



House of Commons

Committee of Public Accounts

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**Services to people  
with neurological  
conditions: progress  
review**

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**Twenty-fourth Report of Session 2015–16**





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Committee of Public Accounts

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# Services to people with neurological conditions: progress review

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**Twenty-fourth Report of Session 2015–16**

*Report, together with formal minutes relating  
to the report*

*Ordered by the House of Commons  
to be printed 10 February 2016*

**HC 502**  
Published on 26 February 2016  
by authority of the House of Commons  
London: The Stationery Office Limited  
£0.00

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### Publication

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### Committee staff

The current staff of the Committee are Stephen McGinness (Clerk), Dr Mark Ewbank (Second Clerk), George James (Senior Committee Assistant), Sue Alexander and Ruby Radley (Committee Assistants) and Tim Bowden (Media Officer).

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## Summary

Over 4 million people in England have a neurological condition. Services for people with these conditions are not consistently good enough, and there remains wide variation across the country in access, outcomes and patient experience. As well as affecting patients, poor care has implications for the NHS; for example, it costs £70 million to deal with emergency admissions of epilepsy patients and many of these admissions are likely to result from shortcomings in care. Neurological services remain poorly integrated with a lack of joint commissioning of health and social care. Over 40% of people with a neurological condition do not think that local services work well together, and only 12% of people have a written care plan to help coordinate their care.

There has been some progress in implementing the recommendations that the previous Committee made in 2012, including the appointment of a national clinical director for adult neurology and some improvements in data. However, these changes have not yet led to demonstrable improvements in services and outcomes for patients. It is clear that neurological conditions are not a priority for the Department of Health (the Department) and NHS England, and we are concerned that the progress that has been made may not be sustained. We therefore intend to review the position again later in this Parliament.

## Introduction

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Neurological conditions, such as Parkinson's disease, motor neurone disease and epilepsy, result from damage to the brain, spinal column or peripheral nerves. Some neurological conditions are life-threatening, with many severely affecting people's quality of life and causing lifelong disability. The most recent estimate, by the Neurological Alliance, indicates that there are 4.7 million neurological cases in England. The NHS spent £3.3 billion on neurological services in 2012–13, representing 3.5% of total spending, up from 3.1% in 2010–11. Hospital activity involving patients with neurological conditions have increased in recent years, although the rate of growth has slowed. There are no specific data on spending on social care for people with neurological conditions or on the number of people with neurological conditions receiving social care services. However, on the basis of the more general data that are available, both spending and activity can be assumed to have fallen significantly since 2009–10.

The previous Committee of Public Accounts reported on services for people with neurological conditions in March 2012, making six recommendations aimed at improving services and achieving better outcomes. In its report in July 2015, the National Audit Office found that the Department and NHS England had made 'good' progress against just one of the six recommendations, with progress against a further three assessed as 'poor', and the remaining two as 'moderate'.



## Conclusions and recommendations

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1. **There remains wide variation across the country in services and outcomes for people with neurological conditions.** Diagnosing neurological conditions takes too long, services in hospitals are variable and local health and social care services are often poorly coordinated. The variation in services is resulting in variation in outcomes for people with neurological conditions. For example, the proportion of adults receiving treatment for epilepsy who remained seizure-free for 12 months ranged from 87% in South-West Lincolnshire to 47% in Hull and North Manchester in 2013–14. Clinical commissioning groups hold the key to improving services and outcomes and reducing variation. They need to be informed by good data on local performance, but progress in this area has been limited. From April 2016, NHS England plans to make more data available by issuing ‘commissioning for value’ data packs to clinical commissioning groups. The packs will include data on local outcomes, activity and costs for a range of neurological conditions.

**Recommendations:** *NHS England should set out by April 2016: how it will use the new commissioning for value data packs to help clinical commissioning groups improve neurological services and reduce the variation in services and outcomes; and how it will then hold clinical commissioning groups to account for their performance in this regard.*

2. The picture of variation in services and outcomes for people with neurological conditions is similar to that for people with diabetes, another long-term condition, on which we recently reported. NHS England needs to consider more widely how it can both: strengthen accountability for local services and outcomes within its overall approach to managing long-term conditions; and do more to help under-performing areas to improve.
3. NHS England is not meeting the objective that the Department set for it that everyone with a neurological condition should be offered a personalised care plan by 2015. The previous Committee recommended that everyone with a neurological condition should be offered a written care plan. Care plans are important in coordinating people’s treatment and helping them manage their conditions in the community. The Department’s mandate to NHS England includes an objective that everyone with a long-term condition, including a neurological condition, should be offered a personalised care plan by 2015. However, just 12% of people with a neurological condition have a written care plan. The Department sought to play down the significance of this shortcoming, stating that progress may not be being accurately measured and that patients may not be aware when they do have a care plan. We do not accept this defence since the Department is responsible for setting meaningful objectives for NHS England and for ensuring that robust arrangements are in place to measure progress.

**Recommendation:** *The Department should confirm how it is measuring performance against the objective that everyone with a long-term condition should be offered a personalised care plan. NHS England should set out a timetable for meeting the objective and the Department should hold NHS England to account for achieving this timetable.*

4. **There is scope to give patients better access to neurologists by using existing resources more effectively.** Over the last decade the number of neurologists in the NHS has grown by around 5% per year and there are now about 650 full-time equivalent consultant neurologists working in the NHS in England. We heard that neurologists needed to be better distributed across the country and that significantly more neurologists were needed to improve services, but NHS England stated that the rate of growth was unlikely to increase over the coming years. Access to neurologists varies across the country for both outpatient appointments and when patients are admitted to hospital. In some hospitals, a specialist neurologist may be available on only one or two days each week. There is potential to make better use of existing neurologists and improve access for patients, by re-designing services and by making more use of other clinical staff, particularly specialist nurses, to carry out tasks currently undertaken by neurologists.

**Recommendation:** *NHS England should report back to us by April 2017 on what it has done to make best use of the available neurologists and reduce the variations in access, including through re-designing services and making more use of other clinical staff, particularly specialist nurses.*

5. **The abolition of the role of national clinical director for adult neurology would lead to a loss of clinical leadership and accountability.** NHS England appointed a national clinical director for adult neurology in 2013, and he has clearly had a positive impact by providing clinical leadership at national level and promoting service improvement. NHS England is reviewing how the various national clinical director roles fit within the broader structure of clinical leadership. While the review had not come to a final conclusion at the time of our evidence session, NHS England indicated that it did not plan to reappoint the national clinical director for adult neurology as it intended to focus on priority areas such as cancer. Instead it envisaged neurology being led in a collaborative way, based around strategic clinical networks. We are not convinced that this would be an effective approach as having a named individual has been shown to strengthen leadership and accountability. We would highlight in particular the impact that the former national clinical director for cancer had in driving improvements in these services.

**Recommendation:** *NHS England should retain the role of national clinical director for adult neurology.*

6. **The Department and NHS England have no plans to improve the linking of health and social care data beyond the 'care.data' initiative, which is unlikely to be implemented before 2020 at the earliest.** The previous Committee recommended in 2012 that national datasets should link health and social care data, using the existing NHS numbers to provide a complete view of all the services that patients are receiving. The Department accepted the Committee's recommendation at the time, but there has been no progress over the last three years. Both the Department and NHS England acknowledged the importance of linking data but said that a generic solution had to be found covering all conditions to avoid the need for inefficient one-off data collections. The Department's proposed solution to linking data is the care.data initiative, which it hopes will be in place before 2020. It said that, following the spending review, funding was available to invest in technology and that the Secretary of State had commissioned a review of the legal issues around care.data.

However, the care.data initiative has had a troubled history and has made little progress to date. More widely, the Department has a poor record of implementing IT programmes successfully.

**Recommendation:** *The Department should report back to us by April 2016 setting out how it plans to link health and social care data, including a clear timetable for when it expects care data to be fully implemented across the NHS.*

7. **The confusion over commissioning responsibilities is leading to ineffective commissioning of neurological services.** The reforms to the health system in 2013 split responsibility for commissioning healthcare—NHS England now commissions specialised services with local clinical commissioning groups responsible for other services. However, for neurology, what constitutes specialised services has not been clear and this has caused confusion over who should be commissioning which services. Clinical commissioning groups have tended not to engage effectively with neurological services as they believe responsibility for these services rests with NHS England. In April 2016, NHS England plans to introduce changes which will mean all neurology outpatient services will be commissioned by clinical commissioning groups.

**Recommendation:** *NHS England should set out clearly by April 2016 which neurological services are specialised services to be commissioned by NHS England and which services should be commissioned locally by clinical commissioning groups.*

# 1 Neurological Services

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1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department) and NHS England, including the National Clinical Director for Adult Neurology, on services for people with neurological conditions.<sup>1</sup> We also took evidence from the Neurological Alliance, from Dr Geraint Fuller, former president of the Association of British Neurologists, and from Dr Paul Morrish, a consultant neurologist and adviser to the Neurology Intelligence Network.

2. Neurological conditions result from damage to the brain, spinal column or peripheral nerves. They include conditions such as epilepsy, which are intermittent and unpredictable, and motor neurone disease and Parkinson's disease, which are progressive. Some neurological conditions are life-threatening, with many severely affecting people's quality of life and causing lifelong disability. In 2014, the Neurological Alliance estimated that there are 4.7 million neurological cases in England (excluding migraine, headache, dementia and stroke).<sup>2</sup>

3. The Department is ultimately responsible for securing value for money from spending on neurological services. The Department sets objectives for NHS England through an annual mandate and holds it to account for the outcomes the NHS achieves. In turn, NHS England supports and holds to account the 209 clinical commissioning groups.<sup>3</sup>

4. Spending on neurological health services has increased at a faster rate than overall NHS spending. The most recent data indicate that, in 2012–13, £3.3 billion was spent on neurological services, accounting for 3.5% of overall NHS spending—up from 3.1% in 2010–11. Between 2010–11 and 2013–14, hospital activity involving patients with neurological conditions increased, although growth in both inpatient admissions and outpatient appointments slowed compared with the previous three years. In 2013–14, there were 464,000 neurological inpatient admissions and 1.7 million neurological outpatient appointments.<sup>4</sup>

5. There are no data on spending on social care for people with neurological conditions, as adult social services are defined by disability and need rather than condition. People with neurological conditions generally fall within the category of 'people with a physical disability' and social care spending on adults with a physical disability has fallen significantly. Spending decreased by £1.6 billion (16%) in real terms from £9.8 billion in 2009–10 to £8.2 billion in 2013–14. The number of adults with a physical disability receiving social care services also fell significantly, from 1.2 million in 2009–10 to 0.8 million in 2013–14.<sup>5</sup>

## Variation in services and outcomes

6. The Neurological Alliance told us that its survey on patient experience had indicated shortcomings in neurological services. The diagnosis of neurological conditions took too long—people often had four or five GP appointments before they were referred to a

1 [C&AG's Report, \*Services for people with neurological conditions: progress review\*, Session 2015–16, HC 301, 10 July 2015](#)

2 [C&AG's Report, paras 1.2-1.5](#)

3 [C&AG's Report, para 1.10](#)

4 [C&AG's Report, paras 1.12-1.14](#)

5 [C&AG's Report, paras 1.15-1.17](#)

neurologist. Services in hospitals varied across the country and there were not enough neurologists and assessing teams to help with getting quick diagnoses. Dr Fuller described neurological services as a ‘Cinderella’ area and said that patients with neurological conditions had been left out compared with those with cancer or heart disease. He thought that the NHS found neurological conditions difficult to deal with because of the range of illnesses involved. Dr Morrish said that surveys indicated that neurological conditions were an area that GPs found particularly difficult.<sup>6</sup>

7. In the community, health and social care services are often poorly coordinated. In a survey by the Neurological Alliance, published in January 2015, 42% of people said that the different people treating them worked well together only some of the time or never.<sup>7</sup> The previous Committee of Public Accounts recommended in 2012 that there should be joint health and social care commissioning of neurological services, but the National Audit Office reported in July 2015 that there were only occasional examples of this.<sup>8</sup> The Neurological Alliance highlighted that poorly coordinated care could often result in people going back into hospital, which cost the NHS money. Emergency admissions are an indicator of poor quality health or social care services, or both, or poorly integrated health and social care.<sup>9</sup> The National Clinical Director said that emergency admissions for epilepsy alone cost the NHS £70 million per year.<sup>10</sup>

8. Dr Morrish said that there were huge differences in services across the country with huge impacts on people with neurological conditions. For example, the proportion of adults receiving treatment for epilepsy who remained seizure-free for 12 months varied significantly across the country. In 2013–14, performance ranged from 87% in South-West Lincolnshire to 47% in Hull and North Manchester. Dr Morrish said that if people remained seizure-free, they were more likely to have a job and a relationship. In addition, they were less likely to die from their epilepsy. He noted that the chances of dying from epilepsy varied by about 50% across the country.<sup>11</sup>

9. There was general agreement that good data, highlighting variations in performance at a local level, was a key part of improving services and outcomes.<sup>12</sup> However, progress in this area has been mixed. Dr Morrish told us that epilepsy was one area where there were good data. The Neurology Intelligence Network has collected clinical commissioning group-level data on the epilepsy care pathway and on emergency admissions across a range of neurological conditions.<sup>13</sup> However, the previous Committee’s recommendation on including specific neurological indicators in the NHS and adult social care outcomes frameworks has not been implemented.<sup>14</sup> In addition, both Dr Fuller and Dr Morrish highlighted that the indicator on adults with epilepsy remaining seizure-free for 12 months had been dropped from the GP quality and outcomes framework, despite the fact that this was a useful measure of how well epilepsy was being managed.<sup>15</sup>

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6 [Qq 1, 43](#)

7 [Q 1; C&AG’s Report, para 1.19](#)

8 [Committee of Public Accounts, \*Services for people with neurological conditions\*, Seventy-second report of Session 2010–12, HC 1759, March 2012; C&AG’s Report, Figure 1](#)

9 [Q1, C&AG’s Report, para 1.23](#)

10 [Q 44](#)

11 [Qq 7-8](#)

12 [Qq 11-12, 67, 70](#)

13 [Q 10, 68, C&AG’s Report, para 2.13](#)

14 [Qq 17, 20-21](#)

15 [Qq 10, 15, 17](#)

10. NHS England told us that in April 2016 it would be making more information available on the variations in neurological services and outcomes by issuing ‘commissioning for value’ data packs to clinical commissioning groups. These packs would include data on outcomes, costs and other indicators across a range of neurological conditions. For example, each clinical commissioning groups would see its outpatient activity and costs compared with the best and worst in the country and against its peers.<sup>16</sup> NHS England explained that this information would be used as part of the NHS Right Care programme which aims to identify where variation exists with a view to improving local commissioning in areas that are under-performing. The National Clinical Director emphasised the importance of the commissioning for value data packs and said that clinical commissioning groups held the key to improving services and reducing variation.<sup>17</sup>

### Personal care plans

11. In 2012, the previous Committee recommended that everyone with a neurological condition should be offered a personal care plan. The Department agreed with this recommendation and included in its mandate to NHS England an objective that everyone with a long-term condition, including a neurological condition, should be offered a personalised care plan by 2015.<sup>18</sup>

12. The Neurological Alliance highlighted that people lived in the community with their neurological conditions for a long time after being diagnosed and leaving hospital. It stressed that care plans, together with care coordinators, were essential for coordinating people’s care in the community. Its own research, and that of its members, indicated that a lack of coordinated care could result in individuals being readmitted to hospital rather than being cared for in the community, which resulted in the NHS incurring additional costs.<sup>19</sup>

13. The latest data from the GP Patient Survey, published in July 2015, show that just 12% of people with a neurological condition have a written care plan.<sup>20</sup> And a survey by the Neurological Alliance, published in January 2015, found that only 20% of people with a neurological condition had been offered a care plan.<sup>21</sup> The Neurological Alliance told us that there were no incentives for clinical commissioning groups to ensure that people had care plans, and there were not enough nurses and care coordinators in the community to help implement care plans.<sup>22</sup>

14. The Department argued that there might be an issue with how performance in this area was being measured. It said that the question in the GP Patient Survey might not produce an accurate picture as patients might not be aware when they did have a care plan. The Department said that it was looking at what would be a better range of questions in the GP Patient Survey.<sup>23</sup>

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16 [Qq 69-70, 110](#)

17 [Qq 70, 108-110, 129](#)

18 [C&AG’s Report, Figure 1](#)

19 [Qq 1, 3, 5](#)

20 [NHS England, GP Patient Survey, July 2015](#)

21 [C&AG’s Report, para 2.28](#)

22 [Q 3](#)

23 [Qq 101-102](#)



## Access to neurologists

15. Dr Fuller told us that there are currently about 650 full-time equivalent consultant neurologists working in the NHS in England (excluding consultants working in stroke services).<sup>24</sup> Dr Morrish said that reports had concluded that there were not enough neurologists in this country and that the existing neurologists were not well distributed. Dr Fuller explained that the lack of neurologists was partly due to the challenging nature of the specialty resulting in many medical students avoiding the area. The National Clinical Director stated that data from the Association of British Neurologists indicated that between 30% and 50% of new consultant neurologist posts remained unfilled due to the lack of specialist neurology trainees.<sup>25</sup>

16. Dr Fuller advocated a 50% increase in the number of consultant neurologists, bringing the total to around 1,000 full-time equivalents.<sup>26</sup> NHS England told us that over the last decade the number of neurologists in the NHS had grown by around 60% in total, an increase of between 4% and 5% per year. It stated that this rate of growth was unlikely to increase over the next four or five years.<sup>27</sup>

17. Dr Fuller said that, for new patients, waiting times for outpatient appointments with a neurologist were generally reasonable. However, for patients with an established neurological condition, access to repeat outpatient appointments was less good as hospitals focused on seeing new patients. Dr Morrish highlighted that there was a 13-fold difference across the country in the availability of neurologists for outpatient appointments.<sup>28</sup>

18. Dr Fuller also explained that, for patients who are admitted to hospital with an acute neurological problem, access to services varied significantly across the country. In areas where there were specialist centres, with neurologists permanently based on site, patients could be seen by a neurologist on four or five days in a week. However, in district general hospitals where the neurologists were visiting, patients might be able to see a neurologist only on one or two days a week. NHS England emphasised that there needed to be a balanced approach in distributing the available neurologists to provide more outpatient appointments in local hospitals, but also to enhance inpatient services in specialist centres.<sup>29</sup>

19. NHS England highlighted the potential to reduce the demands on neurologists, and thus improve access, by re-designing services and care pathways. It cited the example of rapid-access first-seizure clinics for epilepsy, which allowed people to access the right care early on, reducing the need for ongoing follow-up support.<sup>30</sup> The National Clinical Director also referred to other work to re-design care pathways to avoid patients being admitted to hospital with acute headaches and epileptic seizures.<sup>31</sup>

20. The Neurological Alliance and Dr Fuller highlighted that other clinical staff, such as specialist nurses, could also reduce the demands on neurologists. They explained that, where specialist nurses had been used for multiple sclerosis, Parkinson's disease, epilepsy and motor neurone disease, they had made a dramatic difference in, for example,

24 [Qq 26, 29-30](#)

25 [Qq 31-33, 82](#)

26 [Qq 27-29](#)

27 [Qq 73, 76](#)

28 [Qq 1, 7](#)

29 [Qq 1, 74](#)

30 [Q 80](#)

31 [Q 44](#)

preventing admissions to hospital. However, Dr Fuller said that the provision of specialist nurses was patchy.<sup>32</sup> NHS England told us it was working to integrate specialist nurses into community teams.<sup>33</sup> The National Clinical Director said that the NHS needed to work smartly by using other staff to do some of the things that neurologists usually did.<sup>34</sup>

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32 [Q 5](#)

33 [Q 82](#)

34 [Q 75, 82](#)



## 2 National support and commissioning

### The National Clinical Director

21. In 2012, the previous Committee recommended that the Department should appoint a national clinical lead for neurology. Although the Department did not accept this recommendation at the time, NHS England subsequently appointed a national clinical director for adult neurology in 2013. The National Clinical Director, Dr David Bateman, is a practising neurologist and works two days a week in his national clinical director role.<sup>35</sup>

22. NHS England told us that, when it was first established, it had appointed a number of new national clinical directors for a period up to March 2016. It said that it was now undertaking a review of how the various national clinical director roles fitted within the broader structure of national clinical leadership, with a view to reducing its running costs. There were currently 24 national clinical directors but NHS England told us that it planned in future to focus on three areas: its corporate priorities; life-cycle areas such as maternity, children and end-of-life care; and the big killers such as cancer. The review had not reached final conclusions at the time of our evidence session, but NHS England said it did not see neurology fitting within these priority areas and indicated that it did not plan to reappoint a national clinical director for adult neurology.<sup>36</sup>

23. NHS England set out that it envisaged leadership for neurological conditions being provided in future in a collaborative way based around strategic clinical networks rather than through a single national clinical director. There are four strategic clinical networks, including one for mental health, dementia and neurological conditions, which work across 12 regions.<sup>37</sup>

24. The National Clinical Director stated that he felt his role was critical. The experience and connections he had developed during his career as a neurologist had been crucial in being able to facilitate and support the development of important initiatives such as the neurology intelligence network. He said that he felt accountable for neurological services within the resources and time available to him.<sup>38</sup> The Neurological Alliance also stressed that clinical leadership at a national level was vital to improving services and outcomes for people with neurological conditions.<sup>39</sup>

### Linking health and social care data

25. In 2012, the previous Committee recommended that national datasets should link health and social care data using patients' existing NHS numbers. The Department accepted this recommendation at the time, but the National Audit Office reported in 2015 that the Department had in fact not implemented the linking of health and social care data.<sup>40</sup>

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35 [Q 135; C&AG's Report, para 2.2-2.4](#)

36 [Qq 45-50, 133](#)

37 [Qq 50-58; C&AG's Report, para 2.6](#)

38 [Qq 132-134](#)

39 [Q 12](#)

40 [C&AG's Report, Figure 1](#)

26. Both the Department and NHS England agreed that the linking of data across different care settings was vital for planning and improving the quality of services, but said that a generic solution had to be found which covered all conditions.<sup>41</sup> NHS England told us that data collection is currently fragmented across NHS England, the Health and Social Care Information Centre and Public Health England. It emphasised the importance of streamlining these arrangements and moving away from the current practice of expensive and time-consuming one-off data collections.<sup>42</sup>

27. The National Clinical Director said that, within a generic approach, neurological expertise would need to be retained in order to understand and interpret the data. At present, the neurology intelligence network provided this expertise. NHS England told us that the key would be to maintain a neurology focus which added value within a more standardised data collection and analysis process.<sup>43</sup>

28. The Department and NHS England said they saw the care.data initiative as the solution to linking data across different care settings. Although it had had a troubled start, their ambition was to have care.data working by 2020. The Department told us that, following the spending review, funding was available to invest in technology and build the digital framework for patient information to be properly exchanged.<sup>44</sup> It also said that the Secretary of State for Health had asked Dame Fiona Caldicott to look independently at the fundamental issue of patients' ability to opt-out of care.data, and advise on whether linking of data could be done within the existing legislative framework. Dame Fiona was due to report by the end of January 2016 and the Department would then decide how to proceed.<sup>45</sup>

## Commissioning of neurological services

29. Following the reforms to the health system in 2013, clinical commissioning groups commission most hospital, community and mental health services. NHS England commissions specialised health services, which are provided in relatively few hospitals to comparatively small numbers of patients.<sup>46</sup>

30. The commissioning of neurological services is split between clinical commissioning groups and NHS England. However, the Neurological Alliance and Dr Fuller told us that the definition of what constitutes specialised neurological services had not been clear, leading to confusion over who should be commissioning which services. This lack of clarity had resulted in clinical commissioning groups not taking responsibility for commissioning neurological services in the belief that responsibility rested with NHS England.<sup>47</sup>

31. NHS England confirmed that the split between specialised neurological services commissioned by NHS England and general neurological services commissioned by clinical commissioning groups had created fragmentation, particularly for outpatient services.<sup>48</sup> It explained that, in areas where there were specialist centres, a GP referral for a

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41 [Qq 59, 63, 67](#)

42 [Qq 59, 67](#)

43 [Qq 59, 67](#)

44 [Qq 59, 63-64](#)

45 [Qq 63, 91](#)

46 [C&AG's Report, paras 1.6-1.7](#)

47 [Q 25](#)

48 [Q 92](#)

neurology outpatient appointment would be commissioned by NHS England; but in areas without specialist centres, the same referral would be commissioned by the local clinical commissioning group. It accepted that this inconsistency did not make sense.<sup>49</sup>

32. NHS England told us that, from April 2016, all neurology outpatient services arising from a GP referral would be commissioned by clinical commissioning groups. It said that this should allow clinical commissioning groups to have a more holistic view on what neurology outpatient services should look like for local people.<sup>50</sup>

33. We also heard concerns about wide variations in the prices paid for neurological services. NHS England told us that the split between specialised neurological services and those commissioned by clinical commissioning groups might have contributed to variation in the payments received by hospitals for the same services, although this would require further investigation. The National Clinical Director gave the example of the part of the country where he worked where payments for the same service varied by more than 25%. NHS England explained that in this local area there were both specialist centres and non-specialist hospitals, resulting in the same neurological services being commissioned by different organisations at different prices.<sup>51</sup>

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49 [Qq 92, 95](#)

50 [Qq 92-93, 96-97](#)

51 [Qq 95-97](#)

## Formal Minutes

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**Wednesday 10 February 2016**

Members present:

Meg Hillier, in the Chair

Mr Richard Bacon

David Mowat

Deidre Brock

Stephen Phillips

Caroline Flint

John Pugh

Kevin Foster

Karin Smyth

Nigel Mills

Mrs Anne-Marie Trevelyan

Draft Report (*Services to people with neurological conditions: progress review*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 33 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

*Resolved*, That the Report be the Twenty-fourth of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

*Ordered*, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Thursday 11 February at 9.00 am

# Witnesses

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The following witnesses gave evidence. Transcripts can be viewed on the Committee's [inquiry page](#).

## Monday 14 December 2015

*Question number*

**Arlene Wilkie**, Chief Executive, Neurological Alliance, **Dr Paul Morrish**, Consultant Neurologist and adviser to the National Neurology Intelligence Network, and **Geraint Fuller**, former President of the Association of British Neurologists

[Q1–43](#)

**Dame Una O'Brien**, Permanent Secretary, Department of Health, **Simon Stevens**, Chief Executive, NHS England, **Professor Sir Bruce Keogh**, National Medical Director, NHS England, **Dr David Bateman**, National Clinical Director for Adult Neurological Conditions, NHS England

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## Published written evidence

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The following written evidence was received and can be viewed on the Committee's [inquiry page](#). NEU numbers are generated by the evidence processing system and so may not be complete.

- 1 Acquired Brain Injury Forum ([NEU0020](#))
- 2 Action for M.E. ([NEU0022](#))
- 3 Association of British Neurologists ([NEU0018](#))
- 4 Cumbria Neurological Alliance ([NEU0016](#))
- 5 Division of Neuropsychology, part of the British Psychological Society ([NEU0014](#))
- 6 Dr Neil Munro ([NEU0013](#))
- 7 Dr Paul Goldsmith ([NEU0015](#))
- 8 Dystonia Society ([NEU0002](#))
- 9 Epilepsy Action ([NEU0001](#))
- 10 Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks ([NEU0017](#))
- 11 Headway ([NEU0003](#))
- 12 Invest in ME ([NEU0021](#))
- 13 London Neuroscience Strategic Clinical Network ([NEU0012](#))
- 14 MS Society ([NEU0005](#))
- 15 Multiple System Atrophy Trust ([NEU0011](#))
- 16 Neurological Alliance ([NEU0006](#))
- 17 Neurological Alliance ([NEU0023](#))
- 18 Parkinson's UK ([NEU0019](#))
- 19 SUDEP Action ([NEU0004](#))
- 20 Sue Ryder ([NEU0008](#))
- 21 Tees Valley, Durham and North Yorkshire Neurological Alliance ([NEU0010](#))
- 22 The Migraine Trust ([NEU0007](#))
- 23 Yorkshire and the Humber Strategic Clinical Network ([NEU0009](#))

## List of Reports from the Committee during the current Parliament

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All publications from the Committee are available on the Committee's website at [www.parliament.uk/pac](http://www.parliament.uk/pac).

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

### Session 2015–16

First Report	Financial sustainability of police forces in England and Wales	HC 288 (Cm 9170)
Second Report	Disposal of public land for new homes	HC 289 (Cm 9170)
Third Report	Funding for disadvantaged pupils	HC 327 (Cm 9170)
Fourth Report	Fraud and Error Stocktake	HC 394 (Cm 9190)
Fifth Report	Care leavers' transition to adulthood	HC 411 (Cm 9190)
Sixth Report	HM Revenue & Customs performance 2014–15	HC 393 (Cm 9190)
Seventh Report	Devolving responsibilities to cities in England: Wave 1 City Deals	HC 395 (Cm 9190)
Eighth Report	The Government's funding of Kids Company	HC 504 (Cm 9190)
Ninth Report	Network Rail's: 2014–2019 investment programme	HC 473
Tenth Report	Care Act first-phase reforms and local government new burdens	HC 412
Eleventh Report	Strategic financial management of the Ministry of Defence and Military flying training	HC 391
Twelfth Report	Care Quality Commission	HC 501
Thirteenth Report	Overseeing financial sustainability in the further education sector	HC 414
Fourteenth Report	General Practice Extraction Service	HC 503
Fifteenth Report	Economic regulation in the water sector	HC 505
Sixteenth Report	Sale of Eurostar	HC 564
Seventeenth Report	Management of adult diabetes services in the NHS: progress review	HC 563

Eighteenth Report	Automatic enrolment to workplace pensions	HC 581
Nineteenth Report	Universal Credit: progress update	HC 601
Twentieth Report	Cancer Drugs Fund	HC 583
Twenty-first Report	Reform of the rail franchising programme	HC 600
Twenty-second Report	Excess Votes 2014–15	HC 787
Twenty-third Report	Financial sustainability of fire and rescue service	HC 582
First Special Report	Unauthorised disclosure of draft Report in the previous Parliament	HC 539