allow access. Under the Equality Act patients have a right to accessible information and for some people that will be large print but for others it will be Braille, audio or email. This

is particularly important when it comes to the choice of treatment or the clinical team providing treatment. It will also be vital for health providers to have a field code on patients’ format requirements in their medical records.

While physical access to services and an inability or unwillingness to travel will affect many older people with disabilities, the issue of accessible information is unique to blind and partially sighted people and should be highlighted as such in the forthcoming White Paper on the “Information revolution”.

Transition

We are particularly concerned about the transition period to the new arrangements. Eye health services and support services for people with sight loss are often overlooked and this might well be the case with GP commissioners whose main focus will be on the historically larger areas of PCT spending.

The many excellent services provided by NHS hospitals, community optometry schemes, eye clinic liaison officers and independent living co-ordinators need to be protected and extended to cover all patients with eye disease.

March 2011

Memorandum submitted by Urology User Group Coalition (HS 131)

EXECUTIVE SUMMARY

— It is essential that patients with continence and urology problems are able to access the products/devices which are best suited to their individual needs, both to ensure the best clinical outcomes and to provide value for money to the NHS in the long term. However, this does not always happen in practice.

— While the Government has no plans to change the current arrangements for supplying prescribable urology products, it is not clear how they will work within the new system, or indeed they will work better than they do at present.

— We recognise that GPs could play a useful role in improving the quality of care provided, but are concerned that GPs and other primary care practitioners do not have the required specialist knowledge to be able to ensure that their patients have access to the best urology products for their individual needs. We are also concerned about the potential conflict of interest between patient choice and commissioning.

— The UUGC agrees with the aim of the Health and Social Care Bill to increase the accountability of commissioners for their commissioning decisions.

INTRODUCTION

1. The Urology User Group Coalition (UUGC) represents the estimated half a million continence appliance users who rely heavily on urology products and services to maintain their health and wellbeing. We are also representative of many people with the vast range of clinical diagnoses that usually require continence management to be integrated into care and treatment pathways. These include the long term conditions of cancer, stroke, spinal cord injury, MS, spina bifida, Parkinson’s disease and other neurological conditions.

2. We welcome the opportunity to respond to this inquiry. This response will focus on clinical engagement in commissioning, the conflict between patient choice and commissioning, and local accountability.

BACKGROUND: THE CURRENT SITUATION AND CONCERNS ABOUT THE FUTURE

3. For patients with continence problems, it is essential that they have as much choice as possible over the devices they use to help them manage this condition at and away from home. This includes catheters, but also products such as urinary sheaths, drainage bags and other continence products.

4. Currently, access to urology products in primary care is determined by the new arrangements under Part IX of the Drug Tariff for the provision of stoma and urology appliances—and related services—in primary care. This was published in 2009 after an extensive review and consultation, and came into force in April 2010.

5. Part IX of the Drug Tariff lists the products which have already been assessed as being safe and effective, suitable for GP or nurse prescribing, and providing value for money to the NHS by specifying the price which the NHS should pay for each device. This enables urology product users to choose from a comprehensive range of devices, so that they are able to select and use the device which best meets their individual needs.
6. Many patients rely on specific urology products to cope with dexterity and other impairments as well as for their comfort and wellbeing. To a person not using them, two urology appliances may seem very similar—but for the people who use them, even slight variations can cause serious discomfort or difficulty, impeding their mobility, their ability to live relatively independent lives, and even lead to an increase in infections. A less than optimum product can stop self-care and create further care needs causing over reliance on carers—and can prevent both patients and relatives who need to care for them from working. This neither delivers effective commissioning of quality care nor enhanced patient outcomes.

7. However, some PCTs have chosen to formulate their own local arrangements outside of the Part IX arrangements, including restrictive product formularies, which limit the number and range of products available to patients in the area. This produces a postcode lottery for these devices, going against the aims of the national arrangements.

8. This is simply replicating a process which has already been carried out in developing the Drug Tariff, while further restricting patient choice. The amount of bureaucracy involved in accessing products which are not included in local formularies is often prohibitive, and many patients are not aware of their rights. Furthermore, there is a general lack of knowledge among practitioners as to what the Drug Tariff and the Part IX arrangements are.

9. Patients have also found difficulty in accessing the number of products which they need. Provision of continence products should be decided according to clinical need. However, according to the National Audit of Continence Care, “66% of PCTs impose a limit on provision”.

10. While we understand that the current Government has no plans to replace the Drug Tariff as the mechanism for supplying urology products to patients, it does risk being undermined by the developments outlined above. The Drug Tariff is a system which provides commissioners with the necessary range of products, ensures value for money for the NHS, and an appropriate choice of products for patients, while avoiding a postcode lottery in access to products. If the aim is to create a patient centred NHS, then it is important that patients with complex, long-term conditions are able to have a degree of certainty that they will be able to access the products which they need to in order to manage their conditions.

11. At the moment, it is not clear how this will function in the reformed NHS. The move towards greater patient choice and involvement could of course be positive if it works well in practice, allowing patients a proper say on a matter of great individual importance. However there is the risk that GP consortia, led by non-specialists without a detailed knowledge of the needs of urology appliance users, may simply decide to carry on using the same formularies which have been used by PCTs, continuing to restrict patient choice.

**Comments on Specific Aspects of the Bill**

**GP Commissioning consortia**

12. The UUGC recognises that the move to GP led-commissioning has the potential to improve the quality of services by increasing clinical engagement in commissioning.

13. In order to ensure fairness in the commissioning of services, we are keen to ensure that national arrangements, such as the Drug Tariff, will continue to operate. We understand that the Government currently has no plans to change the ways in which urology products are supplied, and we hope that this will continue to be the case. The Drug Tariff allows GPs to make their own decisions about how services are delivered. It provides reassurance to both patients and practitioners about the quality and clinical effectiveness of the products provided, as well as the value for money which they offer.

14. We support the conclusions in the recent report on Commissioning by the Health Select Committee about the importance of clinical engagement in commissioning. We agree that it is essential that this engagement draws from a wide a pool of practitioners as possible in order to deliver the maximum benefit to patients.

15. It is worth bearing in mind that most individuals who have incontinence problems or bladder dysfunction are suffering from a long-term condition such as cancer, stroke, spinal cord injury, MS, spina bifida, Parkinson’s disease and other neurological conditions. These conditions are complex and multifaceted and require a number of different treatment options. Therefore, there is a need to ensure that GPs have access to the specialist knowledge necessary to effectively advise patients on the best treatment options. While two urology products may seem very similar to a GP, small differences can have a big impact on the life of the person using the product, particularly their ability to be independent, to work, and to have a social life. The same can be said of community nurses, who are often more involved than GPs in the day-to-day care of continence product users, but similarly lack specialist knowledge of urology products and their use outside a clinical setting.

16. This presents a particular problem when commissioners implement restrictive formularies which try to limit the products which patients are able to access. Although patients are technically entitled to any product listed on Part IX of the Drug Tariff, they often do not have sufficient knowledge of their rights and of the available products to be able to access them. If neither GPs nor community nurses understand what their patients are entitled to or the effect that inappropriate provision can have on a patient, then they are not in a position to ensure that their patient is receiving the best treatment.
17. While it has been confirmed by the Department of Health that they do not currently plan to change the arrangements governing the supply of urology products to patients, it is not yet clear how the reforms to commissioning will affect arrangements for patients to access urology products. We would be very keen to see those responsible for commissioning in the future take steps to improve their knowledge of specific areas, such as continence, where GPs may not have a great deal of specialist knowledge.

18. This could take a number of forms, including designating a lead commissioner for each consortia on specific areas or ensuring that tailored training and information is made available to commissioners making decisions on issues such as formularies. In areas such as urology care where national policy arrangements and the Drug Tariff underpin patient choice, these should be upheld and not restricted further. While this also underscores the importance of ensuring that patients are able to make their voices heard, it should not be forgotten that they also need to be aware of their rights to access certain products, something which is not always the case at the moment.

**Patient Choice and the Role of the Commissioning Board**

19. One of the key aims to the Bill is to increase the role of patient choice within the NHS, and we support this direction of travel. However, we do feel that there is a potential conflict of interest between patient choice and commissioning, particularly at a time of increased pressure on resources.

20. As mentioned, many PCTs have already put in place restrictive formularies for urology products, with the intent of limiting the choice that patients have over their products. Although many PCTs state that patients are able to access any products which are listed in Part IX of the Drug Tariff, in practice this does not happen because neither patients nor healthcare practitioners are fully informed about the range of available products and what exactly patients are entitled to access. This demonstrates the very real potential for conflict between patient choice and the allocation of resources by commissioners.

21. In fact, this often does not end up saving money for the NHS or the wider public sector in the long term. Due to the invasive nature of many continence products, any difficulties experienced can result in a need for hospital treatment meaning that such arrangements actually run the risk of raising the cost of treating people who use continence devices.

22. The average cost for the admission of emergency urethral catheterisation resulting from infection, is estimated in the region of £1,500 per patient, per visit. In addition, if patients are forced to change products, they must first be clinically assessed before being prescribed with alternatives. In specialist care, the associated and potential costs of such procurement initiatives are a considerable expense for PCTs and could potentially far outweigh any initial savings.

23. There are also the additional costs which result from patients being unable to work or maintain an independent lifestyle due to inappropriate provision of products. There are examples of individuals represented by the UUGC being housebound and reliant on carers for many years due to the fact that the products which they have used have not offered them the confidence and independence to leave the house for extended periods.

24. A further example of the kind of arrangements which give cause for concern is the recent tender for urology products issued by NHS Supply Chain (NHSSC), the organisation which supplies into secondary care settings. However, the new tender proposes to offer an off-script home delivery service to patients in primary care settings, which would see NHSSC becoming the “manufacturer” and supplying products directly to patients.

25. There seems to be a lack of understanding within NHSSC about the different needs for continence care in primary care and secondary care—patients in hospitals using catheters or other products over a short term basis will obviously have different needs and concerns to those patients with long term conditions who use continence products to help them cope with day to day life, and has not been recognised in the proposals.

26. In addition to this, there is a concern that such proposals will undermine Part IX of the Drug Tariff, which provides price protection for the NHS and manufacturers supplying products. If manufacturers can no longer afford to supply products to patients, then this will have a direct effect on patient choice. The proposals also threaten to remove patient choice over how they receive their product (at the moment they are able to fill prescriptions via a pharmacy or via a dispensing appliance contractor, both of which could be undermined by the NHSSC proposals for an off-script home delivery service given its dominant position in the market).

27. The danger is that a national formulary could develop out of restricted supply routes, replacing Part IX of the Drug Tariff, and limiting patient choice further. NHS Supply Chain have said that their aim is to achieve £1 billion of savings to the NHS by 2016; however forcing patients to use inappropriate continence products could undermine this if it ends up costing the Government more money overall due to increased infections, greater need for carers, the inability of those with long term conditions to remain in employment, etc. It is important that the overall picture is considered, rather than aiming to simply make crude short term savings, and that patient interests are put at the heart of decision making.
28. National developments such as this run a real risk of undermining efforts at the local level, by GP consortia, to increase patient choice and the role of patients in decision making. While these decisions are of course not made by GP consortia, they will inevitably impact on the arrangements in place for supplying urology products through primary care and will not support GPs in securing the best options for their patients. We very much hope that GP consortia will avoid the use of such restrictive formulae.

29. The Secretary of State for Health has maintained that there is no potential for conflict between GP commissioners making clinical decisions and allocating finite resources, on the grounds that the first duty of the GP will always be secure the best interests of their patients. However, the developments above show that there is a real potential for conflict between making the best clinical decisions and allocating resources, something which is only likely to increase in the current climate. We do not feel that sufficient reassurances have been given that this situation will be avoided under the new framework, particularly as GPs will have little control over developments such as those coming from NHS Supply Chain.

30. We would welcome more detail on the role of the NHS Commissioning Board in promoting quality and consistency and ensuring that a postcode lottery does not develop for access to products once decision making is devolved down to such a local level. Sir David Nicholson, the NHS Chief Executive, has recently said that the role of the Commissioning Board will be to safeguard the “core values” of the NHS, ensuring a fair and comprehensive system across the country, promoting the NHS constitution, and championing the interests of patients. We understand that the Board will support consortia by providing a national framework for local commissioning. However, we would be interested in further detail on how problems can be drawn to the attention of the NHS Commissioning Board and what steps they will be able to take to promote patient choice and improved clinical outcomes.

HEALTHWATCH AND LOCAL ACCOUNTABILITY

32. The UUGC agrees with the aim of the Bill to increase the accountability of commissioners for their commissioning decisions. It is vital that patients are able to make their voices heard and explain to those commissioning services on their behalf how they will be affected by the decisions they make.

CONCLUSION

33. The UUGC agrees that some of the reforms proposed in the Health and Social Care Bill could potentially lead to improvements in the quality of commissioning. However, we are keen to point out that the national Drug Tariff is essential to ensure that urology patients have access to a full range of products so that they can choose the one which best meets their clinical needs. This will also avoid the danger of a postcode lottery which is present when care decisions are devolved to the local level. We hope that GP consortia will respect the Drug Tariff when implementing the new arrangements, and that the NHS Commissioning Board will help to support patient choice in this area.

March 2011

Memorandum submitted by Abbott Medical Optics, Alcon, Rayner and Bausch and Lomb (HS 132)

On behalf of the Ophthalmology Group—Abbott Medical Optics, Alcon, Rayner and Bausch and Lomb—research based ophthalmology companies developing innovative refractive vision therapies in eye care with a particular expertise in cataract treatments.

We welcome the opportunity to answer the call to provide written evidence to the UK Parliament’s Public Bill Committee currently scrutinising the Health and Social Care Bill and hope that it will prove useful in the further development of the proposed Government healthcare reforms.

In the light of the ongoing healthcare reform debate within the UK Parliament following the initial publication of the Department of Health’s “Liberating the NHS: Commissioning for Patients” proposals, the Ophthalmology Group would like to see improved care for patients with cataract, including prompt diagnosis, the timely provision of patient information on all treatment options, appropriately quick scheduling of operations, effective after care and to ensure that second eye operations are not neglected.

The Group feels that a focus during the Public Bill Committee’s discussions on the Health and Social Care Bill on these areas of cataract treatment is important to ensure that cataract patients are able to get access to the best available treatments and, where possible, stay active, mobile and healthy after surgery.

Summary of the Ophthalmology Group’s Written Evidence:

— The Bill’s proposals offer both opportunities and challenges for eye care with the proposed new way of commissioning services on behalf of patients and the scope that the Bill provides to extend patient choice.

— The Ophthalmology Group welcomes the possibility that is contained within certain clauses of the Bill to ensure that the provision of eye care treatments and services more accurately reflect patient’s needs and choices in the future.
The Ophthalmology Group feels that it is vital that eye care patients have access to the widest possible amount of information about the latest advances in cataract treatment before they undergo surgery and when they first see their consultant so that they can make effective decisions in regards to their treatment options, in conjunction with their healthcare provider.

The Group also feels that it is vital that the representatives on the proposed new structures for the commissioning of healthcare, whether at a local GP Consortia level or those on the proposed Commissioning Board have access to the latest information regarding the most effective cataract treatment options. Ideally, the Commissioning Board would have ophthalmic treatment specialist on it, with a mechanism for either patients or patient advocate groups (or both) to have effective representation at both levels.

It is vital that in areas where patients develop eye conditions associated with ageing, such as cataract, but at an age which is no longer regarded as ‘old’, that decisions are made with long-term goals in mind, and not simply short-term low cost decisions that do not take into account the patients quality of life or the need for them to stay active and mobile.

How people should have greater choice and control over their eye care in the future and how this can be made as personalised as possible in order to meet their healthcare needs

1. The development of a more comprehensive healthcare provider approach to improving the choice and quality of care in the UK provides an opportunity for greater patient involvement in regards to their access to the best available treatment options. However, making the most of this opportunity is dependent on how the proposed new healthcare commissioning and decision making system is implemented.

2. As Article 13F and Article 9 of the Bill outlines, patient involvement in improving their access to the best available cataract treatment options would ideally come about when patient representation is implemented at NHS Commissioning Board and GP Consortia level.

3. Patient focused healthcare and informed choice of treatment could be facilitated using these decision making structures and better decisions may be taken because of the involvement of a wider range of expertise.

4. The initiative on greater patient choice and control by the government so early on in its tenure is welcome and we believe it can be delivered upon in this Bill proposal for reform. However, we feel that what should also be pursued is informed choice made by patients in collaboration with their GP and specialist.

5. In order for this to be a reality patients have to be fully informed about their condition and the treatment options that exist. Otherwise patient involvement at Commissioning Board and GP Consortia level would merely be a token gesture and not represent true patient choice.

6. For example, in regards to ophthalmic services, the operation to remove a cataract is the most common surgical procedure undertaken in the UK. It therefore follows that a cataract operation is the most common opportunity for patients to make a decision, along with their GP and specialist, about the preferred treatment option for them.

7. This is especially true as it is a relatively simple treatment to understand and yet the range of options available to patients in terms of eye lens treatments is currently very wide, particularly in the area of implantable refractive lenses.

8. It is clear that in most cases patients are not being informed about additional treatment options and services, such as implantable refractive lenses with additional benefits for cataract (modern implants also treat astigmatism and/or presbyopia) that can improve the patient’s vision to the extent that glasses may not be required. Indeed, such lenses can correct the patient’s vision significantly and this is a treatment option all people should be aware of since genuinely informed patient choice requires a genuinely informed patient.

9. Article 51 outlining the role of Monitor to in promoting the economic, efficient and effective provision of healthcare services could be strengthened here in order to ensure the most effective eye care treatment services are commissioned.

How GP Consortia can work closely with secondary care, community partners and other health and care professionals to design joined-up services that are responsive to patients need for greater choice and control

10. As stated above, we believe it is important to involve relevant specialist health and care professionals in the decision making by GP Consortia when it is necessary to supplement the knowledge of GPs in order to provide greater choice and control for patients in regards to eye care treatments.

11. A system such as this adds an extra element to the existing commissioning activities currently carried out by Primary Care Trust’s and Strategic Health Authority’s. It will involve healthcare professionals in the process, who have direct contact with patients on a regular basis and whom also often have a greater level of expertise. Such professionals will therefore have a detailed understanding of their health and care needs. The role foreseen for independent advocacy services in Article 170 could help in this commissioning process.
12. Another area of great potential in the greater choice and control agenda within the Bill would be to ensure that local and national healthcare services are linked to a greater extent than they are at present. With members of the GP Consortia being represented on the Commissioning Board such linkage should be easier to foster.

13. Patients with many forms of illness, both short term and chronic, ultimately receive a totality of care from a range of providers eg GP surgeries, specialist units in hospitals, home care nursing and social support. However, this treatment is not always co-ordinated. Delivering joined-up services is essential to good patient care and, ultimately, to ensure that money spent is a good investment rather than a cost to the tax payer or private individual. The role of HealthWatch England, outlined in Article 45A, should help in assisting in this process in the future.

14. A notable example of this potential for improvement is in healthcare services for the elderly. A range of disorders commonly experienced by the elderly include Arthritis, Alzheimer’s disease, Parkinson’s disease, Muscular Skeletal Disorders and Cataract.

15. By looking at these conditions together and addressing how healthcare to treat them can be commissioned effectively and linked up with other services patients can be better served by professionals and have wider access to the best available treatments.

16. Indeed, this is especially important considering longer life expectancy in the UK, the economic burden of chronic diseases and the need for people to be healthier and able to work later on in life.

How the NHS Commissioning Board and GP Consortia can best work together to make effective and efficient healthcare choice and control decisions in the future

17. We strongly believe that specialist expertise must be called upon at all decision making levels in the commissioning of care in order to give patients greater choice and control over their treatment options. This is even more important in order for clinicians to meet the patient outcomes criteria outlined in Article 130 of the Bill, which are effectiveness, safety and quality.

18. Whilst the Bill does focus on how some areas of specialised care will be addressed in the future, we feel that relevant expertise must be involved in all decision making to ensure the best treatment choice and control for patients, as well as secure value for money. In terms of ophthalmic services, this is especially important in order to reflect the link up that exists between GPs and specialist ophthalmologists in the provision of eye care.

New choices of treatment we would like to see in the NHS following the publication of the Bill

19. In regards to the question of which new healthcare treatments we would like to see in the NHS, we think that greater choice in the area of eye care would be a priority, particularly amongst elderly patients undergoing cataract surgery.

20. The Coalition Government has recently announced plans to gradually phase out the compulsory retirement age in the UK, suggesting that the elderly population will be working for longer in the near future and that they will therefore require a good level of vision in order to carry out their jobs.

21. This will require GPs to work closely with secondary care providers, community partners and other health and care professionals who may also have a part to play in terms of the patient’s healthcare needs. Such co-ordination can ensure that they can continue to lead an active and healthy life while staying in employment for as long as possible.

22. This joined-up approach to providing healthcare is particularly important when considering age related visual diseases such as cataract, largely because of the fact that it impedes the passage of light into the eye, having a dramatic impact on a patient’s quality of life.

23. Indeed, as a silently progressing condition, cataract patients often live with a reduced visibility and need frequent prescription changes in spectacles or contact lenses before being appropriately treated by the NHS.

Encouraging people to take more responsibility for their health and treatment choices

24. In line with Article 178, which refers to Health and WellBeing Boards, we believe that patients should be encouraged to seek more information about their healthcare treatment in the UK and should have access to the widest possible choice of treatment choices.

25. This would result in a stronger relationship between patients and their GPs and clinicians as a better informed patient means that they can gain more responsibility over their treatment. Indeed, with GPs controlling up to 80% of healthcare commissioning budgets in England under the Bill’s proposals, this development will also ensure that they have a clearer understanding of their patients needs.

Information taken from the Department for Business, Innovation and Skills website on 9 September 2010, using the website page http://www.bis.gov.uk/retirement-age on the Government’s current consultation on the phasing out of the compulsory retirement age proposals.
26. For example, patients undergoing cataract operations should be made aware of the additional treatment options and extra services, such as “multi-function” and “spectacle free” lens treatment options (otherwise known as the intraocular lens with additional functions for cataract) that are currently on the market.

27. This is generally not the case and hence cataract patients do not routinely have access to all the treatment options and as a result many need to wear spectacles for the rest of their lives.

**Introducing a right to a personal health budget in discrete and specialised areas of healthcare**

28. We support in principle the idea of introducing personal health budgets. Indeed, we think that such budgets would ideally be introduced on a “pilot project” basis in the area of age related diseases. Such a “pilot project” could be trialled with patients suffering from vision age related diseases such as cataract.

29. This is because UK cataract patients do not always have access to all the latest available treatment options. Indeed, current healthcare commissioning procedures under the Primary Care Trust and Strategic Health Authority decision making structures tend to deny cataract patients the chance to make an informed choice about which treatment might be best for them, especially when it comes to lens implant choice.

March 2011

Memorandum submitted by Council of Deans of Health (HS 133)

1. The Council of Deans of Health is the representative voice of UK university health faculties providing education and research for healthcare professionals. The Council plays an influential leadership role in improving health outcomes through its integral role in developing an expert health professional workforce and utilises its collective expertise to inform innovative educational practice and translational research. The Council aims to lead and inform health, higher education and research policies that impact on the development of an expert healthcare professional workforce and improved health outcomes across the UK and internationally.

2. We would like to draw your attention to what we believe are omissions in the Health and Social Care Bill 2011. As you are aware, the Government is currently consulting on the future of commissioning of education and training for the healthcare workforce. This consultation proposes the creation of Health Education England—a national body—and local networks, composed of healthcare providers, to commission education and training locally. Neither of these structures is included in the Health and Social Care Bill. This is understandable, given that they are still being consulted upon. However, the consultation lays down some legal duties that will be incumbent on healthcare providers. Given the process of change, it would appear that the new system of commissioning healthcare education and training will be in place before these duties have been made law. Therefore, we believe that these duties should be made law in the Health and Social Care Bill 2011. These duties are as follows:

- a duty to consult patients, local communities, staff and commissioners of services about how they plan to develop their workforce;
- a duty to provide data about their current workforce and future workforce needs; and
- a duty to cooperate in planning the healthcare workforce and in the planning and provision of professional education and training.266

3. Additionally, we believe that the Health and Social Care Bill should stipulate, as a legal duty, that any willing provider of healthcare within foundation trusts must provide sufficient practice placements for healthcare students—their future workforce.

4. We noted the debate in committee around the following amendment: Amendment proposed (3 March): 174, in schedule 2, page 227, line 11, at end insert—

"2A (1) The consortium must have a board that includes—

(a) a chair appointed by the membership of the consortium;
(b) the accountable officer if this is not the chair;
(c) at least three non-executive directors appointed by the chair that are not members of a commissioning consortium;
(d) at least one patient representative appointed by the local Healthwatch organisation;
(e) such additional clinical specialists that are needed to ensure that expert advice is available within the Board for the commissioning of services, including—

(i) a registered nurse, and
(ii) a member of the allied health professions;"

(f) at least one representative from local authorities in the consortium area;
(g) no more than four other members of the consortium.

(2) The consortium must meet in public.

(3) The agenda and minutes from the consortium board and any sub-committees must be published.”.

—(Liz Kendall)267

5. We fully support the prescription that a registered nurse and allied health professional must be present on commissioning boards. We hope that this amendment, once it has been restructured by the proposers, will be considered again.

March 2011

Memorandum submitted by the Institute of Chartered Secretaries and Administrators (ICSA) (HS 134)

1. ABOUT ICSA

1.1 The Institute of Chartered Secretaries and Administrators (ICSA) is the professional body qualifying and supporting company secretaries and corporate administrators in all sectors of the UK economy, including the NHS. Members are educated in a range of topics including finance, HR, company law, administration and governance, which enable them to add value to any organisation.

1.2 ICSA is the leading international voice on corporate governance and delivers a professional education that gains its strength in the breadth of the syllabus; designed to assist boards and work with senior managers to identify and maximise opportunities within relevant legal frameworks and established best practice.

1.3 In order to provide new evidence to the committee, ICSA contacted Members and non-members involved in the senior management of a range of NHS entities in England. This approach enables our submission to combine the strengths of the ICSA’s knowledge of corporate governance and compliance issues with the practical understanding of how the proposed NHS framework could impact on the day-to-day administration of an NHS body. We therefore feel that our evidence is distilled from a good understanding of the practical issues involved.

2. FOUNDATION TRUST GOVERNANCE FREEDOMS

2.1 The proposed package of freedoms for foundation trusts are perceived as practical and broadly welcomed by those closely involved in their governance. Whether or not governance, as a whole, will be improved as a consequence is questionable. Foundation trusts that use the changes as an opportunity to review their governance structures and work with their governors to establish more robust processes are likely to be better governed as a result. Those that do not may be very vulnerable to failure.

2.2 Regardless of the freedoms proposed in the Bill, foundation trusts still have to operate a governance framework unique within the UK economy and one that presents its own challenges and costs. The additional layer of governance inherent within the dynamic between the council of governors and the board of directors will impact on financial and non-financial resources. The dual nature of the decision-making process on specific areas of business development disadvantages foundation trusts as their governance and accountability framework is more cumbersome operating an almost two-tier board approach. Foundation trusts will have to closely define ‘significant transactions’ in order not to prevent unduly having to seek governor approval on more minor or less significant proposals, and governors will need to remain alert to the accumulative effect of insignificant transactions snowballing into something more significant.

2.3 In addition to the role governors play in voting to approve significant transactions proposed by the board of directors, foundation trusts will, by necessity, be required to spend resources duplicating information and meetings with both the board of directors and the council of governors. In addition, the relationship between members and the foundation trust is also going to require ongoing development and strengthening. Foundation trusts will be required to hold annual members’ meetings, at some cost, but private and charitable competitors may not be under a similar requirement. Heavy governance structures and reporting requirements may prove bureaucratic and expensive and hinder the speed with which foundation trusts can respond to opportunities or threats.

3. GOVERNOR CAPABILITY

3.1 In order for the proposed freedoms to be effective and successful, governors will have to be willing and supported in adapting to an enhanced role. Current governors of foundation trusts have already expressed concerns with the proposals, namely: that the new role is not one they signed up for; current governors do not necessarily possess the skills and knowledge required to hold the board to account; and governors would

267 Proposed in Public Bill Committee session. Tuesday 8 March 2011 (Morning).
3.2 The requirements on governors are going to be onerous, and councils of governors will require at least some, if not all, of their number to have the financial and commercial skills to evaluate foundation trust proposals in relation to mergers, acquisitions and other significant transactions. The new role could also limit the pool of people available who are willing to stand as governors and thus have a real impact on the diversity of the board, and weaken the accountability of the organisation to the wider community.

3.3 There is also concern as to how governors can reconcile their role as representatives of the membership and play a significant part in the strategic decision making process. One issue that is currently unclear is how the members will hold a failing council of governors to account. Governors will require ongoing support to assist in recognising the danger signs; in both financial and quality matters. It is recognised that new markets will appear aimed at training and developing governors, but there is little acknowledgement of the additional costs this will incur for foundation trusts as they will also be seeking to train and develop their non-executive directors.

3.4 Assuming foundation trusts have invested in governor training and development (and sufficient governors have attended), there are few details as to what steps and freedoms foundation trusts and their members have to remove those governors not deemed to be capable of meeting the new challenges of holding the board to account. It is assumed the council of governors will be performance evaluated collectively and individually periodically, but the framework as to who has ultimate responsibility for removing underperforming governors is unclear. As governors are elected by members, it would be natural for the members to remove governors. However, the sensitive nature of sharing performance data of individual governors does not sit comfortably within this arrangement. Similarly, if it is the board of directors that has the power to remove governors, where is the check to ensure that directors do not simply remove those governors that ask the awkward questions and challenge the board of directors in a manner the directors do not feel comfortable with?

3.5 Furthermore, as the chair of the board of directors is also the chair of the council of governors, s/he will be regularly exposed to conflicts of interest. Such situations will require deft and diplomatic management if there is to be an ongoing and constructive relationship between the two decision-making bodies. The comments from colleagues working with foundation trust boards and governors felt the new role of the governor had the potential for more conflict and adversarial relationships between directors and governors; though the greater accountability placed on the board of directors is welcomed.

4. ACCOUNTABILITY

4.1 With legal responsibility comes accountability, and many potential governors will be unwilling to commit to acting as governors until there is a clearer understanding of the role and any potential liabilities. In particular, where governors vote in favour of a significant transaction that consequently triggers insolvency action, would they too be liable under the Insolvency Act for their actions? The proposed freedoms for foundation trusts on their own will not improve governance; suitable accountability arrangements will need to be established for both governors and members. Unfortunately, the Bill does not presently provide sufficient assurance that accountability will be meaningful and proportionate.

4.2 The new duty to hold the board to account is placed on governors and each foundation trust will have to think very carefully about how robust processes can be developed to ensure governors are able to do this. It is expected that best practice in this area will evolve, but it is not guaranteed that unfortunate and avoidable mistakes may be made in the process. Further details either in legislation or supporting guidance would be welcomed by foundation trusts. In addition, positive activities such as the ICSA/Hermes Transparency in Governance Awards could be extended to foundation trusts to benchmark the performance of trusts with regard to disclosure and accountability arrangements.

4.3 Information flows and reporting lines will need to be clarified for specific agenda items and functions, with a balance to be struck between operational detail and commercially sensitive data and the context required for governors to make informed decisions and not act as rubber stamps for the board of directors. Both governors and directors will need to negotiate on the specific information required, along with a review of whether holding governor meetings in public continues to be appropriate given the details likely to be provided to them.

4.4 In addition, consideration needs to be given to what powers governors might be able to exercise within a foundation trust prior to escalating an issue to the advisory governor panel, or other third party, before removing a non-executive director. Without specific guidance, there is likely to be a varied approach by foundation trusts to dealing with conflict between governors and directors; not all of which will represent best practice.

4.5 The foundation trust membership issue has been problematic from the start, and it is hard to see how the proposals will improve and enhance greater member engagement. A lot of work has been done so far, but most of it unsuccessful in terms of developing meaningful membership activities and engagement. Members’
ability to elect governors will be of greater significance when the governors play a more active role in holding
the board to account. As mentioned previously however, the accountability framework which members can
use to inform governor thinking does not exist and the role and purpose of members continues to be vague.

5. **Director’s Duties and Insolvency**

5.1 The key changes for directors are the new duties and the potential for personal liability in insolvency
situations. We welcome the new directors’ duties, as it makes explicit the step change from being a senior
manager to being an executive director, and brings the duties of foundation trust directors in line with the
private sector.

5.2 However, more clarity is needed as to how insolvency legislation will be applied, and how public assets
will be protected. Greater clarification is required to inform governors of their role, and potential liability,
in those situations where a foundation trust may be heading towards insolvency. Governors will also need
to be aware of the powers they have available to prevent a course of action by directors they believe to be
financially threatening to the long term existence of the foundation trust, which does not sit within the
definition of a “significant transaction”.

It is hoped that the above information provides some assistance to the committee in its scrutiny of
foundation trust governance arrangements as proposed under the Health and Social Care Bill. Should you
require any further clarification regarding any aspect of ICSA’s evidence, please do not hesitate to contact
me directly.

March 2011

Memorandum submitted by the British Society of Hearing Aid Audiologists (HS 135)

The British Society of Hearing Aid Audiologists is the professional body representing hearing aid
dispensers who are registered by the Health Professions Council and provide hearing care in the independent
sector. The Society has 1,200 members, around 80% of all registered hearing aid dispensers in the UK.

**SUMMARY**

1. We believe that people needing advice on hearing, and potentially hearing assistance should be able to
access this non-medical NHS-funded care from any willing, qualified provider—where they want, when they
want, from whom they want. Like other primary care services it should be available from as wide a range
of convenient local centres as possible including hearing aid dispensers on the high street as well as specialist
audiology clinics.

**Supporting Statement**

2. Most adults who have a mild to moderate naturally acquired hearing loss do not need to see their GP
and then a specialist audiology/ENT service in a hospital clinic. They have no medical need: they are not
“ill”, they are not “deaf” but simply experiencing a natural and gradual reduction in their hearing ability as
they get older.

3. If people are given real, informed choice, they will accept more responsibility for their own care and
be more likely to wear their hearing aids so increasing the cost effectiveness of NHS-funded essential
hearing care.

4. The wide availability of NHS-funded hearing care will raise awareness of hearing as a public health
issue. Barriers to access and stigma will reduce. More people will access the service when they start to need
it—and it can have most benefit—not when their hearing has declined to a point when rehabilitation and
social and economic isolation have become major challenges.

5. There are huge hidden costs and consequences to untreated hearing loss including missed employment
opportunities and general ill health and psychiatric disorders including depression.

6. Early, effective treatment of age-related hearing reduction is vital as the need to have people
economically active, longer, increases in an era when noise-related hearing reduction will affect the “I-Pod
generation”.

7. The NHS should commission adult hearing care services nationally, to a nationally-set tariff; or at least
with as much national quality and consistency as possible. Ideally the National Commissioning Board
should be responsible for a national Primary Hearing Service (PHS) just as they are other family health
services provided by a whole range of independent contractors.

8. Pending the necessary legislation, adult hearing services should be available from any approved willing
provider on a national list who delivers to clear quality standards, service specification, outcomes and access
criteria, within a national tariff.

9. The excellent work done by the DoH in defining and standardising the national pathway for adult
hearing care and developing patient-experienced outcomes and quality measures, should not go to waste.
10. Service users, commissioners and providers urgently need simple, effective and understandable quality standards because competition on quality and informed patient choice requires transparency, simplicity, clarity and comparability.

11. We do not believe that GP Consortia can be, need to be, or should be expected to be, effective commissioners of essential adult hearing services. It would lead to a postcode lottery.

13. They cannot be expected to give hearing care any priority in the face of major health issues such as heart disease and cancer; and in any case, evidence suggests that GPs are not good at dealing with hearing problems—up to 45% of people who go to their GP with a hearing problem are sent away without any help at all.

14. BSHAA is the professional body for 1,500 Hearing Aid Dispensers, health professionals already well regulated by the Health Professions Council. They have a protected title within a function defined by legislation.

15. These dispensers work within national, regional and local companies and as independent practitioners and the vast majority of them participate in a sector-wide self-regulation scheme of consumer protection good practice.

16. They are experts in testing and assessing hearing and prescribing and fitting hearing aids if required—last year they fitted 200,000 instruments to paying customers—and the are the specialists who could complement the specialist audiology provision for more complex patients and appropriately provide the most cost-effectively quality service for the great majority of the 900,000 hearing aids fitted to NHS patients.

17. Dispensers are SMEs which can provide an innovative, user-driven, accessible, clinically safe and quality service to NHS patients. They welcome the opportunity to compete on quality and want to see clear national and transparent standards and tariffs against which patients can make informed choices and judgements.

Memorandum submitted by Dr Philip Howard (HS 136)

REGARDING PROFESSIONAL SELF-REGULATION BY THE GMC AND OTHER HEALTHCARE REGULATORY BODIES

BACKGROUND

Overview

The Appointments Commission was originally established in 2001 as the NHS Appointments Commission as an “arms length body” of the Department of Health. The initial focus was on the appointment of chairs and non-executives to local NHS boards. In October 2006, it was given new powers to provide selection services for all Government Departments and NHS Foundation Trusts. In 2008 its remit was further increased to appoint members of the GMC.

In January 2009 the new GMC consisting of 12 medical and 12 lay members was appointed by the Commission. This meant that the GMC was a much smaller body than hitherto and that the majority of medical members were no longer elected by members of the profession.

Clause 259 of the Health and Social Care Bill abolishes the Appointments Commission. Its powers and functions are taken over by the Secretary of State. Under Part 2 of Schedule 19 s 8(1) “ Anything which is in the process of being done by the Appointments Commission under an enactment immediately before abolition may be continued by the Secretary of State”.

SUGGESTION

With the abolition of the Appointments Commission the appointment of doctors to the GMC should be by election. This would help to ensure that the medical members of the GMC represent the views of the profession to whom they would be democratically accountable. In order to maintain the confidence of their peers, the medical members ought to be doctors actively engaged in practice and with a license to practice at the time of their appointment.

PROPOSAL

That the Health and Social Care Bill is amended so that the medical members of the GMC are licensed to practice and appointed through election. All registered medical practitioners should be eligible to vote. The same principle should also apply to the other healthcare professional bodies such as the General Dental Council and the Nursing and Midwifery Council with the majority of professional members of the regulatory body being duly elected by their peers.

Suggested amendment to clause 211

To change:

“25C Appointments to regulatory bodies
(1) The Privy Council and a regulatory body may make arrangements for the regulatory body or other persons to assist the Privy Council in connection with its exercise of its appointment power in relation to the regulatory body.

to

“25C Appointments to regulatory bodies

(1) The Privy Council and a regulatory body shall make arrangements with the regulatory body to establish a ballot of the registered members of the relevant professional body so as to appoint a majority of licensed professionals over lay members to that regulatory body.

March 2011

Memorandum submitted by Dr Franz Schembri Wismayer (HS 137)

SUMMARY

This submission considers changes to the role of GPs in allocating resources to individual patients as a result of proposals in the Health and Social Care Bill in the context of changes in health policy since 1990.

It draws on recent perceptions of their roles in resource allocation decisions at the time of the introduction of the internal market to the NHS in 1990. It concludes that the proposed changes in policy are likely to undermine the trust that has enabled the public to see their GP as acting largely in their interest resulting in pressures which together with the extension of the role of the market is likely to lead to an inequitable provision of healthcare, which is unlikely to be politically acceptable, and an increase in overall costs. It argues for the rejection of the restructuring proposed in the Bill and for the considered development of health policy building on gains made in the last decade and seeking public approval as well as genuine consultation with professional groups.

1. I am a member of the Royal College of Psychiatrists and have 18 years of experience as a doctor in the NHS, 16 in the field of Mental Health. I studied for a BSc in Medical Sociology in 1989–90, taking a first, when I researched philosophical, ethicist’s and clinician’s, and health policy perspectives on the microallocation of resources (the allocation or prioritization of particular patients to particular therapeutic or diagnostic interventions) in the NHS in the context of the white paper “Working for Patients” introducing the internal market. I interviewed consultants from a broad range of specialties in a London teaching hospital including a number of local GPs regarding their perception of and responses to problems raised by microallocation in their practice, and how these might be affected by changes in health policy.

2. I found that the problems presented by microallocation decisions extended across all specialties including General Practice in addition to life saving specialties such as ITU bed allocation and selection for organ transplantation in which they had previously been studied. Most doctors interviewed perceived substantial tension between their roles as advocates for the patient and as societal allocators. Nearly all felt non-medical factors entered into their allocation decisions, frequently feeling the decisions were not legitimated by “medical judgement”. Most felt the dual role of advocate and allocator was becoming more difficult and was not maintainable. Responses suggested that doctors were willing to sacrifice a degree of clinical autonomy, being in favour of external input into allocation decisions. Views regarding the impact of the white paper included concerns regarding “buck passing” by the government and identified a challenge to clinical autonomy.

3. The NHS has historically provided a nominally comprehensive service for a relatively low cost in terms of GDP. The “deal” has been that the government put in a limited pot of funding “at the top” while clinicians have rationed healthcare covertly on the basis of “clinical need”. In return for not complaining too loudly about the size of the pot, they enjoyed largely unchallenged clinical autonomy. In this implicit rationing system doctors were often not explicitly aware of their role perceiving themselves primarily as patient advocates. In the late 1980s in the context of increasing developments in medical technology, increasing public expectations of healthcare, and some real limitations in resources, healthcare professionals precipitated the perception of a healthcare system in crisis, often going public with examples of cases vividly illustrating the consequences of resource limitations. Pushed to act the Conservative government proposed the purchaser-provider split and the introduction of the internal market.

4. The impact of The NHS and Community Care Act, 1990, was limited by strict central control of competition preventing politically embarrassing consequences of efficiency gains such as hospital closures or inequalities in access to services. The balance of power however between managers and healthcare professionals did shift, managers gaining greater influence over clinical work. Under New Labour individual GP fundholding was abolished and PCTs took control of budgets, maintaining the purchaser-provider split. Greater third party control of allocation decisions became a reality and the creation of NICE enabled a relatively transparent assessment of the effectiveness and cost-effectiveness of new treatments and technologies facilitating a public debate over decisions whether to fund them and reducing geographical inequalities in provision. There followed a period of unprecedented investment in the NHS coupled to
targets, rewards and sanctions, as well as the development of the market with the creation of foundation trusts and the introduction of a wider diversity of providers as well as payment by results. There has been considerable debate about the impact of these changes.

5. The circumstances of the 2011 Health and Social Care Bill are different. The NHS has enjoyed favourable international comparisons, public approval ratings are high and both the role of GPs in providing an integrated approach to healthcare and in gatekeeping access to secondary services, and the role of NICE in evaluating and controlling the introduction of new treatments and technologies are much admired internationally. The major challenges facing the NHS are maintaining and improving services during a period of severe restraint in public spending and adapting to an increasing frequency of restructuring. The Conservative government has sought to create a perception of an NHS failing in relation to European healthcare systems in order to justify plans for a radical restructuring largely concealed from the electorate in 2010. There is a legitimate debate about whether developing the role of the market in healthcare can improve quality and efficiency, the consensus among health policy analysts being that appropriate regulation is necessary. The NHS bill does not represent this. Initially attracted by the promise of increased power, the Royal College of General Practitioners under Clare Gerada has been clearer sighted about its implications and has begun to recognise a “poisoned chalice”. The BMA’s response has followed a similar pattern.

6. Much of the comment on the Bill has focussed on the consequences of price competition and “any willing provider” as well as whether structural change can be delivered during a real terms fall in health spending. The point I would like to highlight is the potential consequence of making GPs explicitly responsible for the budget and hence for rationing. Rather than “freeing GPs to chose the best treatment for their patients” as Andrew Lansley has disingenuously claimed, tensions between their role as both advocate and allocator will increase. The explicit nature of this is likely to undermine the trust that has enabled the public to continue to see their GP as acting largely in their interest and potentially has a number of consequences. Patients will be more likely to challenge clinical decisions and the demand for diagnostic procedures, referral to secondary care and interventions will increase. Together with the extension of the market these pressures are likely to drive the development of co-payments, the expansion of private health insurance and the development of a multi-tiered service. Soon we will find ourselves having moved from a system that has limited overall costs while delivering provision perceived as largely acceptable and equitable by the public, to a system similar to that in the United States, widely recognised as the most expensive, least efficient and least equitable in the developed world. The British public have a strong sense of fairness particularly with regard to healthcare provision, these changes together with the geographical inequalities likely to result from different priorities set by GP consortia as well as the removal of NICE’s role in approving funding for new treatments are likely to be politically unacceptable.

7. Rather than a precipitate and uncertain restructuring, I believe policymakers should seek considered development in health policy that seeks to build on the real gains made under Labour and seeks public approval as well as genuine consultation with professional groups. The goal of the current government seems to be to push through ideologically driven reform which once enacted will be near impossible to reverse seemingly with little thought for the political consequences. I strongly believe that rather than negotiating minor adjustments to the Health and Social Care bill, it should be opposed in its entirety and health policy rethought from an early stage. I strongly urge the committee to consider the national rather than party political interests when scrutinising this bill.

March 2011

Memorandum submitted by The Institute of Healthcare Management (HS 138)

EXECUTIVE SUMMARY

(i) The Institute of Healthcare Management (IHM) is the professional organisation for managers in health and social care in the UK. (1.1)

(ii) Most of our members (59.1%) are employed within the NHS and work in primary and secondary care. Our primary care members work in GP practices and commissioning. (1.2)

The Institute’s response

(iii) We believe the proposals should result in greater clarity in the commissioner/provider relationship but that the evidence base for the changes and their benefits should be published. (4.4)

(iv) We also believe that whatever the strengths of the proposals, they are unlikely to deliver all the intended benefits without critical concerns being addressed. (4.6)

(v) We are also very concerned about the NHS’ capability to deliver the changes and against the planned timetable. The changes are in themselves radical and wide-ranging, while cutbacks are disorientating and only add to the challenges that managers will face. (4.7)
(vi) Whatever the final shape of the changes, it is vital that managers are involved on the NHS Commissioning Board and its regional offices. How arrangements are run in practice is as important a success factor as organisational and procedural structures. (4.8)

(vii) The changes will require a paradigm shift in the underlying culture of the NHS, particularly if existing NHS staff provide the support to the consortia. (4.9)

(viii) We strongly advise that regulation is not a substitute for professional or managerial judgment (4.13) and that it is important that the Monitor’s and the Care Quality Commission’s functions concentrate on outcomes, as well as inputs and cost, and emphasise continuous improvement. (4.18)

(ix) We believe that more work needs to be done around the role of Monitor and the CQC to take into account, as appropriate, the following principles:
   — Regulation should not be reliant on targets, particularly national targets.
   — Care needs to be taken that the application of competition law does not militate against commissioners developing integrated care pathways.
   — That external regulation can never replace internal leadership and assessment of performance.
   — That Monitor’s remit as an economic regulator should be comprised of limited, clearly set out duties and that Government should be realistic about the number of objectives that pricing signals will deliver.
   — That price competition alone will not drive up standards, particularly in areas not covered by the National Tariff, and risks creating barriers to effective working with a range of partners.
   — That tariffs have to be continually adjusted and refined without increasing the likelihood of “gaming” and allow more risk and gain sharing.
   — The regulatory approach should be risk-based and built on a principles-based approach.
   — There should be further efforts to improve the delivery timely and accurate information across the NHS.
   — The regulators need to carry out their functions without interference.
   — Clarity is needed around the statutory remit of each of the regulators to enable them to work successfully. (4.19)

(x) We believe that data flows between commissioners and providers will need to be better than now for the reforms to be effective, tariffs to be robust and for the changes to deliver benefits for patients. (4.20)

(xi) The proposed changes will mean that leadership at all levels will be vital and that many managers will need additional or enhanced skills to work in the new environment. (4.23)

(xii) The NHS is multi-disciplinary. Managers have to be acknowledged as belonging to a discipline that is critical to a modern healthcare system (4.28) and it is perhaps the time to redefine the term “manager” and move away from the clinical/managerial divide that has bedevilled discussions internally and externally. (4.29)

(xiii) A market approach needs to be applied with caution. Organisations will almost certainly want to seek flexibility in terms and conditions as a result of price pressures. This carries the danger that competition may disadvantage organisations and/or geographies, leading to fragmentation and local skill and resource shortages in a national service. (4.30)

(xiv) The IHM will support other organisations in resisting any attempt to fragment the national control and application of clinical and social care standards of education, training and continuing professional development. (4.31)

Going forward

(xv) The IHM recognises that its position is an interim one. The detail of the implementation plans will inevitably create other issues on which the Committee and the Government will no doubt be seeking—and we will be happy to give—our views. (5.1)

(xvi) We will be more than happy to work with Government to help implement whatever changes emerge from this process successfully and for the benefit of users. (5.2)

1. The IHM

1.1 The Institute of Healthcare Management (IHM) is the professional organisation for managers in health and social care in the UK with 3,923 members.268

1.2 Most of our members (59.1%) are employed within the NHS and work in primary and secondary care. Our primary care members work in GP practices and commissioning.

268 Membership as at 22 March 2011.
1.3 The remainder of our members are drawn from across social care, independent providers, health and social care consultants and the Armed Forces, crossing the clinical/managerial and commissioner/provider boundaries. We are therefore well-placed to comment on the impact and challenges arising from the Bill’s proposals.

1.4 Our focus is improving patient/user care wherever and whenever they need it. We believe that a critical route to this is through the promotion of excellence in healthcare management. We achieve this by publishing standards of management practice, the Management Code (behavioural and ethical aspects of management practice), our Accredited Manager Scheme and Professional and Educational Development framework.

1.5 Managers are vital to the current delivery of care and will play a vital role in delivering the changes. Our members specifically will do so with integrity, honesty and openness, probity, accountability and respect in line with our Management Code and with the benefit of patients as their ultimate goal.

1.6 Ultimately, with their families and children, our members are also taxpayers and users of and stakeholders in the NHS and its services. They also want to see effective services delivered cost-effectively.

2. The background

2.1 The Health and Social Care Bill was introduced on 19 January 2011 to give effect to the Government’s aims of putting patients first, focussing on continuous improvement and empower clinicians to innovate.

2.2 Through the provisions of the Bill, the Government intends to:
   — Establish an independent NHS Commissioning Board.
   — Increase GPs’ powers to commission services on behalf of their patients.
   — Strengthen the role of the Care Quality Commission.
   — Develop Monitor into an economic regulator for the NHS.
   — Cut the number of health bodies to reduce NHS administration costs.
   — Extend the role of Monitor to the provision of adult social care.

3. The context

3.1 The challenge for the NHS is putting in place the leadership and management capability to deliver £20 billion in efficiency savings by 2014–15 while implementing these radical changes.

3.2 The nature of Monitor’s new role will also be critical. The White Paper that preceded the Bill clearly set out that, like other regulators, Monitor should have “ex ante” powers to protect essential services and help open the NHS up to competition and be able to take “ex post” enforcement action.

3.3 The Bill adds Monitor to the Competition Act 1998 and the Enterprise Act 2002. It sets out its primary duties, including the promotion of competition and the economic, efficient and effective provision of health and adult social care and desirability of securing continuous improvement. It also sets out proposals for Monitor’s oversight of national tariffs and the possibilities of local modifications. In all cases, the mechanisms remain unclear.

3.4 The BMA believes that competition, alongside rising costs (eg treatments, an ageing population, technology) and reform will be disastrous. It remains unconvinced that competition will bring benefits for patients. The King’s Fund has expressed support for increased competition where it benefits patients, although it sees the Bill as promoting competition at the expense of collaboration and integration of services.

3.5 The NHS Confederation sees quick adjustments in prices as a major drive in successful markets and that the lessons of Payment by Results suggest that:
   — There is a limit to the number of objectives it is possible to pursue through pricing signals and tariffs have to be continually adjusted and refined.
   — Tariffs have to send clear signals to providers about what they need to do and be sufficiently high powered to make it worth responding but not so high powered as to create ‘gaming’ or other distortions.
   — Item of service tariffs are very effective if the objective is to increase the quantity of what is produced. New forms of tariff will be needed to allow more risk/gain sharing between commissioners and providers.

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Notes:

269 The IHM Management Code.
270 Health and Social Care Bill (HSCB), Bill 132 2010–11.
271 Equity and Excellence: Liberating the NHS, paragraph 4.28.
272 HSCB, Chap 2 Sections 52 and 53.
273 HSCB, Chap 2 Sections 103–104 and 110–111.
274 BMA written evidence to the Public Bill Committee, 11 February 2011.
275 King’s Fund Briefing on the Health and Social Care Bill.
276 Liberating the NHS. What might happen?, NHS Confederation 2011.
4. The Institute’s response

4.1 The IHM response covers the scope and speed of the changes, the role of sector regulation and the role of workforce regulation.

The scope and speed of the changes

4.2 Taken as a whole, the proposals represent the most sweeping changes to health and social care in England since the creation of the NHS.

4.3 They will increase the level of commercialisation across health and social care and create a market in which health commissioners will have greater freedom to provide services through any qualified provider.

4.4 We believe the proposals should result in greater clarity in the commissioner/provider relationship but that the evidence base for the changes and their benefits should be published. The SHAs and PCTs increased the complexity of accountability and budgetary control without always bringing benefits for patients or operational efficiency.

4.5 On the other hand, the creation of GP-led commissioning consortia alongside GP practices and GP-led provider consortia has the potential to ‘muddy waters’ and blur roles and accountabilities.

4.6 We also believe that whatever the strengths of the proposals, they are unlikely to deliver all the intended benefits without critical concerns being addressed:

— The need for Government to lay out in advance what it considers to the correct measures of success of the reforms.
— Doubts that the commissioning consortia will have all the skills and capability required to operate the new arrangements effectively.
— Any rigidity in National Tariffs will reduce the ability of providers to respond to the needs of commissioners in terms of cost.
— The need to emphasise outcomes and not inputs in the contracts between commissioners and providers.

4.7 We are also very concerned about the NHS’ capability to deliver the changes and against the planned timetable. The changes are in themselves radical and wide-ranging, while cutbacks are disorientating and only add to the challenges that managers will face. The cost reductions required in the first year alone are greater than the NHS has ever delivered but savings are needed over four consecutive years.

4.8 Whatever the final shape of the changes, it is vital that managers are involved in the NHS Commissioning Board and its regional offices. How arrangements are run in practice is as important a success factor as organisational and procedural structures.

4.9 The changes will require a paradigm shift in the underlying culture of the NHS, particularly if existing NHS staff provide the support to the consortia.

The role of sector regulation

4.10 As NHS services start to be delivered by a wider range of commissioners and providers, an effective regulatory regime becomes even more important.

4.11 The proposal for Monitor to become an economic regulator has attracted direct analogies with others. Indeed, the Secretary of State has confirmed that it will have “concurrent powers” with existing regulators.277

4.12 The King’s Fund has pointed out that the approach set out in the Bill places a heavy onus on Monitor as the economic regulator to oversee a step change in competition in the healthcare market. It sees the outcome as dependent on how Monitor interprets its duties and invokes its powers.278

4.13 We strongly advise that regulation is not a substitute for professional or managerial judgment. A tick box approach, reliant upon process and not outcomes, does not guarantee quality. W Edwards Deming saw a need to “...cease dependence on inspection to achieve quality ... by building quality into the product in the first place”.

4.14 There have been high profile examples of failures in inspection regimes. These include the failures in the Mid Staffordshire NHS Foundation Trust, where the inquiry report highlighted:

— The high priority placed on the achievement of targets, creating a fear that failure to meet targets could lead to the sack.279

— Evidence indicating that the Trust was more willing to rely on favourable external assessments of its performance than internal assessment.280

277 Evidence to the Health Select Committee 22 March 2011.
278 King’s Fund Briefing.
279 The Independent Inquiry into the care provided by Mid Staffordshire NHS Foundation Trust. HC375–1, February 2010, p 16.
280 Ibid. P 16.
— Independent scrutiny would help restore confidence in searching for and explanation of why appalling standards of care were not picked up.\textsuperscript{281}

4.15 The report by Lord Laming into the case of “Baby P” also identified key issues that needed consideration:
— There remained significant problems in the day-to-day reality of working across organisational boundaries and cultures.\textsuperscript{282}
— Effective leadership sets the direction of an organisation, its culture and values, and ultimately drives the quality and effectiveness of services.\textsuperscript{283}
— Performance indicators were inadequate. They focussed on processes and timescales and their impact on positive outcomes was unclear.\textsuperscript{284}

4.16 The range of regulators includes the utilities, postal services, aviation, financial services, pensions, fair trading and competition. The regimes are, however, linked by the duty to further and protect the interests of consumers.

4.17 The House of Lords Select Committee on Regulators reported on the regulatory process in November 2007.\textsuperscript{285} Many of its findings relate to specific sectors and their regulatory bodies but a number dealt with principles that the Committee believed were more widely applicable:
— Independent regulators’ statutory remits should be comprised of limited, clearly set out duties.\textsuperscript{286}
— Regulators should consider risk-based regulation more explicitly, particularly as a means of using resources more effectively.\textsuperscript{287}
— Regulators should consider the scope for replacing detailed rules by a move to a principles-based approach.\textsuperscript{288}
— Regulated industries need to recognise the need for regulators to receive timely and accurate information on their activities.\textsuperscript{289}
— A mechanism is needed for resolving potential policy conflicts so that regulators can carry out their function without interference.\textsuperscript{290}
— Clarity is needed around the statutory remit of a regulator to enable it to work successfully.\textsuperscript{291}

4.18 It is therefore important that Monitor’s and the Care Quality Commission’s functions concentrate on outcomes, as well as inputs and cost, and emphasise continuous improvement. Providers should be able to deliver services of an acceptable quality within the limits of a National Tariff without an over-specification of how they deliver them.

4.19 We believe that more work needs to be done around the role of Monitor and the CQC to take into account, as appropriate, the following principles:
— Regulation should not be reliant on targets, particularly national targets.
— Care needs to be taken that the application of competition law does not militate against commissioners developing integrated care pathways.
— That external regulation can never replace internal leadership and assessment of performance.
— That Monitor’s remit as an economic regulator should be comprised of limited, clearly set out duties and that Government should be realistic about the number of objectives that pricing signals will deliver.
— That price competition alone will not drive up standards, particularly in areas not covered by the National Tariff, and risks creating barriers to effective working with a range of partners.
— That tariffs have to be continually adjusted and refined without increasing the likelihood of “gaming” and allow more risk and gain sharing.
— The regulatory approach should be risk-based and built on a principles-based approach.
— There should be further efforts to improve the delivery timely and accurate information across the NHS.
— The regulators need to carry out their functions without interference.

\textsuperscript{281} Ibid. P 24.
\textsuperscript{283} Ibid. P 14.
\textsuperscript{284} Ibid. P 15.
\textsuperscript{286} Ibid. Para 3.13.
\textsuperscript{287} Ibid. Para 4.36.
\textsuperscript{288} Ibid. Para 4.45.
\textsuperscript{289} Ibid. Para 5.23.
\textsuperscript{290} Ibid. Para 5.59.
\textsuperscript{291} Ibid. Paras 3.4 and 3.6.
Clarity is needed around the statutory remit of each of the regulators to enable them to work successfully.

4.20 We believe that data flows between commissioners and providers will need to be better than now for the reforms to be effective, tariffs to be robust and for the changes to deliver benefits for patients. The issue of data quality has already been identified by the Audit Commission.\(^{292}\) It has identified HRG error rates of between 0% and 28%\(^ {293}\) (a quarter of trusts averaging 12%)\(^ {294}\) and clinical coding errors at an average of 11.3% in 2009–10.\(^ {295}\) It also saw scope for commissioners improving their contract management and monitoring arrangements.\(^ {296}\)

4.21 It has also demonstrated that the quality of submissions underpinning PbR tariffs was variable. Basic quality checks on the data were often lacking and the quality of reference cost submissions needed to improve.\(^ {297}\) All these issues are about quality but we are aware that, in many Trusts, timeliness is also a critical issue.

The role of workforce regulation

4.22 The scale and speed of the changes and the potential for fresh regulatory approaches will have a significant impact on the workforce.

4.23 The proposed changes will mean that leadership at all levels will be vital and that many managers will need additional or enhanced skills to work in the new environment. The shape of the consortia is still unclear and the Institute of Commissioning Professionals sees the current challenge as determining what good leadership of a consortium will look like.\(^ {298}\)

4.24 Even before the Bill, a survey for Skills for Health had identified that directors and managers saw re-skilling, training and staff development as the most pressing concern for health workforce managers, ahead of budget cuts or maintaining service quality during organisational change.\(^ {299}\)

4.25 The survey also identified which workforce development solutions and support could best help them over the next year. Responses included:

— Greater availability of standardised training for emerging roles.
— Cost-effective tools and guidance to support workforce transformation.
— Training and advice to help managers deal with organisational change.

4.26 The emphasis on standardised training chimes with the BMA’s concerns that “... appropriate national oversight of key issues such as education, training and workforce”\(^ {300}\) is needed to reinforce what it sees as the founding principles of a national service delivered in a “... cooperative and coordinated environment...”\(^ {301}\) The Royal College of GPs, more supportive of the aims of the Bill as a whole, has doubts around the destabilisation of the NHS.\(^ {302}\)

4.27 Clearly these concerns are in the context of the education and training of clinicians. For managers the position is slightly different. A range of bodies delivers training and accreditation across various disciplines. We believe that these provide national, sometimes international standards. The IHM provides the health and social care-specific training and accreditation expertise.

4.28 The fact remains that the NHS is multi-disciplinary. Managers have to be acknowledged as belonging to a discipline that is crucial to a modern healthcare system. Similarly, back office functions, eg ICT, booking systems, medical records and bed management, provide vital support to frontline staff without which services would simply not be delivered.

4.29 It is perhaps the time to redefine the term “manager” and move away from the clinical/managerial divide that has bedevilled discussions internally and externally. The current proposals will put clinical staff into clear leadership roles but managers will also need to lead to implement the changes successfully.

4.30 A market approach needs to be applied with caution. Organisations will almost certainly want to seek flexibility in terms and conditions as a result of price pressures. This carries the danger that competition may disadvantage organisations and/or geographies, leading to fragmentation and local skill and resource shortages in a national service.

4.31 The IHM will support others in resisting any attempt to fragment the national control and application of clinical and social care standards of education, training and continuing professional development.

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\(^{293}\) Ibid. P 7.

\(^{294}\) Ibid. P 8.

\(^{295}\) Ibid. P 9.

\(^{296}\) Ibid. P 5.

\(^{297}\) Audit Commission. P 5.

\(^{298}\) Commissioning Leadership, Doug Forbes, Institute of Commissioning Professionals, 2011.

\(^{299}\) Survey of 400 health sector directors and senior managers, Skills for health, January 2011.

\(^{300}\) BMA written evidence to the Public Bill Committee, 11 February 2011.

\(^{301}\) Ibid.

\(^{302}\) Response to the Health and Social Care Bill, Dr Claire Gerada RCGP, 19 January 2011.
5. Going forward

5.1 The IHM recognises that its position is an interim one. The detail of the implementation plans will inevitably create other issues on which the Committee and the Government will no doubt be seeking—and we will be happy to give—our views.

5.2 We will be more than happy to work with Government to help implement whatever changes emerge from this process successfully and for the benefit of users.

March 2011

Memorandum submitted by Changing Faces (HS 139)

1. Introduction

Changing Faces is the leading UK charity that supports and represents people who have disfigurements to the face, hand or body from any cause. A “disfiguring” term is the generic term for the aesthetic effect or visual impact of a scar, burn, mark, asymmetric or unusually shaped feature or texture of the skin on the face, hands or body. It is estimated that 542,000 (one in 111) people in the UK have a significant disfigurement to the face and approximately 1,345,000 (one in 44) people to their face and body. “Significant” is taken to mean “psychologically and socially significant”.

Changing Faces advocates for better access to and better quality of psychosocial and mental health care for people with visible differences as a result of an accident or illness, or from birth. People with disfigurements are significantly more likely than people without disfigurements to develop mental health problems, a problem that is currently not fully reflected in national and local health budgets. In addition, the necessary cross-specialty commissioning requires understanding and awareness of the specific psychosocial needs of people with disfigurements which we know is not always the case. ‘Severe disfigurement’ is included in the Equality Act 2010 and thus comes within the remit of the Equality Duty.

We urge politicians, health professionals, commissioners and policy makers to recognise and address the psychological and social (psychosocial) impact of having a disfiguring condition. It is their responsibility to (re)develop appropriate services to prevent and/or treat psychosocial problems if they occur. Psychosocial services, if provided during physical treatment as part of the care pathway, result in significantly better patient outcomes and patient satisfaction. We strongly support the development and extension of multi-agency partnerships as mental health problems are frequently associated with wider social problems, either as cause or effect. Multi-agency partnerships are therefore vital. We stress the importance of partnerships with the social care sector as well as with the employment and education sectors.

2. Summary of Our Response to the Health and Social Care Bill

Changing Faces is very concerned with the lack of evidence for the need for reform of the NHS in general and the lack of convincing evidence on whether and how marketisation is going to improve patient care. We think that a strong focus on price is a very risky approach which may jeopardise the potential positive effects of the Bill on patient experience. In addition, we are worried about the combination of cuts and reforms, which we believe needs to be dealt with more transparently.

We welcome the vision of the Bill to strengthen evidence based commissioning and decision making led by clinicians, the strong focus on improving information, and a patient centred approach which is guided by patient experience and health outcomes. As a charity, we are however concerned that GPs need a lot of support in commissioning mental health services; PCTs’ mental health commissioners have developed knowledge and expertise that must be passed on to GPs so there needs to be a clear strategy on how to realise this. Changing Faces welcomes the strategy as set out by the Department of Health but is afraid that lack of emphasis on mental health prevention will negatively affect patients with disfigurements in the transition stage. The GPs we work with report to have limited specialist knowledge on mental health and are concerned that this will negatively affect the care for patients with disfigurements who have psychosocial needs.

We are very aware that mental health does not currently benefit from the same degree of public consideration as other health issues and we fear that GPs will not be able to prioritise the commissioning of psychological therapy services, when other services are considered more popular. We think that the Improving Access to Psychological Therapy Services (IAPT) for people with long term conditions may improve access to services for people with disfigurements, however there needs to be an understanding of how a changed appearance can adversely affect normal day to day living, as this can form the basis of people’s psychosocial issues. Our client group currently reports that understanding is poor amongst the majority of health and social care professionals.

For our client group, integrating physical and mental health care is of utmost importance, as many people with visible differences suffer from functional impairments, accompanied by pain, itch and other side effects of treatments and health conditions. We see the Bill as an opportunity to improve the integration of care, which is currently highlighted by the health professionals we frequently work with as a serious weakness in specialties such as Ophthalmology, Dermatology, Oncology and Plastic Surgery services. The majority of the people supported by Changing Faces report that their psychological and social needs are currently not
fully met and that health and social care professionals lack understanding of the difficulties of living with a disfigurement. It is for this reason that we think people with disfigurements are at particular risk of losing out as any reform comes with the risk of threatening continuity and quality of services.

There are some good practice examples in cleft lip and palate care where all members of the multi-disciplinary team have a shared responsibility to recognise and respond to psycho-social needs of patients and parents. In burns care, quality standards based on NICE guidance include protocols and guidelines on psychosocial care, acknowledging its crucial importance in ensuring quality of life of patients.

Based on anecdotal and academic evidence from health and social care professionals we advocate for mainstream commissioning of mental health services and reduce the number of cases referred to the independent board. We are concerned about the potential lack of transparency of the Commissioning Board and consortia’s decision making and believe that meetings need to be open to the public and patients need to be involved in decision making at all levels (personal, operational and strategic). From consultation with health professionals, we understand that there is a strong likelihood that access to services will vary depending on where people live; a lack of consistency of care that Changing Faces is alarmed about.

We urge the Public Bill Committee to consider our evidence and concerns and create a Bill that supports the reduction of the health inequalities of over one million people with disfigurements in the UK. A reduction of the incidence of mental health issues in this population will contribute to improved social participation and cost savings in all other area’s of life.

*March 2011*