

HOUSE OF COMMONS

ORAL EVIDENCE

TAKEN BEFORE THE

HEALTH COMMITTEE

**MANAGEMENT OF LONG-TERM CONDITIONS**

TUESDAY 29 OCTOBER 2013

DR PETER FISHER and PROFESSOR GEORGE LEWITH

PROFESSOR NIGEL MATHERS, ALASTAIR BUXTON, EMILY HOLZHAUSEN and  
VICTORIA MATTHEWS

Evidence heard in Public

Questions 149 - 230

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## Oral Evidence

Taken before the Health Committee

on Tuesday 29 October 2013

Members present:

Mr Stephen Dorrell (Chair)

Andrew George

Barbara Keeley

Charlotte Leslie

Grahame M. Morris

Andrew Percy

Mr Virendra Sharma

David Tredinnick

Valerie Vaz

Dr Sarah Wollaston

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**Examination of Witnesses**

*Witnesses:* **Dr Peter Fisher**, Clinical Director and Director of Research, Royal London Hospital for Integrated Medicine, and **Professor George Lewith**, Professor of Health Research, University of Southampton, gave evidence.

**Q149 Chair:** Gentlemen, thank you very much for joining us this afternoon. As you know, this is an inquiry we are doing into services for people with long-term conditions. We are looking forward to the evidence you are going to present to us about the role that can be played by integrated medicine in this process. Could I ask first that you briefly introduce yourselves, please?

**Professor Lewith:** I am George Lewith. I am a professor of health research at the university of Southampton in the primary care department. I have done quite a lot of research in this area. We have a unit dedicated to looking at integrated medicine in primary care.

**Dr Fisher:** I am Dr Peter Fisher. I am clinical director of the Royal London Hospital for Integrated Medicine, which is part of the University College London Hospitals NHS Foundation Trust. I am a doctor, a consultant physician, I practise homeopathy and I am also a physician to Her Majesty the Queen.

**Q150 Chair:** Thank you. To get the session started, could I ask first of all purely a question of semantics? There is confusion caused these days, I think, by the phrase “integrated medicine”. Does it apply to what used to be called complementary and alternative therapies or does it apply to service reorganisations? I wonder if, from your perspective, you have any thoughts on the semantics of it. More importantly, I would like to go straight into the question of the evidence base for integrated medicine, how substantive that is and how that is pursued through peer assessment, peer review and made available to your professional clinical colleagues.

**Dr Fisher:** Yes, I accept there is some scope for confusion about the term “integrated—or, as the Americans say, “integrative—“medicine” in that very frequently it is used to mean integration between primary and secondary care and integration between

primary care and social care, whereas we are tending to use it more in the sense of integrating various forms of complementary medicine. What is useful is the concept, which I believe you can find in the Department of Health's submission—it mentions Kaiser Permanente in the States—of horizontal and vertical integration, vertical integration meaning between secondary and primary care and horizontal meaning across secondary care. We certainly do both of those in our hospitals. For instance, we have a good collaboration with our cancer care colleagues. But, for instance, in the area of insomnia—and this is an extremely prevalent problem for which good treatments do not exist actually—we integrate, so we have a specialist care unit within our hospital and, increasingly, we are implementing vertical integration with primary care. There are some problems with the contracting situation which inhibit that, where we would like to get on with it but are facing bureaucratic obstacles.

As to the evidence base, there is evidence for many things in complementary medicine. Perhaps the strongest and most important single piece of evidence is acupuncture in pain. George is better qualified to talk about that than me and I am sure will do so later. But there are a number of other areas where there is useful and good evidence. Insomnia, as I just mentioned, is an extremely prevalent problem. There are several people in this room who suffer from it, without doubt; 25% or 30% of the population suffer from it at any one time and the GPs do not know what to do with it. We opened our service and immediately got swamped. We got into trouble with our trust: “Why are you breaching the 18-week rule?” The answer was that we were not expecting quite such a tidal wave of referrals. There is evidence where CBT—that is, cognitive behaviour therapy—for insomnia works well. It is a drug-free alternative, and one of the things I will return to later is the question of polypharmacy: that is, too many drugs are being used and we need safe, effective non-drug alternatives.

*Professor Lewith:* The issue of evidence is complex. If we look at the whole NHS from the perspective of a GP, which I am—although I retired, it kind of gets into your bones, as anybody who is a GP will tell you, and it is difficult to lose it—there is not a lot of evidence for many of the things we do in day-to-day practice. Having said that, in my 30 years of doing research in this area, it has been very difficult to get funds, so there is a scarcity of money available in spite of the fact that I worked with a House of Lords Committee in 2000 to create PhD and postdoctoral fellowships through the Department of Health and we were able to secure quite a few of those in Southampton. We have more evidence than we did 20 years ago but we do not have enough evidence in some areas and in others we have none.

The evidence in terms of specific therapies is very powerful for acupuncture, pretty powerful for some of the mindfulness meditation approaches and reasonably powerful for some of the herbal medicines. The evidence is probably non-existent in areas such as reflexology and aromatherapy and patchy in others, such as healing. So there are various levels of information that we have from rigorous randomised placebo-controlled trials. The current NIH policy of increasingly looking at pragmatic studies that inform clinical decision making at the bedside or in the consultation is a very powerful way to look at complex interventions such as complementary medicine because they are all complex; they involve a lot—certainly an enhanced element—of placebo and non-specific components along with, probably, some specific effects. That is the evidence that is emerging. They are quite difficult to investigate and evaluate. The most powerful treatment that most GPs have at their disposal in many chronic long-term conditions is the contextual effects of seeing the doctor. One of the ways we might develop evidence is to learn from the complementary therapies about what they do so effectively and reproduce it in conventional medicine.

If we take a more anthropological statement about what this means contextually in terms of our society—why is it that 15% of the population each year look at CAM, and that figure rises dramatically, sometimes up to 90% in chronic and long-term conditions—then we

get a different kind of evidence. We get powerful evidence that says that many people use complementary medicine to empower and enable themselves to self-manage, from cancer through to complex, difficult-to-diagnose-and-treat conditions like fibromyalgia and many of the long-term conditions like arthritis and diabetes. In all these chronic conditions, without fail, we get very high use of CAM. If you ask the patients why they are using CAM, they talk about different kinds of consultations, consultation environments and empowerment processes and that is something that we really need to take notice of if our new NHS is genuinely—and I say that advisedly—to take on the process of having the patients at the centre of it because that has been a long-term political promise that has not always been fulfilled.

**Q151 Chair:** The core question—then I am going to pass it to Andrew—is whether the assessment of evidence of what you referred to as CAMs is different—

**Professor Lewith:** No.

**Q152 Chair:**—or whether you are content for the treatments to be tested by randomised placebo-controlled trials like any other form of intervention in healthcare.

**Professor Lewith:** I am a professor in a conventional department of general practice that last year came third for quality in its RA in the UK. I would not survive a minute if I did not think that the multiplicity of research methodology that we have available to us is not adequate. The issue is how you pose the question. It is about how you design the question, the kind of questions that you ask—not about the research methodology—and whether the questions are valid from the patient’s perspective about complementary medicine. Very often, the double-blind randomised controlled trial with a placebo is impossible to construct from a patient’s perspective in terms of a CAM intervention because a CAM intervention is too complex and multifaceted to do that—we need different kinds of studies—but they are certainly *BMJ*-publishable studies.

**Dr Fisher:** If I may add one thing to that, there are issues—essentially, I agree with George—around the interpretation of studies. For instance, it is a sore point with the acupuncturists that NICE refuses to recognise acupuncture for, say, osteoarthritis of the knees. There are two different ways of controlling it. You can either compare it with normal treatment or you can compare it with sham acupuncture, which essentially means bad acupuncture where you put the needles in the wrong points and superficially. The problem is that that is an active placebo and the trials show that it does have more effect than nothing at all but less effect than real acupuncture. But, of course, from the patient’s perspective the choice is not between having real acupuncture and bad acupuncture. Hopefully, they are going to get either good acupuncture or nothing. That is the real choice. NICE refuses to see it that way because it does not recognise that sham acupuncture is actually an active intervention. So there are issues around the interpretation of the results if you apply a very simple drug kind of model.

**Professor Lewith:** We can get into a very complex argument about—

**Chair:** I am fully aware of that and am also conscious that—and I should have made it clear at the beginning—we have a vote at 4.30 and another panel of witnesses so we are needing to move reasonably briskly. Can I go to Andrew and then to Sarah?

**Q153 Andrew Percy:** Thank you. We are all interested in the evidence on the effectiveness of alternative medicine, particularly those of us like me who have no medical background. I have family members who have used alternative treatments and they seem to think they have worked and others who have not had that success. So I am wondering, in terms of this evidence of the effectiveness, what is the actual approach with alternative

therapies? Is it about managing the pain and discomfort or is it about dealing with the underlying pathology?

**Professor Lewith:** It is both. If we take the example of acupuncture, which is the best researched because it has had the most money spent on it—which I started writing about, in methodological terms, 30 years ago—it takes away the pain. There is good evidence that good acupuncture will take away pain in a variety of different conditions. If you start moving an osteoarthritic knee because it is less painful, you will get repair and reconstruction. So conditions which you may think are chronic are probably remediable to movement. If you have a positive consultation environment, an encouraging process, a treatment that is pretty safe compared to non-steroidals—the anti-inflammatories you buy over the counter which kill 2,000 people a year in this country—and you have a process of encouragement happening with diminished pain, you will get some degree of actual repair and you will get an improvement in quality of life. The choices for a GP are, “Do we refer to an acupuncturist? Do we refer to physiotherapy? Do we give the patient some non-steroidals? Do we encourage them to take exercise?” And how effective is that from a GP without enough support?

**Q154 Andrew Percy:** If there is no addressing of the pathology, what is the benefit of the alternative therapy?

**Professor Lewith:** You and I, if we are lucky—or unlucky—will probably live to about 90. I am pretty good on going to 80 but I am not sure about 85 to 90. You and I will develop a series of chronic long-term conditions which will be incurable, with probably a 50% chance that one will be a cancer which we will not die of; we will have to live with it and we will die with it. That is the human condition. We have hospitals that are designed to cure specific conditions and they are full of old people with multimorbidity on polypharmacy.

**Dr Fisher:** This does raise a very big philosophical issue, which in homeopathy specifically we call constitutional treatment, which can be summarised as treating the person not the disease, and our hospital has a very positive feedback. If you look at the feedback, broadly speaking it divides into two things. One is, “They were so nice to me. They treated me as a whole person and they thought not just of my knee”—or my cancer or whatever—“but me as a whole person.” The other thing is that it worked; it relieved the symptoms when other things did not. If you look at the history of medicine, there is probably no time in the entire history of medicine when this idea of treating people rather than diseases has been as eclipsed as it is now. In just about any other time or indeed any other place in medicine the idea was of treating people as a whole, not saying, “Okay, this is a disease. I am a specialist in that, so you have to go and see somebody else for this disease,” which of course results in polypharmacy, with different pills for different ills. Multimorbidity poses a huge challenge to this one-disease framework, which has become a victim of its own success as it has almost eliminated large areas of disease. But now we are left with a large residue of interlinked, complex, multiple diseases where you need to treat the person, not the disease.

**Professor Lewith:** Can I add something? You will dismiss this contextual process as not very powerful. We recently completed a study looking just at the homeopathic consultation and, in terms of quality of life and standard rheumatological measures, in a double-blind randomised controlled trial, the effect of delivering that consultation is as powerful as a new biological—one of the new TNF-alphas, which cost a huge amount of money and deliver “cure”, supposedly, to rheumatoid arthritis. So we consistently underestimate the contextual effects while the patients and the clinical trials are continually telling us that the contextual effects are powerful, long-lasting and result in lifestyle change and self-help. Those are the things that we need for long-term comorbidity, polypharmacy and self-management.

**Q155 Andrew Percy:** It sounds to me, particularly on homeopathy, which is the one I would be most sceptical about, as if you are saying that simply sitting down and talking to somebody who has rheumatoid arthritis and making them feel better about themselves has an effect. Physiologically, delivering a homeopathic remedy does nothing to them, does it?

**Professor Lewith:** That is a long debate, but I am talking about the context and there is evidence for and against homeopathy that we can come to later. If I take a whole pile of people in a general practice and consult negatively with them around sore throats and say, “Why are you bothering me with a sore throat? Haven’t you read what it says in our instructions? Just go away and look after your sore throat,” or if I say, “Look, I am really sorry, you have a very bad sore throat. Do come back to me in five days if it is not better,” what difference do you think that different process makes in the symptoms that they present with over the next two weeks?

**Dr Fisher:** If I can comment on that as a homeopath and rheumatologist, somebody who has at times earned a living doing conventional rheumatology, I do homeopathy on patients with rheumatoid arthritis all the time and I would not do it for two minutes if I thought it was purely placebo. I have absolutely no qualms about maximising the non-specific effects of my consultation, but I do not think it is true that homeopathic medicines have no genuine real physiological effect.

**Professor Lewith:** To finish my point, you will halve the time they will get symptoms if you are nice to them. It is really simple. This is actually quite important because if you halved the time that people had flu, you would halve the time off work. So being nice to people and approaching them as whole people has a big effect on their symptoms. It is not woo-woo; it is not nuts. There are huge volumes of clinical trial evidence that tell you that.

**Q156 Andrew Percy:** But that could be delivered within regular medicine.

**Professor Lewith:** It could be delivered within regular medicine. That is exactly what we are trying to say. I specifically said that we need to learn the lessons from complementary medicine and deliver them better conventionally, but you are not going to get GPs who are working 14 hours a day within the current health system, and who are all pretty disillusioned, to have increased compassion. We need to find a solution to the management problems that have been created in primary care and the staff shortages. But we could do it. It is quite possible to do it.

**Q157 Dr Wollaston:** Coming back to that, yes, absolutely this is about the consultation environment, the doctor as drug and the lesson that conventional medicine has to learn from those approaches.

**Professor Lewith:** Yes.

**Q158 Dr Wollaston:** But is there not a problem when you are delivering something for which there is no evidence beyond its effect as placebo, where there is nothing detectable remaining from it, that there is a concept that there is a memory of water, and that kind of thing—the idea that perhaps, for homeopathy, you should have a different scale of proof and that it is about pragmatic studies? Why should not homeopathic remedies be subject to the same standards of proof through a randomised double-blind placebo-controlled trial? Are you aware of any large-scale randomised double-blind placebo-controlled trials which show that homeopathy has any advantage over a placebo? I completely agree that the placebo effect is powerful, but I also understand that it is relatively short-lived. I am slightly concerned that you imply it could be a cure for rheumatoid arthritis because these are not long-term sustained benefits and there is a risk, is there not, with undermining the confidence that somebody has

in their clinician, if they are telling them that something is proven to be effective when there is no proof that it is effective beyond the placebo effect?

**Professor Lewith:** Can I take your discussion in several sections?

**Dr Wollaston:** Yes.

**Professor Lewith:** You are wrong that the placebo effect is not long term. You are simply wrong. Look at the data. Secondly—

**Q159 Dr Wollaston:** But there are people who disagree with you on that, who would say that is contentious.

**Professor Lewith:** You are welcome to disagree.

**Dr Wollaston:** I am not saying that I do. I am saying others disagree with you on that.

**Professor Lewith:** I know there are others who disagree with me on that, but that is not what the data tell us. The published meta-analyses tell us that the placebo effect can be quite long term.

**Dr Wollaston:** Can be.

**Professor Lewith:** Any treatment does not hit 100% of people. The second issue is that complementary medicine is not just homeopathy. The third issue is that we use non-evidence based treatments in primary care more than half the time in all sorts of conditions. From irritable bowel through to insomnia and childhood colic, we are continually reassuring patients that we are going to give them something, for which we have no evidence, to alleviate what often is a short-term, benign or acute condition that will self-resolve.

**Q160 Dr Wollaston:** Yes. So you are suggesting that we give something that has nothing in it that could cause harm.

**Professor Lewith:** I am not suggesting that we use homeopathy in primary care. I am not specifically talking about homeopathy and I am not going to go down the homeopathic track because I think that is a blind alley. We have had debates about homeopathy and I do not want to engage in those debates. There is a lot more to complementary medicine than homeopathy. Homeopathy is not complementary medicine. Complementary medicine, or integrated medicine, is a much broader field that encompasses some evidence-based treatments, some treatments for which we have little evidence and some treatments for which there is equivocal evidence. If you want to return specifically to homeopathy, I can give you some information and I can tell you what I feel about that as a balanced view. If you look at the 200 or so RCTs in homeopathy—and Peter will talk more knowledgeably about this than I—you will see the evidence cuts both ways, that there are some positive trials and some negative trials. Most of them are very small and many of them are very poorly done.

**Dr Wollaston:** Therefore, you cannot really—

**Professor Lewith:** Therefore, what we have is, “We do not know.” We have a situation where we do not have a clear answer because we have equal positive and negative systematic reviews which interpret the questions differently. If your statistics are really good, you will realise that the way you ask a question in a systematic review predicates the answer. There have been homeopathic reviews published by *The Lancet* that have said homeopathy has a real effect and then the same data have been taken with slightly different questions and resulted in a negative review. That to me, as a scientist, tells me we do not know. We do not have the clarity of answers that you presuppose. It is just not there. It is implausible as a treatment, but the clinical evidence from the clinical trials is equivocal and that is where we sit.

**Q161 Dr Wollaston:** Can I take you back to the point that you made at the beginning, which is that very many of these are of very poor design with very low numbers? If you have a poorly designed trial with very low numbers that cannot be statistically significant, it cannot be included as a positive study because it is clearly statistically insignificant.

**Dr Fisher:** I am sorry, but it is not true that the trials are of worse quality. When *The Lancet*, in 2005, published a comparative analysis of matched trials of homeopathy and conventional medicine, it found 21 trials of homeopathy that were of good quality versus 14 of conventional medicine. In other words, the homeopathic trials were 50% more likely to be of good quality. In certain areas, most notably perhaps upper respiratory tract infections and allergy, the evidence from meta-analyses is clear that it is clearly positive.

**Q162 Dr Wollaston:** Could you perhaps share some of those? Later on could you give the Committee a list of those ones? That would be helpful.

**Dr Fisher:** By all means, yes. There was a study commissioned for the Swiss Federal Government that found 29 studies in upper respiratory tract infections and allergy, of which 26 were positive.

The other thing about pragmatic trials is that they have shown—they have mostly been done in France and Germany—that integrating homeopathy gives better results and very often for the same or less cost with fewer drugs, even when corrected for the fact that, for instance, patients who use homeopathy tend to have healthier lifestyles, are less likely to smoke and tend to be better educated, and that is important and relevant. You can correct for those. Of course, they are not randomised in that you cannot force people to have one—they are making a choice—but when you correct for those differences you find that homeopathy gives you better results for the same cost and very often with fewer drugs. That is important.

**Q163 Dr Wollaston:** Do you feel that a lot of this is the phenomenon of the context of the consultation—

**Dr Fisher:** No, not in those—

**Dr Wollaston:**—and the effect of the clinician and how they are consulting?

**Professor Lewith:** You cannot have your cake and eat it.

**Dr Wollaston:** No, I am asking you.

**Professor Lewith:** “You cannot have your cake and eat it” is a fundamental principle of science. You cannot run a randomised controlled trial which is well blinded and controlled, have a positive result and say it is the contextual factor and not the homeopathy. On balance, as to the evidence, there is positive stuff, but if you did another meta-analysis now you would still find, like 95%—or probably 98%—of Cochrane reviews, the conclusion you would come to would be, “The evidence is equivocal. We need more research.” Some 98% of Cochrane reviews, which are the basis on which we are supposed to provide evidence-based medicine, come to that conclusion. Homeopathy would probably fall into that category if you took the emotion out of it, and there is a lot of emotion and I do not think it is worth going there.

**Chair:** Shall we move on?

**Q164 David Tredinnick:** I want to get on to the general subject, but while we are on homeopathy, just to put this in another context, in the last Parliament the Science and Technology Committee ran an evidence check on homeopathy and decided that there was not much evidence out there, and since then, it is my understanding—and I would like your comment on this—that a lot of research has been done. In fact, I am looking here at the International Homeopathy Research Conference held in Barcelona this year in which there are a whole mass of different trials that have been brought together. I think it was attended, but

please correct me if I am wrong, by speakers from 20 countries and attendees from 31 countries. I looked out just one trial here about sleep, anxiety and depressive disorders, the so-called EPI3 programme, which appears to show that by combining homeopathic medicine and conventional medicine you get greater patient satisfaction, a better result and also you reduce the amount of conventional drugs that are being consumed. Would somebody like to comment on that and then we will move on?

**Dr Fisher:** The EPI3, yes, is a study done by the university of Bordeaux and they had three groups: one was musculoskeletal, one was upper respiratory tract and the other was, as you mentioned, sleep and anxiety disorders. Essentially, what they did was to compare French GPs with “orientation homéopathie” doctors. This means that they are not dyed-in-the-wool homeopaths but, in the French way, they have a diploma and they are allowed to put their names in the Yellow Pages as “orientation homéopathie”. They compared the patients and the outcomes. What they found, for instance, in musculoskeletal disorders was that the severity of the conditions was very similar and the outcomes were similar. The difference was the number of non-steroidal drugs prescribed. The homeopaths prescribed about half the number of non-steroidal drugs and they are, as George has already pointed out, a dangerous class of drugs. Similarly with anxiety disorders, they had better results and one thing they did look at specifically with that was lost opportunity—in other words the allegation that is sometimes made against homeopathy that you are wasting time and delaying effective treatment. They specifically looked at that and found it not to be true—that there was no lost opportunity.

**David Tredinnick:** We can leave the homeopathic things, but I think, from what I have heard, there has been a sea change since that report was done in 2009-10 by the Science and Technology Committee and I imagine that is something that that Committee might want to revisit to update itself.

**Q165 Dr Wollaston:** May I say one thing in terms of the lost opportunity? Ainsworth’s pharmacy was recently marketing a measles vaccine, a homeopathic vaccine. Is that not an example of where you might lead some parents to believe that, if you label something a vaccine, it could give you meaningful protection against a serious infectious disease?

**Professor Lewith:** I think it is appalling and we should be stopping it.

**Dr Fisher:** The party line of the Faculty of Homeopathy for a very long time has been to say, “We support the official guidelines on immunisation.”

**Q166 Dr Wollaston:** But do you think there is a problem with marketing something for children that you label as a vaccine when it has no detectable components within it and no—

**Dr Fisher:** I do not think they would be allowed to market it as a vaccine.

**Dr Wollaston:** I have seen it. It is a real issue.

**Dr Fisher:** I do not approve of that.

**Dr Wollaston:** You do not approve of that. Thank you.

**Professor Lewith:** We are pretty rational people. We are just trying to present you with the evidence.

**Q167 Dr Wollaston:** I know, but I think it is very important to say that there are examples where you could have opportunities missed if people feel that they are giving their children protection against measles that contains nothing.

**Professor Lewith:** I understand that. Can we deal with the issue of the safety of complementary medicine and the safety of the practitioners, because I think this is what you are getting at? Complementary medicine across Europe is practised by 350,000 providers

approximately, according to the recent EU survey which I was part of generating. About half of them are doctors and the other half are non-doctors. If we look specifically at the United Kingdom—and I have been involved with this process for a long time, longer than I care to remember—the quality of complementary practice in this country has improved hugely over the last 30 years. We have registered medical providers in osteopaths, chiropractors, acupuncturists and, soon to be, herbalists. There is a dramatic advance in the education and quality of the people providing complementary medicine in this country, who are now increasingly regulated through the PSA. That was not the case 30 years ago.

In any branch of medicine, we get idiots: we get them in conventional medicine and they make stupid claims—hopefully they get struck off by the GMC—and we get them in homeopathy, in acupuncture and in chiropractic. If we look at the relative risk and benefit, it costs you and me quite a lot to be insured as GPs. It costs an acupuncturist about £150 a year. Actuaries do not muck about. As far as I can see, if you were an actuary you would be looking at the real risk of adverse reaction, being sued and likely harm. Those are at least an order of magnitude—if not more than an order of magnitude—lower for most complementary medical practitioners than most conventional medical practitioners simply because we do more harm as conventional medical practitioners and we are more likely to do more harm. Therefore, our actuarial risk is very much higher. There has been a hugely positive trend in improving training in complementary medicine, but you cannot possibly expect us to defend the idiots.

**Chair:** I do not want this to degenerate into a dialogue.

**Q168 David Tredinnick:** We need to move on, but just on that safety issue, Arthritis UK published a report on complementary medicine and found that 20, I think—most of them—were all safe.

**Professor Lewith:** There were two reports, one on complementary medicine and one on complementary practice.

**Q169 David Tredinnick:** Of the 20 therapies, I think they found that acupuncture was effective in osteoarthritis, rheumatoid arthritis and fibromyalgia, to name but a few.

Can we focus now on long-term conditions, which is the subject of the inquiry? You are saying that complementary and alternative medicine is effective in long-term conditions when integrated into conventional treatments. Can you explain that?

**Professor Lewith:** Yes. I can explain that in that, where we have evidence, the use of things like, as I mentioned earlier, acupuncture and complex psychological interventions such as mindfulness are powerful. They give people, particularly with things like mindfulness meditation, things that they can do for themselves over the long term which are quite constructive. Things like the practice of tai chi and various different, what might be loosely described as, complementary medicine exercises—and you might include yoga in that as well—are also very powerful and enabling and the evidence is quite strong that if you persist with these approaches you get long-term health benefits. We know with cancer that people who use complementary medicine on their cancer journey, which is between 20% and 40% of people with cancer, get a huge amount of ability to self-care and a lot of positive survivorship skills from using complementary medicine, not as a cure but as a long-term survivorship process. There are other areas which we need to look at, but the general impression that we get when we look at CAM versus non-CAM use in almost all chronic illness is very positive patient feedback and improved self-care and self-help. That is what we really need to head for in many older people with long-term incurable conditions because that is what we will probably all get.

**Q170 David Tredinnick:** Dr Fisher, your hospital apparently has the highest rating in the United Kingdom in terms of satisfaction, or very nearly. Is that right?

*Dr Fisher:* Yes, from two independent sources—Dr Foster and NHS Choices.

**Q171 David Tredinnick:** Is it right that you have pioneered integrating different treatments, leaving homeopathy aside for a moment, and that there are other therapies that you have brought together? Is that right?

*Dr Fisher:* Yes, over a very long period. We are part of one of the leading medical academic centres in the UK, University College London. For instance, we introduced acupuncture into the NHS—and I am old enough to remember when people thought that we were mad Maoists when we did this—in 1977, I believe.

**Q172 David Tredinnick:** As to this patient satisfaction, you also provide herbal medicine.

*Dr Fisher:* We provide herbal medicine, homeopathy and a variety of psychological interventions. Increasingly, as I say, we are integrating vertically with primary care, although that is sometimes inhibited by the contracting situation, but also horizontally with other colleagues in the trust.

**Q173 David Tredinnick:** To what extent does the approach of bringing complementary medicine into the mainstream require the co-operation of practitioners? Perhaps you could tell us whether you have that in your hospital.

*Dr Fisher:* Of course you must have a very high degree collaboration of colleagues. Gradually, we are winning.

**Q174 David Tredinnick:** We are talking about doctors, are we?

*Dr Fisher:* Healthcare professionals. Actually, very often, the interest is greater in other healthcare professionals. Midwives, for instance, are very interested, as are nurses and physiotherapists. A large number of physiotherapists now use acupuncture. So, very often, it is other health professionals, but of course the co-operation of the big cheeses, who are generally doctors, is essential.

**Q175 David Tredinnick:** My last question to you—and then I will turn to Professor Lewith, if I may—relates to your experience in your hospital where you are using these different treatments and you have co-operation with your practitioners to do so. What impact has that had on referrals, secondary care investigations or interventions? Do you believe there is any detectable difference in referrals to hospitals?

*Dr Fisher:* It is something we have not studied formally—it is quite a complicated issue to study—but we do believe that we simplify matters. Some of these people are seeing multiple specialists, having multiple treatments for nominally—and I do emphasise “nominally”—what are said to be different diseases. But very often it is just the way we think of things, putting things into boxes. A very wise consultant once said to me, “The reason doctors make a diagnosis is not for the benefit of the patient. It is for the benefit of the doctor.” That is because you put it into a nice little box and you feel you are in control of it, whereas disease is inherently a chaotic process. Very often, people are being shoved into multiple boxes. I think we can simplify things and reduce the number of treatments, although I cannot point to hard evidence. I wish I could.

**Q176 David Tredinnick:** Thank you. To both of you, focusing on long-term care, is the risk of requiring a secondary care intervention higher if a long-term condition is treated using integrated medicine?

**Professor Lewith:** We are not sure. There is some evidence from the States that suggests it may be lower. We suffer from a lack of good research funding in good units. Now there is a changing culture among primary care researchers that complementary medicine is something that is legitimate to look at rather than something that is illegitimate, but we still do not have enough information to answer that properly. So probably yes, but the balance of evidence is not clear.

**Q177 David Tredinnick:** This is my last question. There is a vast amount of money spent on research every year. Do you think there is enough spent on establishing the effectiveness of these integrated therapies?

**Professor Lewith:** A few years ago, we published a paper in the *BMJ*—I published with Ernst—showing that 0.00085% of the NIHR budget was spent on what might loosely be called complementary medicine when 15% of the population was using it every year. I have spent three decades trying to raise the level of that research because these are questions that need answering. We have got somewhere and there are some really good things happening, but it is still a very small cottage industry and it needs to be bigger in response to patient needs.

**Q178 Grahame M. Morris:** Clearly, you are excellent advocates and you are practitioners of alternative medicine and homeopathy and so on, but my questions are about demand in the system. Under the terms of our inquiry today, we are looking at the management of long-term conditions and whether they could be better managed with an integrated approach. What is your assessment of the demand in the system currently in terms of numbers of patients and perhaps a proportion who would seek to have alternative therapies?

**Professor Lewith:** I will answer this very briefly from the data that we have from both the UK and Europe. Probably between 15% and 20% of European populations want to have access to integrative medicine. When they have chronic conditions that figure probably goes up, from the data we have, to about 50% to 60% of the population with chronic long-term conditions. The caveat is that sometimes these are not great surveys, but we can see from the demand in Germany—and there is no reason to believe that the population in Germany is radically different from the population in the UK—that it is very substantial and it is a demand that is not being currently met by the NHS. I can leave Peter to talk from first-hand experience about that.

**Q179 Grahame M. Morris:** Is there any difference between the assessed demand—or the studies that you referred to from Germany and elsewhere—in a hospital setting compared to in a community setting? If I might ask a supplementary as well because I know time is short and other people want to get in, in terms of who pays—the \$64,000 question at this time of tremendous pressures and the need to deliver the management of long-term conditions—is it your considered opinion that the system, that the NHS, should meet the costs where there is demand and where there is proven benefit?

**Professor Lewith:** There are two questions there. The first one is that in Germany the provision is in both primary and secondary care but the more sophisticated provision is in secondary care. The Germans have a very different system and invest more in their healthcare than we do. They have a universal insurance-based system so there is a fee for service, which is very different from the NHS and that puts different pressures on the provider. I do not think

I should talk about whether I think complementary medicine should be provided as part of the NHS. There needs to be a real national debate about what the NHS should provide. The people should make the decisions about how their taxes are spent. I have a very firm belief in British open debate and justice, but we are in a very difficult position in our current financial climate with the decisions that we make about what we should and should not provide within the NHS and whether we should provide better beds or better newspapers at a cost. I firmly believe that universal healthcare is a fundamental human right, but I do not know what level the taxpayer will wear and what level the politicians will provide.

**Dr Fisher:** The evidence from France and Germany suggests that it does not add to cost but does improve outcomes. This has been studied by the German “Krankenkasse”, the large insurance companies, with essentially that conclusion. As for the pent-up demand, there is a lot, we are very aware. Indeed, we employ a lady in our hospital, who is sitting right behind me, who spends a lot of time dealing with queries from patients: “I want to be referred and I cannot. My GP will not refer me. What can I do?”

**Q180 Grahame M. Morris:** In your hospital, Dr Fisher, do you know what proportion of patients pay for alternative or complementary treatments?

**Dr Fisher:** We do not know. We are an NHS hospital so all our patients come in on the normal NHS terms and conditions. We know that a high proportion of patients, particularly with chronic diseases—50% or higher—do use complementary medicine and also that they very often do not tell their doctors, actually for the wrong reasons, because they think their doctors will poo-poo it or not understand it.

**Professor Lewith:** The majority of people who use CAM do not communicate that to their conventional carers.

**Q181 Grahame M. Morris:** I suppose it is my opinion, and I know we are here to hear yours, but I have visited the German health service and the Autowawert health insurance facility—admittedly some years ago—and personally I did not think it was a patch on the provision and the arrangements that we have, but maybe you have a different perspective.

**Professor Lewith:** There is good and bad in every system and I think the Germans have very easy access to healthcare. We tend to use GPs to ration healthcare. There are arguments for and against both. There has to be some kind of rationing because the demand is huge and there will have to be some kind of co-payment system. I do not think that is a decision for doctors to make. That is a decision that we all make together.

**Chair:** Happily, it is not a decision for this Committee either.

**Q182 Charlotte Leslie:** Can I ask, how responsive are clinical commissioning groups to the demand for commissioning of integrated medical treatments?

**Dr Fisher:** That is a complicated question and a very fluid one. At the moment, we have a system whereby we have agreed a number of care pathways, for instance for fibromyalgia and irritable bowel syndrome, insomnia and cancer where the CCGs—it was the PCTs but the clinical commissioning groups have just inherited them—will agree to see patients without asking questions, without prior approval. We then have a large number of other areas where we do require prior approval but we have an agreed system whereby we have a tick box and it is adapted for the condition, “This patient has tried these two of the following drugs or has had chronic complex problems,” and a number of pre-agreed criteria for things that fall outside the pre-agreed pathways. So we do have a system that more or less works, although there are still quite a lot of patients who are unhappy about it.

**Q183 Charlotte Leslie:** Have you seen a change in attitude on the move from PCTs to CCGs? Has there been a culture change or a change of attitude in that move?

**Professor Lewith:** Complete chaos.

**Dr Fisher:** The quick answer is that we have heard very little from the CCGs because they seem to be preoccupied with other things. We are a bit nervous about what they might do when they finally get their act together.

**Q184 Charlotte Leslie:** You have said in the past that you think commissioners often do not hear the evidence of cost-effectiveness of integrated medicine approaches. Do you stand by that and why do you think that is?

**Professor Lewith:** There is an inherent bias. For instance, if you look at any trial on antidepressants which has been followed up for a year, you will see that the real treatment and the placebo treatment group are both better a year later, with often very little difference. If you look at any pain trial in acupuncture which is followed up for a year, you will see the acupuncture group and the real treatment group are better at the end of the year. That demonstrates that placebos last a long time, even if you think acupuncture is a placebo. If you look at the cost-effective data, you get really powerful data from acupuncture for OA in a knee, probably about £3,000 per QALY. I think it is £3,000 or £4,000 per QALY, yet NICE sets up guidelines which say, “We are only going to look at real versus sham trials, not at the pragmatic trials,” whereas when they look at exercise, how would you do a placebo for exercise? They look at pragmatic trials for exercise. We know that exercise does a lot of good, but we cannot design a placebo because it is a complex intervention. So there is an institutional bias against complementary medicine in the interpretation of perfectly legitimate scientific data.

**Q185 Charlotte Leslie:** Is there any deeper cause for that bias?

**Professor Lewith:** Yes.

**Q186 Charlotte Leslie:** What is that?

**Professor Lewith:** It is the fact that there is a lot of negative publicity about complementary medicine and the sane, rational voice of sensible scientific evidence is rarely heard. It is a great opportunity for us to be allowed to present that in this Committee.

**Dr Fisher:** There is also a culture—this so-called single framework, or pill for every ill, for a short description—which naturally the pharmaceutical industry falls into. I am not attacking the pharmaceutical industry as it has achieved wonderful things, but its job is to manufacture and market drugs and it does it very effectively. It has created an atmosphere where it is very difficult to think in a different way.

There was a recent thing published in the *BMJ* looking at, for instance, exercise versus drugs for coronary heart disease. What was really striking was that they had a little triangular graph with the thickness of the graph indicating how many trials there are. There was a huge, thick line connecting control and drugs and a tiny, thin little line connecting control and exercise. In other words, there are vastly more data on drugs, although actually the data suggest that exercise is just as effective. We have to get away from it when we face this problem of not just long-term conditions but complex conditions and polypharmacy. Drugs are overused to an enormous extent. There is a big philosophical question here about moving away from this and seeing people as a whole person—this idea of treating people, not diseases, when very often the diseases are only nominally separate. They are not really separate. It is the same person.

**Q187 Charlotte Leslie:** So in a sense, are you saying there is a subconscious commercial driver that is affecting—

**Professor Lewith:** There could be.

**Dr Fisher:** No, I am not saying that. I am not attacking the pharmaceutical industry. I am saying that there is so much work doing it that way that it is almost difficult to see that, “Actually, you could do it this way.”

**Q188 Charlotte Leslie:** Let us say that changed. What capacity is there for trained staff and resources to supply integrative medicine treatments at the moment if they were to be commissioned?

**Professor Lewith:** There are a large number of well-trained complementary therapists out there who have PSA-recognised—

**Dr Fisher:** I think you mean HPA.

**Professor Lewith:** They are Professional Standards Authority-recognised, which is the bigger regulator, and they would work for much less than the average GP.

**Q189 Charlotte Leslie:** You are saying it is a system’s reluctance to change something new—

**Dr Fisher:** For us, as an NHS provider, they have to be statutorily regulated. It is a complete no-no: if they are not statutorily regulated, we will not employ them and I think for good reason. The step to statutorily regulating some of the professions is a very small one. With the herbalists, the Government are committed to doing it, I believe. The acupuncturists are very well trained. It is a small step, but we cannot take the responsibility to employ somebody who does not come with the proper statutory regulation.

**Professor Lewith:** The hospice movement thrives on complementary medicine, it is very much about whole-person care and we give a lot of people a good death with that in mind—and that will increasingly be so for both malignant and non-malignant disease. There are a large number of complementary therapists who work in a perfectly legitimate way within the hospice movement, sometimes voluntarily but sometimes for a relatively small salary. There is an untapped capacity out there of well-qualified, registrable, employable people.

**Chair:** We need to move on.

**Q190 Valerie Vaz:** We have had a lot of evidence from various organisations and people regarding long-term conditions. They range from things like diabetes and epilepsy to motor neurone disease and Duchenne and Becker muscular dystrophy. Could you outline how your patient-centred integrated medicine would work in relation to some of these long-term conditions?

**Dr Fisher:** Our biggest single area is musculoskeletal disease, which is indeed one of the biggest causes of disability in the country. Osteoarthritis is just about the commonest disease there is and we will all get it if we live long enough. The NICE document on osteoarthritis is a pretty miserable guideline: “Take your painkillers until your knees are ready to be replaced.” That is a slight parody, but that is what it is. There is not a huge amount to offer. We offer acupuncture, herbal treatment, homeopathy and a range of treatments and get very good patient feedback. Then we discharge the patients, after a course of treatment, back to the GP. Very often, they get sustained treatment and then they can come back. Many of these things could and should be offered in the primary care setting.

There is an issue around the contracting arrangements. One I have encountered very recently is our insomnia clinic. When we set this up, we got into trouble because we had a tidal wave of referrals and our trust was saying, “Why aren’t you meeting the 18-week wait

target?” We said we were not expecting the tidal wave. Then there are the insomnia online programmes. We wanted to institute an online programme such that a patient could be referred and we would say, “Okay, we will assess you and you can use this online programme.” Our trust initially said, “You cannot do that because you are taking the business away from us,” and I had to bang my fists on the table and say, “Don’t be ridiculous. One, we are healthcare professionals, not bankers, and we should be doing what is right, not what is profitable. Secondly, it is not even true that it will take business away. It will get our name out there and we will be seen to be doing the right thing and will encourage more referrals.” But, at the same time, we also recognise that there are quite a lot of complicated cases. Many people with insomnia are dependent on sleeping tablets. Interestingly, nobody appears to know how many. Everybody agrees that a lot of patients with insomnia are dependent but there appear to be no data on how many—an interesting little lacuna. Those patients do require specialist advice on how they are going to get off the tablets, so that we would do in our secondary care centre. But it was really rather irritating, when we were trying to do the right thing, to run into this problem about rivalry between primary and secondary care. Only some fairly strong arguing changed their mind.

**Professor Lewith:** I think you are trying to ask how we would deliver it and I will give you an example. We have an increasing problem with men with prostate cancer because we are getting better at diagnosing it. There is more diagnosis, more follow-up, a 30% increase every five years in the number of people being seen in hospital with prostate cancer. We know that anxiety is the primary trigger for radical intervention in men who do not need radical intervention. They get anxious and want it out, after which they have a 50% chance of incontinence and impotence—so a very diminished quality of life. Almost certainly, the data that we have are strong evidence that there is no increased 12-year survival between those who have an operation and those who do not. So we need to reduce anxiety to reduce costs, improve quality of life and reduce radical interventions. Mindfulness is a very good way to do that.

I have designed and am now delivering with one or two groups of Macmillan nurses in UCLH Macmillan Cancer Centre an online mindfulness-based programme for these men which they will accept. It is difficult to get old men to accept talking and mindfulness, but we have designed a way to do that that seems to work. We could then deliver that in conjunction with specialist clinics, get them off the books and minimise operations. Those are the kinds of things that we can do practically. It is not about replacing conventional care. It is about learning the lessons and working within.

**Q191 Valerie Vaz:** Can I move on quickly to some of the long-term conditions? There are two or three that a patient gets. You spoke very eloquently about patient-centred care. How would you deal with those multiple conditions, the multimorbidity?

**Professor Lewith:** You would deal with them by asking the patient what they want rather than delivering what your specialty demands. You are moving back to a generalist approach, to a patient-centred approach, so you may give them goals and suggest some approaches with herbs, with exercise and approaches with acupuncture for their pain. So you will get one or two approaches that you may be using and one or two approaches that they may use themselves to keep them off their long list of polypharmacy and as active as possible.

**Q192 Valerie Vaz:** How does that work? Obviously diabetes and obesity go together, don’t they, so how do you—

**Professor Lewith:** You can work that in the same way that you can run a good musculoskeletal clinic if your rheumatologist works well with the physiotherapist. Your physiotherapist can provide both acupuncture and conventional physiotherapy. So it is

providable. A third of our physiotherapists in the NHS are acupuncture trained. It is just a question of letting it happen.

**Valerie Vaz:** Thank you.

**Chair:** Can we have a brief question?

**Q193 David Tredinnick:** Just for your information, there is a mindfulness course in the House that is being run for the second time. It is completely oversubscribed from Members of Parliament.

**Dr Fisher:** There you are.

**Q194 David Tredinnick:** I think one or two of us know a bit about it. I have two questions to finish. What are the benefits to patients of encouraging greater independence and self-care in the management of their long-term conditions?

**Professor Lewith:** They are huge. That is a really difficult question.

**David Tredinnick:** Can we have a quick reply, just the key points, because we are running out of time?

**Professor Lewith:** The key points are that they take more control over their own care, have a sensible debate with their GPs about what they should take, and they learn to self-manage conditions rather than panic. If you give them digital interventions to back up the process, you can teach them self-care processes, but they are very often really simple, simple things that they can purchase over the counter and things that they can do themselves or in local community groups.

**Q195 David Tredinnick:** This is the last question. Several of our witnesses have advocated a multidisciplinary team approach to drawing up individual care plans for people with one or more long-term conditions. Where would complementary and alternative medicine approaches sit within this treatment model?

**Professor Lewith:** It would be exactly the same.

**Dr Fisher:** Everything we do is based around multidisciplinary teams so we have physiotherapists providing acupuncture, occupational therapists providing psychological therapies and doctors providing herbal medicine. Everything is a team. We would welcome other professions if they were statutorily regulated. It is just not our job as an NHS provider to certify that somebody is competent, although I have no concerns that some of the professions, notably the herbalists and acupuncturists, are indeed competent. We need that certification before we can employ them.

**Professor Lewith:** I have one last point. If you give people treatments that they want to choose and believe in, they are more likely to get better, provided those treatments are safe and it is a reasonable thing to do within their diagnosis and not a silly approach—

**Dr Fisher:** And indeed to take them. Of course, many people do not take prescribed drugs.

**Professor Lewith:** Precisely. It is not a case of recommending homeopathic MMR vaccinations. You are much more likely to get patient buy-in, adherence and success. Responding positively to people who want to choose complementary medicine, which is a significant minority, is a powerful therapeutic thing to do.

**Chair:** On that note, we need to draw this to a close. Thank you for your evidence, which we will take fully into account.

### Examination of Witnesses

*Witnesses:* **Professor Nigel Mathers**, Vice Chair of Council, Royal College of General Practitioners, **Alastair Buxton**, Head of NHS Services, Pharmaceutical Services Negotiating Committee, **Emily Holzhausen**, Director of Policy and Public Affairs, Carers UK, and **Victoria Matthews**, Assistant Long Term Conditions Adviser, Royal College of Nursing, gave evidence.

**Q196 Chair:** Ladies and gentlemen, thank you for waiting patiently for this evidence session. I should say that we have a vote coming in the House of Commons at 4.30 so we are on a very short time frame. Could I ask you briefly to introduce yourselves and tell us where you come from?

**Professor Mathers:** My name is Nigel Mathers. I am a GP in Sheffield. I am also vice-chair of the Royal College of General Practitioners and I am a professor of general practice at the university of Sheffield.

**Alastair Buxton:** My name is Alastair Buxton. I am a pharmacist. I work for the Pharmaceutical Services Negotiating Committee. We represent NHS community pharmacies in England.

**Emily Holzhausen:** I am Emily Holzhausen. I am director of policy and public affairs at Carers UK, representing family members who care unpaid—6.5 million of them.

**Victoria Matthews:** I am Vicki Matthews. I am a specialist nurse, recently retired from 30 years' full time in the NHS, and I am here representing the Royal College of Nursing today. I believe I am what is called "vintage".

**Q197 Chair:** Thank you very much. I would like, if I may, to begin by asking each of you to answer a general question to get the propositions on the table which the Committee will then wish to follow up. You will know this session takes place in the context of our inquiry into services delivered for people with long-term conditions and each of you from your different professional standpoints will have, I am sure, some key points you want to make about how services need to change compared with what we have now in a way that will deliver both better value and better quality to the target group we are talking about— people with long-term conditions. Can I ask you each for two or three key points, rather than a laundry list of 27 points, that need to be addressed? Could I start with Professor Mathers?

**Professor Mathers:** Thank you, Chair. I have four points. One is, if we are to improve the quality of care for people with long-term conditions, we need to move to a whole-system approach. By that I mean the "Year of Care" model with the four different components, where we have engaged patients and practitioners, a practice infrastructure that supports the process and a commissioning base.

Secondly, care planning should be the norm in terms of delivering care to people with long-term conditions in general practice.

Thirdly, we need to focus on multimorbidity. All the NICE guidelines, all the pathways, are designed for people allegedly with only one condition, but most people have multiple conditions.

Finally, if we are to deliver this, we need to shift more resources into primary care.

**Alastair Buxton:** Unsurprisingly, I would say that I want my profession—community pharmacy—to be playing a much greater role working with our colleagues from primary care and also in secondary care. When we look at the services that we provide in community pharmacy, the most important relating to long-term condition management is ensuring that we help people to optimise the use of their medicines because we know that at least half of people do not use their medicines effectively.

We also want to ensure that people are able to self-care and to avoid long-term conditions if possible. There is a big focus within the community pharmacy sector on

supporting people to live healthier lives. We also want to help people who do have long-term conditions to live independently within the community. We believe that putting all of that together as a community pharmacy offering can sit alongside what would be described as the first pillar of the NHS, being hospital, and the second pillar, general practice, community pharmacy and our other primary and community care colleagues. We should be sitting there ensuring that we are able to work, in a more holistic team-based approach, with our general practice colleagues and to start to take on more of the burden of long-term condition management, working collaboratively with general practice.

**Emily Holzhausen:** The first would be recognition of where care happens for people with long-term conditions. That is primarily with people with the long-term conditions supported by their families, so of course we are talking about 6.5 million people there, understanding that the system impacts on those families enormously. So it would be an impact test: what decisions do you make that help people care? Are the decisions you make going to tip somebody into unemployment if they are caring full time, or are you going to support the family to care in this situation long term?

Families tell us that they would like more integrated care. They would certainly like more information and advice up front, which means that they need to be identified early, both by healthcare professionals—and there are some great examples of where people do that—but also across with social care.

Quality is definitely going up the agenda for families. We are starting to measure some of those issues for families as well, so across health and social care the “families and friends” tests and other measures that are in place are absolutely critical.

**Victoria Matthews:** For us—and I speak both for the College and as a nurse—we support moving care as close to the patient and family’s home as possible. For us, the key issues are, for example, the allocation of community resources. With a larger proportion of care taking place nearer to the home and in the community, there is a more urgent approach needed in terms of allocation of resources and skills of the community work force.

Also increasing staff numbers, particularly community nursing, is an area of grave concern. The work force expanded and peaked in 2010, but in the last three years we have seen a fall of 1,744 full-time roles, which is equivalent to 3.6% of the work force. District nursing also has been declining year on year, with a 17% decrease. So we do need to increase numbers to bring care closer to home.

Self-care is essential, particularly in the management of long-term conditions. It brings many benefits, not just for the individual but for clinicians, commissioners, for Government and for society as a whole. It empowers people to take ownership of their condition, aspects of their treatment and managing their lives yet to be lived. You must not forget that a lot of people with long-term conditions are young people who still have a life ahead of them. But I would say, look at this document here, “Clinical Guidelines for Chronic Conditions in the European Union”, and I quote: “The role of chronic disease management, including the role of the patient in managing their care, merits much more attention. However, we should not allow our continuing focus on prevention to diminish. Despite decades of work in the areas of health promotion and disease prevention, we still have a long way to go in identifying cost-effective actions to address the main risk factors responsible for chronic diseases.” So self-care is much more complex than those two words might suggest.

The next issue for the RCN is specialist nurses and a single point of care. We know they are fit for purpose. We know that at the moment they are probably suboptimal and could be utilised much more effectively.

Finally, there is public health and prevention. Even with the budget being ring-fenced, the RCN has real concerns over future funding for preventative services as local authorities position themselves to provide these services during considerable financial constraint.

**Q198 Chair:** I am obviously going to throw it open to the Committee, but it is very striking that all four of those high spots focused, among other things, on the need to rebalance services towards the community and I guess, if we had sat here at any time in the last 25 years, we would have heard similar points being made. I wonder if, just as a matter of fact, whether you think resources are relatively shifting towards the hospital sector or towards the community sector currently and, depending on what your answer to that is, what you think would be the most effective way, or step that could be taken, to speed the flow of relative resources into the community. Shall we do it in the same order?

**Professor Mathers:** The evidence I have seen is that resources for primary care, community care and general practice have reduced in the last three years by a substantial amount, in real terms by £400 million. The resources are moving in the wrong direction at the moment. The way to address that is through integrated care, particularly integrated primary and secondary care as well as integrated health and social care in terms of working as multidisciplinary teams, for example. I can give plenty of examples, but from my own practice—

**Chair:** I do not want it to be a dialogue. That is an answer to the first and second questions.

**Alastair Buxton:** I would certainly agree with that. From my perspective, the way that we in pharmacy can start to help to shift the care into primary care is, on the assumption that our GP colleagues and practice nursing colleagues are increasingly going to be taking on a greater role managing people who currently are being managed in secondary care, we would look to try and create some space for them within their practices by shifting, but using a collaborative approach, certain patient cohorts into community pharmacy. For example, there have been discussions recently with some GPs about moving people with hypertension who have recently been diagnosed and do not have any co-morbidities, who are relatively simple, if you like, patients to manage at the start of their life of long-term conditions. Shifting them to community pharmacy would give space for more complex patients to be managed in a more thorough manner in general practice but with an expectation that, as they become more complicated, potentially, they then transition back to the general practice taking on the wider part of care.

**Q199 Valerie Vaz:** What would you do?

**Alastair Buxton:** For example, we currently have two services, which we describe as medicines optimisation services, the medicines use review service and new medicine service that we offer to lots of patients: 2.8 people received an MUR—a medicines use review—last year. Quite a large number of them are people with asthma, for example. So, I would like to see all pharmacies providing MURs and the new medicine service. The vast majority, about 90%, of pharmacists do provide MURs. I would like next year for them all to have to provide that service and to have to offer it to patients with asthma.

**Q200 Valerie Vaz:** I am trying to get to what you said about patients with hypertension. What exactly would you be doing with them? Is it just about managing their drugs?

**Alastair Buxton:** It would be managing their condition in totality, managing their medicines, which is the way that, largely, we manage that disease. There are clearly other interventions around exercise and so on that could be made, but it would be undertaking the management in exactly the way that it is undertaken in general practice now but transferring that responsibility to community pharmacy, so they get shifted across following the same NICE and prescribing guidance and so on.

**Q201 Dr Wollaston:** Do you mean the pharmacist would be prescribing the drugs and reviewing and taking their blood pressure?

**Alastair Buxton:** That could be one approach, or where there is no need for modification of doses we could use a repeat dispensing service where the GP has authorised products for prescribing for some time, or the use of patient group directions and other legal techniques to modify doses rather than modify drugs, for example.

**Emily Holzhausen:** I can only talk on the evidence from families, which is that it is not moving in that direction. The census has shown us an increased number of people taking on care and an increase in the ill health among carers as well. This has been the subject of quite some debate as to where resources lie. Certainly, if we look at the report published by the Royal College of Physicians, it is talking in the Future Hospital Commission about those sorts of services being based far more in the community. So, for me, it is unlocking the types of payment arrangements that are there, these different services, with people who work in secondary care looking at far different roles to be able to bring the care closer to home.

We are very mindful of the fact that some families have to travel further and further for specialist treatment and that takes a huge toll on them. If you look at parents of disabled children, they can be travelling up to hundreds of miles away—or cancer treatment, for example. While people make the best of the transport that is there and a lot of volunteers help them to get there, it is still a huge commitment and that puts a lot of pressure on families. We need to be mindful of the way we organise things and the wider impact that we have on families, but, on the whole, while people want the best specialist care, it is better to provide care closer to home in terms of wider impacts.

**Victoria Matthews:** I agree with what everyone else has said and I liked what you said about “unlocking” things as well. I said earlier that many specialist nurses are working at suboptimal level because of artificial constraints and I think that the direction of travel to bring care close to home is still not right and we do have a way to go yet.

If you look at the community nursing work force, 38% of nurses are 50 or over and a huge number are going to be retiring in the next decade. We need to have a major rethink about how we attract nurses to work with long-term conditions in the community and avoid these silos, particularly with the specialist nursing, that we have seen in tertiary and secondary care in the past.

**Chair:** Thank you very much. David Tredinnick wants to ask about commissioning, I think.

**Q202 David Tredinnick:** What examples have you seen of good commissioning of primary and community services for long-term conditions under the new arrangements and what barriers are there to successful commissioning?

**Professor Mathers:** The clinical commissioning groups, of course, do not commission primary care and there is not a facility to do that except through things like quality improvement projects and service development. What would be really helpful is for all CCGs to develop strategies for long-term conditions and develop programmes of work around care planning, long-term conditions, delivering multidisciplinary teams through a quality improvement programme, and then that would need to be supported by the local area teams of the NHSE but also by the local health and wellbeing boards. It would be a big step forward if all CCGs were required to produce strategies for long-term conditions using this mechanism because, at the moment, there is not another way to do it. For example, all CCGs need a strategy for diabetes, dementia and end-of-life care, to name but three. But, as I say, the mechanisms are not easy to do it. It is really hard to deliver this.

In Sheffield, we have a CCG that is committed to introducing care planning into everyday care and there are 88 practices in Sheffield. We have created this quality improvement programme and, of the 88 practices, every single one signed up to engage in developing care planning. So GPs are willing to do it, but it is just about freeing up capacity and providing a mechanism whereby they can, for example, introduce care planning for long-term conditions.

**Alastair Buxton:** In terms of a good example of commissioning, I would cite one example from 2010 where the PCT on the Isle of Wight used the medicines use review service within the community pharmacy contractual framework to focus on asthma patients, and this was before we had a national asthma target. They also trained other healthcare professionals, practice nurses and GPs, to ensure that all patients were receiving the same message. That was a good example of getting everybody in primary care working together. The focus of the service was ensuring that people use their inhalers and use them properly. That saw emergency admissions for asthma fall by 50% over a three-month period and the number of asthma-related deaths fall by 75%. Building on that, South Central SHA—as it was then—rolled that out across the whole of the area and saw similar results, which were investigated by the Cambridge Consortium, and saw a positive impact on reducing hospital admissions. But I have to say that is one good example. Sadly, in community pharmacy, we seem to have seen more bad examples of commissioning in the past and rather piecemeal approaches taken.

From our perspective, we see a national approach as allowing us to drive greater patient impact in community pharmacy. The 2.8 million MURs that we are providing every year would not have been provided if they had previously been commissioned by PCTs. We recognise that is working against the localisation agenda, but, if we accept that that is a strong driver and will continue to be so, we would at least suggest that one of the solutions is to look for more standardisation because, as NICE codifies a way that healthcare professionals treat conditions, we should not see significant differences in the way that a healthcare professional manages asthma or hypertension on the Isle of Wight compared with Sheffield, for example. There may be different approaches in different people undertaking that management, but we need to ensure that we do not duplicate effort at a local level, creating service specifications and designing services, because the PCTs were terribly good at doing that and wasting an awful lot of commissioner time.

**Emily Holzhausen:** It is probably right to recognise that the changes in the structure have halted or decommissioned some quite progressive work that was happening. Carers Trust has undertaken a piece of work—because it runs a lot of local carers' centres—looking at the level of CCG commissioning of carers' services and support and has found there has been not a hiatus exactly but that things have been put on hold in quite a lot of areas. In good areas of commissioning, we get good joint commissioning between health and social care to support families and there are numerous different examples that have happened. In Kensington and Chelsea, for example, there is commissioning of link workers that go into GP practices to offer to link up with the rest of the services that exist—so to look at managing the whole family, if you like, with all the different issues that they might have. In other places, like in Hertfordshire, they have used breaks funding very creatively around commissioning. Another area I know of in the past that has used commissioning well around breaks funding has given funds directly to GPs to prescribe breaks. So there is a whole range of different commissioning out there, but I also think that it is still early in the days of health and wellbeing boards to look at the level of support for carers. Places like Southwark have very detailed examples of the type of population that they have, looking at their joint strategic needs assessment, but others are not yet well developed.

**Q203 Andrew George:** Can I be clear on that particular point? Is it that the new structure has created an impediment to innovation in new ways of integrating, or is it simply that the process of change has slowed the progress that was previously being made?

**Emily Holzhausen:** At the moment, it would be fair so say that the structural change has been the largest change to services. I am sure there are new impediments that people had not thought of before, but that in itself has taken a little while to get going again.

**Chair:** Do you want to come in on this?

**Victoria Matthews:** Briefly to say that for me, good commissioning is commissioning that integrates, listens to and acts upon the voices of a whole range of health and social care professionals, but, most importantly, listens to and acts upon the voice of the person living with the long-term condition and their families and carers and does that in a truly democratic way, not just a piecemeal lip-service thing. There are many examples of fantastic, innovative commissioning, and I guess good commissioning is commissioning that is brave, innovative and thinks outside the box, for want of a better term.

**Chair:** Very quickly, David, and then I will go to Barbara.

**Q204 David Tredinnick:** Some of you may have heard the previous session and I wonder what you feel about patients who might want to go down the complementary route: whether you think that is part of the personal choice agenda that the Government have set up.

**Professor Mathers:** Personal health budgets can be very useful there in terms of, if someone has a continuing long-term condition need and is eligible for a budget, then the individual will have freedom to decide, with their broker, how they spend that money and that may well be integrated care, complementary medicine, acupuncture or whatever. That seems to me entirely appropriate under the system that we have.

**Victoria Matthews:** May I briefly come in there and pick up on a point you made about brokerage? The RCN fully supports personal health budgets, but we have to be mindful that there are some people who on the surface appear to be perfectly capable of managing their personal healthcare budgets but may have subtle and complex, maybe cognitive problems where they do not make such appropriate decisions. This is where it is important that key health professionals broker and help navigate—that good decisions are made in terms of what care package they need, whether it is complementary or orthodox medicine.

**Q205 Barbara Keeley:** This question is to Emily Holzhausen because it is about carers. What are the implications for carers of greater treatment of long-term conditions in primary and community care? You have already touched on travel as an aspect and presumably that would improve in primary and community care rather than travelling to specialist hospitals. I have a few sub-points. What should the priorities be for NHS and local authority care services if they are seeking to assist? What involvement should family carers have in multidisciplinary care teams and care planning? The final point is, is it even realistic to talk of this? Is it adding an extra layer for people who are already busy—care workers and family carers—to say that they should be involved? Do they even have time to do that?

**Emily Holzhausen:** There are lots of really important questions there. The first point is that there are definitely inherent benefits in treating people closer to home. Very often, people feel more comfortable and the travel is better. The risk, of course, is that there is an unwritten expectation that family, or the person with the long-term condition, will take on more themselves. Certainly, I know in the past there used to be situations where carers would feel that it felt like a bit of a break if somebody they cared for went into hospital. We need to be very mindful of the fact that if parents of disabled children are doing very complicated medical procedures at home and being trained to do so, in the best cases, by nurses and other community professionals, we need to involve people in all of this. I am always surprised that

we train professionals and require even healthcare assistants and care workers to be highly trained and yet there is an expectation that the family will just go away and do it. Many a time I have had a man or a woman on the phone saying, “I don’t understand. The care workers have come in and they will not move this person. I am only 5 foot 2 and I have to move my husband who is 6 foot 1 on my own, but they cannot because of health and safety reasons.” We need to be careful that we are not building up problems for the future.

As I said, about 2 million people have given up work to care; about one in five or six people will do so in their life. There is a great amount of stress that people feel when they are trying to care for people and it is not just about people in their own homes but also increasingly about people caring at a distance, mothers and fathers living further away from sons and daughters, not being on hand to know that things are well and functioning. Where there are opportunities for this as well is around the use of technology: the ability to see different patient records, the ability for consultants to do remote consulting, telecare and telehealth and also just how people use technology. We have produced a report recently which shows that only about 30% of people use technology for health and care, yet the vast majority of people use it in everyday life, and I am talking about internet technology as opposed to the ordinary telephone. So there are some definite positives and negatives. We do need to improve identification of carers and the link straight into support. Although it might take more time up front, long term it makes economic as well as moral sense.

**Q206 Barbara Keeley:** As to the last point about care planning, the involvement you touched on, does that mean an extra burden? Is it realistic or would people welcome it?

**Emily Holzhausen:** The health and social care sector is probably stretched at the moment. To incorporate that, we need to look at where it has worked well. Certainly for people with complex conditions, there is evidence to show that you bring the family on board earlier, you teach one person and you teach a generation. I worry a little that there is not enough flex in the system to be able to do it for everybody. Again, this is where we are finding the use of the internet and online tools for people with lower level needs—if people can self-serve through those kinds of tools and be empowered in that way—to be quite an investment. But we have to get this right. If we look at the demographics—you are all familiar with that—we simply cannot afford to ignore this issue and that is why the Committee is considering it. Certainly, with the pressure on our health service and how we manage that, but also for families, we cannot continue to have long working lives until we are at least 67 and state pension age and care for our relatives. Families will collide at that point with different responsibilities, as they are doing now.

**Q207 Dr Wollaston:** I want to return to the issue of funding. We have heard some strong arguments in the evidence that we have received that the resources need to shift from secondary to primary care. I know, Professor Mathers, you have called for an urgent review of the payment-by-results framework. Why do you think it does not support effective management of long-term conditions and what would you suggest we replace it with and why?

**Professor Mathers:** The problem with payment by results, of course, is that you receive money for every episode of care, so actually it is an incentive to see more people in secondary care because, obviously, the more often you go into hospital the more the income increases. We think it is really important that payment by results is reviewed and that different ways of funding long-term conditions in primary care are looked at.

**Q208 Dr Wollaston:** Could you talk us through what you would want to see in its place and why that would be more effective?

**Professor Mathers:** It would be more effective to have the joined-up health and social care budget, for example. I am not talking about integrating primary or secondary care budgets there. I am talking about, if we had in the community an integrated health and social care budget, it would enable care planning to be delivered far more effectively by multidisciplinary teams and reduce the number of hospital admissions, particularly unnecessary hospital admissions of frail elderly. As long as there was not cost shifting between health and social care—and I have been assured that that is not the case with the new integration budget—that is the way to tackle the issue of providing the right resource in the community for the right person at the right time through multidisciplinary teams. Practices do have multidisciplinary teams but they do not generally include contributions from secondary care, nor indeed from social care. That image, that vision, for multidisciplinary teams has to include, for example, a community geriatrician and a social worker as well and practices working together in federations because there is limited resource. Using that integrated budget, I think we could deliver much better care for people with long-term conditions by keeping them out of hospital.

**Q209 Dr Wollaston:** It is very complicated, is it not, because you have NHS England commissioning GPs, you have personal budgets and other budgets? Do you think it should just be one simple system, or do you find all the different sources of funding difficult and complex?

**Professor Mathers:** I do not think it is possible to devise a system that you could apply all over the country in every single circumstance. It is very complicated at the moment, but I believe we need a mixed economy. We really do need various areas to try different ways of getting the funding right to support the delivery of care to people with long-term conditions. The pilot sites are very important and there are lots of good examples, such as Torbay, which has integrated health and social care budgets to some extent. There is lots of good learning out there that we should somehow bring together into a range of models, a range of options, a menu of choices for different areas to say, “We could do it this or that way,” because those relationships on the ground in the different areas are so important in terms of delivering what we want to deliver. Does that answer the question?

**Dr Wollaston:** Yes. As you say, there is not a “one size fits all” but at the moment there is such a different range of sources of income. Are you finding it very complex?

**Professor Mathers:** We are finding it extremely complex. The RCGP, in conjunction with a number of other organisations, has set up the “Action for Long-term Conditions”. The “Action for Long-term Conditions” includes organisations such as the Health Foundation, NHS England, NHS IQ, the Richmond Group of Charities, the Royal College of GPs and various other contributors. We are trying to collect all this learning and part of the work programme is to have one stream that looks at the different models for trying to do this because we have the complication of Monitor influencing all this as well. It is incredibly difficult and complicated, but we cannot do it without contributions from all the different stakeholders, which is why we have set up the “Action for Long-term Conditions”.

**Chair:** We are not going to solve that problem in the 25 minutes left to us, so, Andrew, do you want to ask another question?

**Q210 Andrew George:** Yes. You said a moment ago that you are not impressed by, or rather oppose, the use of the payment-by-results system and yet at the same time say that there should be other methods of resolving the management of long-term care through the budget-setting process. On the other hand, you say that you do not see the integration of primary and secondary care as the method by which you should achieve it.

**Professor Mathers:** Budgets. That is the next stage. If we can get integration of health and social care budgets to deliver better quality care in the community, that is the first step. The second step, obviously, would be to engage secondary care, but it is such a difficult subject that to do it all at once would be very difficult. But if there is a flow of resources from secondary to primary care and there is the integration funding, then here is a great opportunity for us to transform the care of people with long-term conditions in the community.

**Q211 Andrew George:** But you will still be left with a tariff-based payment which will be tempted to kind of suck patients into secondary care in order to achieve their payment by results.

**Professor Mathers:** Exactly, and that is why we have called for an urgent review.

**Q212 Andrew George:** What we have in this desire to achieve better integration is a lot of lamenting and a lot of advocating that we need to find solutions. Given that you are, after all, the Royal College of GPs, and it has been suggested that you are now centre placed in the commissioning and shaping of the NHS, do you not think that you have a central role in designing a method by which long-term care can be better integrated? I am surprised that you are so timid in suggesting that secondary care integration with primary care is a second—way over the horizon—step that you are not prepared to propose at this stage.

**Professor Mathers:** We have to be realistic and we do chair the alliance for long-term conditions, which has a very large number of stakeholders, so we are providing clinical leadership in this area. But nothing can be delivered without the agreement and participation of other stakeholders in the whole process. It would be very nice to set that as an aspiration, but I think in the NHS one has to move step by step rather than trying to transform it overnight.

**Valerie Vaz:** I have a couple of quick questions.

**Chair:** Emily Holzhausen wants to come in as well.

**Q213 Valerie Vaz:** You mentioned the “action” and then the “alliance” “for Long-term Conditions”. What is its proper title and who is in it?

**Professor Mathers:** I am sorry. It is the “Action for Long-term Conditions”. It is an alliance of various stakeholders with a common narrative.

**Q214 Valerie Vaz:** Could you give us the examples of who is in it?

**Professor Mathers:** There are the Health Foundation, the King’s Fund, the Royal College of GPs and some of the Richmond Group of Charities. I think there are 15 different organisations and I am sorry I cannot remember all of them just at the moment. We are practitioners set to transform the delivery of care for long-term conditions because we are the people who are going to have to deliver it by developing four work-streams: one is developing the metrics, “How do you measure it?”; one is developing the models, “How do you deliver it?”; one is looking at the finance, “How do you pay for it?”; and one, of course, is the engagement of people with long-term conditions. So we have these work-streams to try and tackle some of the issues. But it is, as I say, a big job.

**Q215 Valerie Vaz:** Yes. I want to quickly talk about something you mentioned in your evidence about section 75 regulations. Do you feel inhibited by them at all?

**Professor Mathers:** I will pass on that question; I am sorry. I will have to have a look.

**Emily Holzhausen:** I want to quickly mention this. We have been talking about integration and different funding models and I want to recognise the different pressures on the supply side of funding if we are talking about closer integrated services in that the pressure on

social care funding in particular makes it an unequal balance because of the different settlements there. It is an opportunity, with the Care Bill coming along, to look at where funding goes into that, where the Government look at where they set their eligibility criteria and whether, in the future, for the management of long-term conditions and people living with long-term conditions in the community, it makes better economic sense to invest in the lower eligibility criteria, bringing in more people. I realise there is a price tag attached to that, but, at the moment, it is an unequal conversation around integration of the two sources of funding.

**Q216 Chair:** The proposition of rebalancing funding within the system implies that the price tag is paid by decommissioning services, the demand for which should not arise if we had proper services in the community. That is the challenge.

**Emily Holzhausen:** Indeed. That is the challenge.

**Q217 Chair:** Does anyone want to comment on the challenge? Then I am going to Grahame next. Do you want to come back on section 75? It is the politician's code for competition policies.

**Professor Mathers:** Yes, absolutely. I wanted to check what we had said in our evidence. We think that there is a risk of fragmentation of care. It makes it very difficult for CCGs if there are so many competing providers and the selection needs to be done on quality. As I say, we have received assurances that that is not going to inhibit the introduction of integrated care for people with long-term conditions.

**Q218 Grahame M. Morris:** This is building on what Emily told us a little earlier. Time is quite short and we are looking for your opinions and evidence to help us formulate this report. There is a consensus that it is preferable to manage long-term conditions, where it is practical to do so, in the community, but what we are interested in currently is, "What are the barriers?" You mentioned a positive thing that could be done there in terms of the eligibility criteria for the Care Bill, but currently what are the barriers to transferring existing longer term care, integrated care, from the hospital setting into the community? I am just asking Emily now. Maybe you can quickly give us your thoughts.

**Emily Holzhausen:** If we look towards Northern Ireland, for example, there are important cultural barriers between health disciplines and social care disciplines, between a clinical model and a social model of disability that need to be brought together. Some of the training for some of the new health professionals coming through is starting to unpick that slightly. Of course, the different funding mechanisms are structurally complicated. We know that co-locating teams makes a huge amount of difference. The health and wellbeing boards are being seen as a really important vehicle for getting joint work together. Certainly, the clinical commissioning groups are just finding their feet with commissioning and learning what to do there. I do still think it is an issue. Even though we have to repurpose the finances within the system, the demographic pressures are such that what we have in the system will not be enough to sustain things going forward even if we make things more efficient in the way that we use services.

The simple things could make an enormous difference. If we do, for example, identify carers and give people the right information and advice earlier on, helping people self-manage quicker, just like with dementia, if we diagnose people earlier and help the families to care quicker, not only is that hugely important within that family—

**Grahame M. Morris:** Long-term pay-back.

**Emily Holzhausen:**—to be able to manage but, emotionally, the difference it makes is huge. So there are some very practical things which have a very personal impact for families.

**Alastair Buxton:** If I could come to one of the practical issues in bringing more care into primary care, whoever is providing it, it is information flows and the fact that they do not generally, particularly between secondary care and primary caring, flow in an elegant, electronic and efficient manner in most areas.

**Q219 Chair:** Or between the pharmacy and the general practitioner.

**Alastair Buxton:** That is absolutely where I was going—between ourselves and general practice and other primary care practitioners and community providers with general practice. Working in a pharmacy, if I have an issue I need to raise with a patient's GP, with their consent, I would wish to review their record as appropriate to ensure I am not posing a question that perhaps the GP has already dealt with. But, assuming there is a legitimate reason to send some information through to me, I do not want to create more work for my GP colleagues. At the moment, I may create admin work of copying and pasting data into the patient's records and our IT systems just do not work well. That is an area where we need leadership, probably from NHS England, to help perhaps bang some heads together to ensure that we get some standards for intra-operability between different—

**Q220 Chair:** You also, if I may say so, need your colleague on your right to join you at the party.

**Professor Mathers:** Yes. We have worked very closely with the Royal Pharmaceutical Society to produce a document called "Working Together", which looks at practical options for GPs and pharmacists to work much more closely together, because this is part of the integrated care agenda.

**Q221 Chair:** So you come with a single view, in answer to somebody's question, as to what happens next—Grahame's question, "What is it that is standing in the way?" It is inadequate information. Pharmacy and general practice comes with one view of the right answer, does it?

**Professor Mathers:** We come to the Committee with an agreement on principles for working together. The devil, of course, is always in the detail and it is for local arrangements to be agreed and made.

**Alastair Buxton:** I would suggest that we have the agreement in principle but there is work that needs to be done nationally on the standards for IT, because you do not want to be defining standards for intra-operability at a local level. That is where I really believe that NHS England now is the new organisation that is going to hold the ring on that particularly and needs to take action to bring everybody into one room and bang heads together to ensure we do start to make progress.

**Q222 Valerie Vaz:** But you can only do that on certain conditions. You are only taking a few things, like hypertension. You are not looking at the patient and their other conditions.

**Alastair Buxton:** I am talking about general access. If we have the Government's commitment—and rightly so—to give patients access to their own GP records, I would hope that, where the patient consents, a pharmacist would have full access where there is a need for that. It could be a simple query about a prescription they are dispensing, that they need to check something. If they are dispensing Warfarin, an anticoagulant, they may want to be able to look at the latest test results in the patient's record, if the patient does not have their hand-held record, for example, to ensure it is safe to dispense that medicine and that the dose is appropriate. It is that that we simply cannot do at the moment.

**Q223 Valerie Vaz:** I understand that. It is kind of complex, isn't it, and there are many conditions so you would only be looking at one part? Your patient X has hypertension but also has diabetes. You would only be able to deal with the one, not the other, and they would still have multiple people to deal with, would they not?

**Alastair Buxton:** That, of course, depends on how the service is commissioned. My comments earlier on were suggesting where we believe we need to start. Our GP and practice nurse colleagues need to learn to work with us in community pharmacy and that is why some of my GP colleagues are suggesting, "Start with hypertension. That would be good for us. We can build up confidence in your competence as professionals." Indeed, so can the patients as well, which is going to be critical within this. So start with single conditions but absolutely recognise that that is not the way to go long term. We need to have a holistic approach and I would want to see people with multiple morbidities being supported with optimising their use of medicines by the pharmacy team. It may be that there is a specialist nurse providing the expertise for one disease and the pharmacist is dealing with another, but, yes, I would definitely like to see a more holistic approach taken in pharmacy. But it is about how we start and start simple.

**Professor Mathers:** In our practice—

**Chair:** With respect, we have 10 minutes left. Grahame has been interrupted and a GP wants to come in. Dr Wollaston, could you be very brief and then I am going back to Grahame. Is that okay?

**Q224 Dr Wollaston:** Going back to the issue of notes, is it time we had something a bit more radical and that patients own their notes rather than the Secretary of State? Therefore, they can have their notes accessible to whomever they would like them accessible to, can correct the very many errors that we find in patients' notes and some of the comments that are inaccurate and certainly prescribing errors, and also that whole principle of self-management. What is the panel's view on that?

**Professor Mathers:** Patient-held records are a very good idea. We have had them for 30 years in Sheffield for mothers holding the records of their children. The notes never get lost and they always come to surgery with them. As an example of patient-held records, that is a very good one that has worked over many years and I see no reason why that should not be extended.

**Emily Holzhausen:** From the point of view of family, where consent is given, it certainly smoothes their journey, though confidentiality is an important issue to discuss properly and well. I have to say, from the family point of view, that if we can get expert views from community pharmacists on perhaps a complex medication regime, that is brilliant. That is brilliant integrated care that gives families confidence from people who spend four years training to be experts in their field.

**Q225 Grahame M. Morris:** I quickly want to ask Victoria to answer a question. I know earlier you said that the key concern of the RCN and nurses is lack of specialist nurses. A number of us have been putting the case for more nurses, for numbers to be published and minimum standards laid down. For example, for hepatitis C nurses, NICE says we should have one specialist nurse for 40 patients in the community and one specialist nurse for 20 patients in a hospital setting. What is the problem? Are the specialist nurses being drawn into the hospital setting? Is that a barrier to treating some of these complex conditions in a community setting?

**Victoria Matthews:** It is a dilemma, in that it is a barrier and, to some extent, a need because they need to be current and up to date in terms of treatments, as treatments become increasingly complex.

**Q226 Grahame M. Morris:** So it is numbers and training.

**Victoria Matthews:** Yes. It is a dilemma, but I think there is also a risk that you end up with silos of specialist nurses in these centres and I would like to see them reaching out more. Probably their key relationship is with their GPs.

**Chair:** Grahame, can I interrupt you to let Barbara in before she goes and then come back to you?

**Q227 Barbara Keeley:** It is about personal health budgets that I specifically wanted to ask. We heard about some aspects of this earlier, but in terms of carers being involved in that situation, what contribution can personal health budgets make to that and are there any services that are relevant and that are possibly being used to manage long-term conditions at the moment that will not be available with personal health budgets, or is it a positive step?

**Emily Holzhausen:** It is a positive step. Our learning from direct payments within social care is that, on the whole, about 65% of carers say that the services to the person that they care for are better and they prefer them. We have seen a slight fall-off in the last couple of years, down to 57%, for satisfaction rate, which is starting to worry me, and an increase in the number of carers who say that administration has increased. So, overall, it is better.

The natural transition is to continuing healthcare. If you imagine you are employing this team around you who are supporting you, then you get continuing healthcare funding and you cannot employ them any more, that is a real transition issue for families who have got used to certain workers. So we can really celebrate the fact that it moves across into continuing healthcare. What we need to guard against is a tendency to over-proscribe, "You cannot use that for that and you cannot use that." It is all about choice, outcomes and a certain level of trust and, on the clinical side, good quality clinical input to help people make choices. What I do not want to see is it transferring across to families again, where you almost get the unpaid care manager who is at home managing this huge, complex number of direct payments and financial returns and all those sorts of things and they are effectively managing that full time and on income support. That is not a healthy way for a family to be. We need to guard against the administrative side while really recognising the enormous positives that it can bring as well.

**Chair:** Grahame.

**Grahame M. Morris:** I am happy with the answers I got and time is short.

**Chair:** In that case, we will go to Valerie on obesity.

**Q228 Valerie Vaz:** We have been told that obesity is a contributory factor for long-term conditions such as diabetes and arthritis. What role do you think primary and community care would play in preventing this?

**Professor Mathers:** Shall I kick off on that?

**Valerie Vaz:** Answers in five minutes, or less actually, because there is a vote shortly.

**Alastair Buxton:** All of us in primary care need to make every contact count, as has been said previously, and within community pharmacy it is really important that we make use of our wider teams. We have the opportunity to do that via public health campaigns. We are currently contracted to NHS England to provide six of those that are organised by the area teams at the moment. We proposed to Public Health England that we ought to ensure we have national topics, so every pharmacy in the country would be promoting "Stoptober", this last month, for example, so that we get more bang for the buck out of what has been invested there.

Making use of support staff is another thing. They often live locally within the community and we have seen some fantastic examples from the Healthy Living Pharmacy

approach that started in Portsmouth. Following the White Paper on pharmacy, we now have over 700 accredited Healthy Living Pharmacies. A key difference between them and a normal pharmacy is that the staff have been trained to be health trainer champions and are being taught the techniques of behaviour change. They are getting on and doing that both within the pharmacy and sometimes outside the pharmacy. I saw an example of a pharmacy that was organising a walking group for people locally to get them out and exercising, which obviously has much wider benefits as well. But we need to do that collaboratively across primary care, I would say.

**Professor Mathers:** There are three things for GPs.

**Valerie Vaz:** No sweets at the counter.

**Professor Mathers:** Those three things are making every contact count, being a pointer to additional help and services, and supporting public health campaigns and legislation to reduce the amount of sugar and salt in food.

**Victoria Matthews:** Work further upstream and invest in your school nurses. Start at the beginning.

**Chair:** Okay, thank you.

**Q229 Valerie Vaz:** Emily, do you want to—

**Emily Holzhausen:** We know that families neglect their own health when they are caring, so I would say equal access to services is really important for families who are caring full time.

**Chair:** We should exercise this time pressure more often. Do you want to come in on training, Sarah?

**Q230 Dr Wollaston:** Having read the Cavendish review—the recommendations about bringing in the healthcare assistant work force and helping with their continuing professional development, and indeed initial training—what role do you feel that has in the future of long-term care?

**Victoria Matthews:** A very significant role. The regulation, training and development of healthcare support workers is a critical issue for the RCN.

**Professor Mathers:** I think it is essential to, and a key component of, care planning.

**Emily Holzhausen:** Absolutely—backing for the Cavendish review.

**Chair:** This is evidence in 140 characters, for which we are very grateful. Thank you very much.