All Party Parliamentary Group
Primary Care & Public Health

Inquiry Report into the NHS White Paper & Patient, the Public & Health Professional Engagement

December 2010

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i. About the APPG

The All Party Parliamentary Group on Primary Care & Public Health

The Group was established in 1998 by Stephen Hesford MP, Dr Howard Stoate MP, members of parliament until the May 2010 elections, and Lord Hunt of King's Heath who is the current chairman alongside Kevin Barron MP. The function of the Group is to raise the profile of primary care and public health within Parliament; to speak within Parliament on behalf of both users and those working in the NHS; to place primary care and public health high on the Government's agenda and to inform debate by parliamentarians with outside bodies.

Current membership

Officers:

Lord Hunt (Co-chair)
Kevin Barron MP (Co-chair)
Baroness Gardner (Executive Officer)
Baroness Masham (Secretary)
Julie Elliott MP (Executive Officer)

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Dr Philip Lee MP
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Powers:

Although APPGs are registered in Parliament, they are unofficial interest groups of cross party MPs and peers with the objective of raising awareness about issues in parliament, important because they represent parliamentarian opinion and keep Government informed of this. As far as powers are concerned, unlike Select Committees where Government is required to respond to inquiry reports and attend meetings if requested, there is no such obligation in the case of All Party Parliamentary Group inquiries and meetings. Attendance and responses from Government are completely at the discretion of Ministers.

Secretariat:

Secretarial services are provided by PAGB, the body representing the consumer healthcare industry. We would like to make it clear that the views expressed in this report however are solely those of the All Party Parliamentary Group on Primary Care & Public Health.

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Address: PAGB, Vernon House, Sicilian Ave; London, WC1A 2QS.

ii. Structure of the Inquiry Report and Acknowledgements

This is the report of a four month inquiry into public, patient and health professional engagement and the NHS White Paper. Following a short introduction, the report begins with the conclusions and recommendations and continues with a synopsis made up of highlights from the written and oral evidence.

In this Inquiry we wanted to assess what Government is doing to encourage health engagement of patients, the public and those working in the NHS. The benefits of health engagement are widely acknowledged and linked to improved health outcomes, patient empowerment and long term efficiency savings in the NHS. For the purpose of the Inquiry we invited views of the NHS White Paper and whether it contains the framework to engage patients and the public to allow people to be informed and engaged in making the right health choices for themselves and their family members. And, since it isn't enough to simply engage patients and the public, those working in the NHS must also be engaged in order to encourage and educate patients on how to look after their own health during NHS interactions.

In order to understand whether proposals in the NHS White Paper are enough to engage people, patients and health professionals in encouraging people to take responsibility in their own health we invited respondents to answer a series of questions which are set out in the next chapter.

We would like to take this opportunity to thank those individuals that took the time to give evidence at the oral hearings, those who attended them and to the organisations, and individuals that submitted written evidence to the inquiry (please see Annex i for details).

We are also grateful to Government for giving oral and written evidence; these are included in Annex ii and iv. If you would like to receive evidence from any of the remaining organisations, please contact the secretariat.

This report has been sent to Government for their consideration.

1. Introduction

Government's vision for health was unveiled in the White Paper, "Equity and Excellence: Liberating the NHS". Proposals are designed to strip away layers of Whitehall bureaucracy, to devolve power and responsibility for commissioning services to healthcare professionals through GP consortia, and to allow for improvements in efficiency.

Government is very much in favour of people taking greater responsibility for their lives and we wondered if this is reflected in health policy. In order for people to take greater responsibility in their own health care, they have to be engaged and encouraged to look after themselves. To be supported into having the confidence to make the right health decisions.

For this to happen it is vital that patients and the public are engaged in their health and given information and education to do this. It is also important that those working in the NHS are engaged and supported to inform patients of the ways in which they can help themselves.

Increased engagement is key to securing the health system of the future, according to Sir Derek Wanless's 2002 long-term vision for health, to lessen demand and allow for improvements in productivity.

Through the NHS White Paper, Government hopes to address demand and cost pressures in the NHS and to make the £20 billion efficiency savings in the next three years; if implemented correctly health engagement can help towards these efficiency savings whilst at the same time making the public and patients more empowered in their health decisions.

In addition to patient experience, we also invited respondents' views on the huge structural changes being proposed in primary care and asked if PCTs and SHAs could have been part of the solution in improving healthcare to their local populations.

1.1 Terms of Reference

Our terms of reference for this inquiry were as follows:

Do you think the reforms announced in the NHS White Paper will deliver the health improvements promised by Government?

Will engaging the public and professionals save money and save lives?

Have we given enough time to embed the last major reconfiguration, could SHAs and PCTs have been part of the solution?

Does the NHS White Paper have what it takes to achieve the fully engaged scenario through greater engagement and increased productivity?

If not, what can be done to improve productivity in the NHS?

2. Conclusions & Recommendations

Summary

The vision of the NHS White Paper, putting patients and the public first and improving health outcomes are excellent aspirations. Much of what is proposed in the White Paper is ambitious and requires a great deal of support and leadership in the NHS not to mention a significant amount of vision on the part of users and those working in the health system. The structural changes are vast and will result in a very different NHS to the one we know now and some respondents refer to this as "the new world".

Reforms such as these require far more detail than is available in the NHS White Paper in fact many proposals are lacking detail although, when questioned, the Health Minister told us the NHS White Paper is deliberately a brief statement of Government's vision.

There is no doubt that Government is committed to encouraging people to take greater interest in their health and take responsibility for it. Its ethos of "no decision about me without me" is proof of this and the provision of health information is a major priority in the White Paper. However, information especially on-line, is not enough and won't reach everyone and so we feel more should be done. One way of encouraging health engagement is through health professionals. People and the public trust professionals working in the NHS and so health professionals are ideal in assisting people to realise their full potential in looking after their own health.

There is no mention of how new commissioning organisations will take on public and patient engagement for their local areas. Whilst it is good that

local populations will drive local services it is essential that patient and public engagement is not lost in favour of bigger priorities.

A national programme to ensure patients understand how to use health services and how to take care of their own health is also needed and is something that should be encouraged at national level. We are hopeful that public health programmes engaging people in their health are proposed in the forthcoming Public Health White Paper.

Whilst encouraged by Government's obvious commitment for greater health engagement and look forward to seeing these policies fully implemented as planned, with our recommendations taken into consideration; we have concerns about the scale and pace of the structural reforms proposed in the NHS White Paper and the potential loss of crucial expertise as a consequence of this.

Recommendations

2.1 Will the NHS White Paper deliver the health improvements expected by Government?

Many of the proposals made in the NHS White Paper are positive and could potentially deliver the health improvements expected by Government. The lack of detail around proposals however deters us from emphatically saying whether Government's vision will be realised.

Recommendation i:

We recommend that more information should be made available on how Government proposes to implement many of the policies in the White Paper. Subsequent papers surrounding the proposals made in the NHS White Paper, including the forthcoming Public Health White Paper are more in-depth and provide greater clarity to proposals particularly around implementation.

2.2 Will engaging the public and professionals save money and save lives?

It is clear that health engagement is necessary for the future of the NHS and the NHS White Paper contains encouraging strands of engagement for example, its ethos of “no decision about me without me” and the promise of shared decision making consultations. However, the failing is the lack of detail once again. There is no clear implementation plan on how these elements will work in practice. To begin with we feel it is essential that all NHS interactions have at the heart of them an element of self care and self-management whether this is during a GP consultation or a visit to A&E.

Recommendation ii:

For the NHS staff of the future we recommend colleges and universities include in their training, elements of how to engage patients into helping themselves and take responsibility for their own health, to empower patients and allow a more fulfilling two-way consultation thus co-creating better health outcomes.

Recommendation iii:

For current NHS staff there is a need for training courses, to help professionals realise their potential in encouraging greater positive health behaviours in their patients and the public. These should be supported by incentives in frameworks such as QOF to encourage those working in the NHS to include self care education as part of their consultations and interactions with patients.

2.3 Have we given enough time to embed the last major reconfiguration, could SHAs and PCTs have been part of the solution?

We have been convinced that with a few modifications to PCTs and encouraging greater local health partnerships, the vision Government is seeking could be met without embarking on the radical reforms being proposed.

The reforms such as they are will also be extremely costly, result in a drop in productivity in the NHS and there is also the real threat of losing crucial expertise that currently exists in PCTs and SHAs and we are concerned for the future of the health system if these experts are lost.

Recommend iv:

We recommend Government re-think the scale and pace of structural reforms and approach it in a more measured way that will ensure continuity of management and leadership. This can be done by building on existing arrangements, strengthening GP commissioning within current structures and streamlining the organisation of the NHS by reducing the

size and numbers of PCTs gradually as functions are handed over to commissioning consortia at a more progressive rate.

Recommendation v:

We recommend that if Government intend to continue with their reforms as they are now, then it is imperative the transition period is managed properly to include an effective plan for transferring the expertise that lies within these organisations and ensure the growing body of knowledge on patient and public engagement is not lost to the new commissioning consortia and the NHS Commissioning Board.

2.4 Does the NHS White Paper have what it takes to achieve the fully engaged scenario through greater engagement and increased productivity?

We are convinced that achieving the Wanless fully engaged scenario will be a great challenge in the NHS especially in light of the structural reforms which will divert attention away from driving up productivity.

We conclude it is important to intensify levels of engagement to help efficiency savings and NHS productivity during these challenging times.

Recommendation vi:

We recommend more is done beyond on-line information to support people taking responsibility for their own health. We recommend the implementation of public health information programmes nationally and

locally that incorporate social marketing to ensure the right messages are aimed at the right people at the right time in their lives.

Recommendation vii:

We recommend also that this is made national legislation to ensure new organisations understand the importance of health engagement.

Recommendation viii:

We recommend programmes are fully evaluated with respect to their impact on health behaviour with on-going research to ensure we continue to understand why people adopt unhealthy behaviours and who would benefit from change.

2.5 If not, what can be done to improve productivity in the NHS?

We conclude that the greatest way of improving productivity in the NHS is for greater engagement and communication between everyone involved in the NHS. Partnership working is essential to ensure a patient centred NHS and this is recognised in the NHS White Paper.

Recommendation ix:

We recommend the expertise and experience of all healthcare professionals including secondary care clinicians, nurses, managers, therapists and pharmacists as well as GPs are maximised to ensure the

new system works. It might be necessary to have in place a framework of principles for NHS organisations in order to ensure everyone is clear in what is expected of each other. This is especially important in the “new world”.

3. Summary of Evidence

Do you think the health reforms announced in the NHS White Paper will deliver health improvements promised by Government?

Our members support the Government's objectives. Empowering and engaging patients is clearly the right thing to do. There are strong arguments for involving clinicians more closely in decisions about the design of care and management of resources. We also see major opportunities to improve the way the NHS works for patients, if the reforms operate effectively. However, after analysing the proposed new system, we have identified significant risks, worrying uncertainties and unexploited opportunities. All these need to be addressed if the reforms are to have the best chance of success. **NHS Confederation**

Many respondents support the aims of the NHS White Paper to put patients and the public first and improve health outcomes. They welcome Government's expressed commitment to patient empowerment, improving the patient experience and promoting shared decision-making. These respondents are also confident that, if implemented effectively, then it will result in excellent health benefits.

There were some concerns expressed by the King's Fund, the BMA, RCN and RCGP however about the scale, pace and cost of the reforms (in excess of £3bn according to RCN). Such ambitious reforms are likely to divert effort, at a time when improvements in productivity are crucial.

According to Civitas it takes a period of three years after major structural reforms before performance levels are back to pre-reform levels. This risk may well be exacerbated by the loss of expertise in the new organisations and it was essential that every effort should be made to preserve the excellent managers and leaders before PCTs and SHAs are phased out.

Concerns were raised about the skills of GPs with the Greater Manchester Directors of Public Health Group making the point that GPs do not have the skills and experience to enable them to focus on whole populations. They want to see public health advice and support available within commissioning arrangements to ensure the whole population are engaged in looking after their own health and other public health aspects.

There were mixed feelings about the focus from targets to outcomes in the NHS and while Executive Directors of Public Health in Wigan agree with the re-orientation, they feel some process measures may give a better indication of patient experience. Arthritis Care and members of the Queen's Nursing Institute (QNI) feel this is true of the 18 week target and abolishing it will result in people waiting much longer for treatment.

A public health registrar in Stockport feels cost cutting will impact significantly on public health functions since health promotion messages and investment in health promoting services are often the first causalities during financial pressures. Cost cutting is also a worry for Arthritis Care and QNI; whilst Arthritis Care fears essential services will be cut, QNI have already had reports on manpower reductions, down grading of posts, ending innovative projects and a rush to retirement. They make the point that workforce issues should be addressed early on if Government wants to achieve the vision in the NHS White Paper or no one will be around to deliver the health services of the future. The RCN agrees and expressed their concern that NHS staff will be asked to carry out their roles, finding efficiency savings and moving towards reform when faced with the possibility of redundancy or working with insufficient colleagues and reduced resources to support them.

Will engaging professionals and the public save money and save lives?

Yes, depending on the nature and quality of the engagement.

There is a considerable body of evidence that engaging patients in decisions about their care promotes better care and more rational resource allocation too. Shared decision making is the process whereby informed patients are supported to make a decision where they face treatment options or need to plan the management of their long term conditions. Evaluations of patient decision aids and various other forms of self-management support show that they can lead to the following benefits:

- Improved knowledge and understanding (health literacy)
- More accurate risk perceptions
- Greater comfort with decisions
- More participation
- Fewer patients choosing major surgery
- Better treatment adherence
- Improved confidence and coping skills
- Improved health behaviours
- More appropriate service use, with cost neutral or cost-saving effects

National Voices

Arthritis Care agrees that engaging clinicians, patients and members of the public in healthcare decisions has the potential to greatly improve quality, improve health outcomes and save money through avoidance of unnecessary or repeat visits or test and thereby also save (and improve) lives. National Voices adds that engagement is vital to ensure a sustainable NHS in the future.

Respondents remain optimistic, but feel the mechanisms to achieve greater engagement amongst patients, the public and health professionals

are lacking in the NHS White Paper. Respondents admit this is difficult; the NHS Confederation makes the point that past Governments have attempted to engage and empower patients with poor results.

Achieving greater engagement would require a cultural change in the NHS; for those working in NHS organisations to want to engage themselves and help engage their patients. The NHS Confederation would like to see patient and public engagement integral to everything. National Voices would like patient engagement to be at the heart of every NHS interaction; examples of this could be a GP educating a patient along the lines of self care for a sore throat or a geriatrician advising a patient on how to prevent another fall.

Civitas believes engaging professionals and the public comes about at the organisational-level through clinical leadership, supported by effective management, persuading other clinicians through insight, relevant data and storytelling that what is happening now needs to change. NHS Cumbria is an example of where engagement has worked, comparing month one in 2010 with the same month in 2008 saw a drop of 2% in non-elective admissions and 13% in A&E attendances, compared with 8.9% and 4.7% increases across England.

Picker Institute is concerned that GP consortia will not implement patient and public engagement; they would like to see the relevant competencies (1-3) of the World Class Commissioning framework translated into a compulsory framework for GP consortia; with the indicators reviewed and amended appropriately.

Have we given enough time to embed the last major reconfiguration, could SHAs and PCTs be part of the solution?

PCTs should be part of the solution. Evidence from the World Class Commissioning framework shows improved performance on the part of PCTs on the previous year. While there is still much room for improvement, the best performing PCTs have learnt much over the past five years about approaches to needs assessment, tendering, contract and relationship management, and have developed commissioning skills that will need to be learnt afresh in many GP consortia. The best PCTs also involve clinicians in leadership roles: a key goal of introducing GP consortia.

There is a certain obvious irony in the Coalition Government titling its White Paper *Liberating the NHS*, and claiming to be promoting greater devolution and increased localism, but in reality introducing yet another centrally planned reorganisation of the NHS akin to those initiated by previous governments, in which a particular organisational form (in this case GP commissioning consortia) is mandated, and a centrally imposed timetable for its implementation is imposed. **Civitas**

Most respondents felt PCTs should be part of the solution and Civitas highlighted recent data that showed the improved performance of most PCTs. Many respondents wanted modifications made to PCTs and to redefine their role; Civitas believes their role has caused confusion in the past and they should be seen as impartial commissioners with support from Government. NHS Salford suggested PCTs' power is strengthen over dominant providers and savings targets are introduce and see these changes as a more measured approach to collapsing the whole system.

Members of the RCGP agree that there is no need for such a wholesale change in NHS structures and worry about the lack of a regional structure equivalent to the SHA in the new system. They are happy for more GP involvement and want to see more GPs on the boards of current PCTs; allowing GP knowledge and experience to be brought to the fore.

The NHS Confederation agrees with the RCGP and welcomes involving clinicians more closely in decisions about the design of care and management of resources.

In the White Paper there is huge emphasis on clinicians to deliver productivity improvements and the RCGP doubts whether they have the capacity to do this alongside their professional responsibilities. Some respondents also doubt that GPs have the skills and knowledge needed to manage the complexities needed to run successful consortia.

Does the NHS White Paper have what it takes to achieve the fully engaged scenario through greater engagement and increased productivity?

We are surprised and disappointed that the proposals include no specific or practical commitments to increasing the range, reach or impact of engagement;

we hope and expect that this will be redressed in the proposals for the new Public Health Service and its Outcomes Framework;

otherwise, much will depend on developing robust NHS and Public Health Outcomes Frameworks that effectively performance–manage commissioners and providers: this means making best use of available experience and expertise to develop useful, reliable and meaningful indicators.

The White Paper and related consultation documents do not explain how the proposed structural reforms will increase the extent or impact of

engagement. There is, in particular, no explanation of how existing engagement evidence, best practice or performance management will be integrated into the new NHS structure and commissioning arrangements. **Picker Institute Europe**

We have, according to the King's Fund's 2007 analysis been progressing in line with the middle of the three scenario's set out in Wanless's 2002 review of future NHS funding, the solid progress. Continuing to meet this scenario would, according to the King's Fund require the NHS to deliver £14 billion of productivity improvements by 2013/14 which equates to productivity gains of 3-4 per cent a year to maintain quality and avoid cutting services.

This is a major challenge for the NHS and whilst the NHS White Paper has the potential to deliver improvements in productivity, this will be hampered due to the structural changes diverting attention from the essential task of delivering productivity improvements; this won't be helped by the cuts in management costs and the likelihood that experienced leaders will leave the NHS.

The NHS Confederation's view is that higher levels of public engagement are needed for patients to take a more active part in managing their own health care. And whilst information is key, more needs to be done beyond the publication of information to achieve cultural and behavioural changes towards people taking responsibility for their own health. They believe too that processes have to be put in place to ensure professionals adequately engage the public.

If not, what should be done to increase productivity in the NHS?

There are opportunities to improve efficiency at every level of the health system. The most significant opportunities will come from focusing on reducing variations in clinical practice - evidence suggests productivity improvements valued at £4.5 billion could be made in hospitals alone by bringing performance up to the level already achieved by the best. This means, for example, reducing the length of time patients spend in hospital and reducing admission rates through better care in the community. More effective working across systems, with flexibility to integrate primary and secondary care can contribute to both cost and quality improvement.

Significant savings can also be made by tackling inefficiencies in support services and back-office functions, reducing spending on low-value interventions and redesigning care pathways (especially for people with long-term conditions), and increasing workforce productivity by improving staff performance, tackling sickness absence and adopting more flexible ways of working. Delivering productivity improvements on the scale needed will require action at all levels of the system, especially within clinical microsystems – the frontline teams delivering care to patients who have the most important role to play in reducing clinical variation. This should be the single minded focus for the NHS during the next few years. King's Fund

Most respondents see the potential for huge health improvements if proposals in the NHS White Paper are implemented. Although, there were many suggestions of how efficiencies can be made as stated above by the King's Fund.

The NHS Confederation highlights the importance of drawing upon the expertise and experience of all healthcare professionals including

secondary care clinicians, nurses, managers, therapists and pharmacists as well as GPs to ensure the new system works.

Respondents were concerned about the transition period to the new system and the NHS Confederation pointed out this should not be underestimated and should be managed properly. National Voices agreed and asked that an effective plan is set up for transferring the expertise that lies within PCTs and SHAs including the growing body of knowledge of patient and public engagement.

Greater consideration has to be given to the mechanisms for achieving successful patient, public and health engagement in order to result in patient and public empowerment and to encourage a more effective use of NHS resources.

National regulations should be put in place in order to ensure consortia are accountable for identifying and meeting health needs of their population and encourage people to engage in taking care of their health.

Commissioning organisations have to have a clear set of principles to help shape the way they operate and to help them understand national expectations.

The medical director for NHS Salford sees the need for a strategic publically owned blueprint that clearly describes what the NHS is going to look like in a particular area, region or nation. This should be based on what the NHS can afford and the principles or shifting resources from secondary to primary care and treatment prevention. Clinicians in hospitals and primary care should be personally responsible for budgets and surpluses made in secondary care should be reinvested in primary care.

The point was made that educational establishments need to prepare students for the changes in the health care system. The RCGP agrees and

asks Government not to overlook the importance of medical education for the future development of the NHS.

Whilst many respondents felt the massive reforms should not be implemented, many made the point that if they are, Government should allow time for change to happen before reorganising the system in the next few years. Along the same lines, a respondent from North Yorkshire asked Government to establish clear priorities for all NHS organisations and resist constantly adding to them.

ALL PARTY PARLIAMENTARY GROUP

Primary Care and Public Health

Annex i – Organisations & Individuals that submitted written evidence

Dr Yasmin Ahmed Little
Dr Bryan Anderson – NHS Lincs
Association of Directors of Public Health
ARMA
Arthritis Care
British Medical Association's GPC
Company Chemists' Association & Aim Pharmacies
CIVITAS – Institute for the study of civil society
Geraint Day, Swindon Local Involvement Network (LINk),
Department of Health
Mo Girach, Special Adviser on Social Enterprises
Dr Hope, NHS Salford
Dr Julian Morgan, Wolverhampton GP
King's Fund
Leed's University
Lloydspharmacy
Pickers Institute Europe
National Voices
NHS Bucks
NHS Cumbria
NHS Direct
NHS Hereford
NHS North Yorkshire & York
NHS Salford
NHS Wigan
North West SHA
Queens Nursing Institute (QNI)
Royal College of General Practitioners
Royal College of Nursing (RCN)
Soda
Albertina Teague

Annex ii – Evidence Submitted By Government

ALL PARTY PARLIAMENTARY GROUP
PRIMARY CARE AND PUBLIC HEALTH

THE NHS WHITE PAPER AND PUBLIC ENGAGEMENT

Submission from the Department of Health

1. Do you think the reforms announced in the White Paper will deliver the health improvements promised by Government?

The White Paper, *Equity and Excellence: Liberating the NHS*, provides a coherent framework for reform of the NHS, based around three key themes:

1. Putting **patients** at the heart of everything we do, giving them more choice and control, easy access to the information they need. Patients will be enabled to take part in decisions about their care: 'there will be no decisions about me without me';

2. A relentless focus on clinical **outcomes** so that that the NHS achieves outcomes that are among the best in the world; and

3. **Empowering clinicians** to use their professional judgement about what is right for patients by giving front-line staff more control. Micromanagement by the Department of Health will end.

The White Paper explains how patients will be placed at the heart of the NHS, with greater say and choice over their healthcare. Choice of provider should support improved health outcomes by giving providers of NHS funded care an incentive to improve the quality of their services in order to retain existing patients and/or attract new patients. Indeed, research shows that choice and competition lead to improvements in the quality of health services.

It also sets out the Government's aim to achieve healthcare outcomes that are among the best in the world. This ambition underpins many of the White Paper proposals - from the new NHS Outcomes Framework to extended patient choice and the information revolution. Moreover, greater autonomy for the NHS will give practitioners and providers more time to focus on improving outcomes.

Improving quality and health outcomes should be the primary purpose of all NHS-funded care, but there can be no meaningful accountability for this unless we know what quality means and are able to measure it. We intend to replace the current performance regime with separate frameworks for outcomes, which set direction for the NHS, public health and social care, provide for clear and unambiguous accountability, and enable better joint working.

The NHS Outcomes Framework will include a focused set of national outcome goals determined by the Secretary of State, against which the NHS Commissioning Board will be held to account, alongside overall improvements in the NHS. It will cover three measures of quality:

- the effectiveness of the treatment and care provided to patients – measured by both clinical outcomes and patient-reported outcomes;
- the safety of the treatment and care provided to patients; and
- the broader experience patients have of the treatment and care they receive.

We envisage that the NHS Outcomes Framework will go beyond ensuring that there is accountability for better outcomes, and actively drive up quality across all NHS services in order to achieve better outcomes. The NHS Commissioning Board will work with GP consortia, clinicians,

patients and the public to deliver improvements against the outcome goals set in the NHS Outcomes Framework, and their progress against these outcome goals will be made publicly available.

The NHS Outcomes Framework and extended choice will most effectively improve health outcomes if they are supported by high quality, reliable information. The White Paper sets out how we intend to bring about an information revolution to make sure that everyone has access to information for better health outcomes - from patients using information about healthcare services to make choices that could improve their health, to practitioners making sure that they are providing the best possible care to their patients; from providers responding to patient feedback to regulators making sure that providers meet essential quality and safety levels.

The only way to make sure that these proposed changes will actually achieve improved health outcomes is to liberate the NHS from unnecessary bureaucracy and process-oriented targets. The White Paper sets out how we intend to give professionals and provider greater autonomy, so that they can focus on securing the quality, innovation and productivity needed to improve outcomes. And giving local authorities a role in promoting the joining up of local services will strengthen the democratic legitimacy of the NHS at the local level.

2. Will engaging professionals and the public save money and save lives?

The evidence shows that people who share decisions about their health and care in partnership with their clinicians are more likely to follow their treatment and care plans, and so have better health outcomes. For example, research shows that people with long-term conditions who work collaboratively with clinical teams and openly share in discussions about responsibility and risk are likely to have better clinical outcomes. The Wanless Report also shows that shared decision-making can bring significant reductions in cost.

For these reasons, we want the principle of 'shared decision-making' to become the norm. We want to realise the potential of patients as joint providers of their own care and recovery. Subject to Parliamentary approval, the proposed NHS Commissioning Board will champion patient and carer involvement, and the Secretary of State will hold it to account for progress.

The consultation paper *Liberating the NHS: Greater choice and control*, published on 18 October, explores how we can make shared decision-making a reality and what support and information people need in order to have a say in their healthcare.

Empowering professionals to focus on clinically-evidenced healthcare outcomes rather than top-down process targets is central to improving quality of care. It allows them to concentrate on what should be the focus of their job. Evidence from the experience of GP fundholding also shows that bringing together clinical decision-making with the financial responsibility for those decisions, as our proposals for GP commissioning intend, reduces costs.

3. Have we given enough time to embed the last major reconfiguration, could SHAs and PCTs have been part of the solution?

The role of SHAs and PCTs do not fit with the government's vision of an autonomous NHS. One of the core purposes of the White Paper's proposals is to put decisions in the hands of clinicians and to free providers from unnecessary interference by central government. It will not be possibly truly to devolve power to professionals and providers if the command and control role exercised by SHAs at the regional level continues.

Similarly, giving responsibility for commissioning to GP consortia is central to the government's vision of shifting decision-making as close as possible to the patient. Primary care professionals' role in coordinating all the services that patients receive place them in the ideal position to

commission care for their patients. If we are to realise the prize of empowering professionals in this way, the commissioning role of PCTs must be transferred to GP consortia.

Initially, as set out in the Coalition Agreement, the government intended to maintain the PCT's role in public health improvement and to ensure a stronger voice for patients locally through directly elected individuals on PCT boards. However, the government decided that this was an ineffective and expensive solution. We propose to better achieve the same aims by transferring health improvement functions to local authorities, building on their existing democratic legitimacy. This will both realise administrative cost savings and achieve greater alignment with local government responsibilities for health and wellbeing.

Removing unnecessary management layers is an essential part of placing power in the hands of patients and professionals, improving efficiency, and delivering better value for the taxpayer. The NHS will have greater autonomy, matched by increased accountability to patients and democratic legitimacy. These changes will free practitioners to focus on improving outcomes, and will drive efficiency. Management cost savings alone will be £850million per annum from 2013/14 onwards, which will be reinvested in frontline services.

The White Paper explains how, in future, GPs rather than PCT managers should decide how to use NHS resources to get the best health care and outcomes for their patients. The financial power to change health services will be in the hands of the NHS professionals whom the public trust most, whilst giving more responsibility and control over commissioning budgets will help GPs consider the financial consequences of their clinical decisions.

We recognise that a number of PCTs have made important progress in developing commissioning experience, which we will look to capitalise on during the transition period. PCTs will have an important task in the coming years in supporting practices to prepare for these new arrangements.

Subject to Parliamentary approval, the NHS Commissioning Board, which will support GP commissioning, will become fully operational from April 2012, removing the need for SHAs. In the meantime, SHAs will continue to have a vital role in delivering financial control and performance, and driving improvements in quality and productivity.

4. Does the NHS White Paper have what it takes to achieve the fully engaged scenario through greater engagement and increased productivity?

The government shares the ambition of Derek Wanless' fully engaged scenario. We envisage improved health outcomes, high levels of public engagement with health and confidence in the NHS, and an NHS that is more responsive and efficient.

A key feature of the fully engaged scenario is high public engagement as a result of widespread access to information. The White Paper sets out our intention to bring about an NHS information revolution, to make sure that people have access to comprehensive, trustworthy and easy to understand information from a range of sources.

The Department of Health will consult on proposals for the information revolution, and will develop an information strategy to deliver it. By 2015, we envisage a number of key improvements in the information available, including patient and service user access to their health and social care records and greater information about the services available to them and the quality of those services.

Our intention is that increased use of patient generated information such as patient-reported outcome measures (PROMS), patient experience data, and real-time feedback will support the NHS to be more responsive, enabling services to better match what patients need and want from their care.

Improved openness and transparency should lead to higher public confidence in the NHS, as people will be able to access information on how the NHS is delivering the outcomes for which it is accountable. Moreover, better access to information will inform patient choice and support improved health outcomes. Information for patients about their own health, for example by having greater control over their records, could form a basis for personal health strategies and help people to take greater responsibility for their own health and well-being - the 'active ownership' envisaged by Derek Wanless.

Productivity is a key driver of the 'fully engaged' scenario, and the White Paper sets out the Government's commitment to a more productive NHS. We will remove unnecessary layers of bureaucracy to give providers and practitioners greater autonomy and allow commissioners to focus on investing public resources effectively. The introduction of GP consortia means that responsibility for clinical decisions and for the financial consequences of those decisions will be brought together. The White Paper reforms will also increase the focus on the outcomes commissioners are achieving, and this will help to drive the delivery of quality and productivity improvements across the NHS.

The Public Health Service will have a key role in achieving the improvements envisaged in the Wanless Report. The Government is committed to protecting and helping to improve the nation's health and wellbeing. To achieve this requires a stronger focus on public health and the prevention of disease, working in partnership with services to treat ill health. It requires a greater focus on evidence-based approaches to drive behaviour change. The Department will set out its programme for public health, including the streamlining of existing public health bodies and functions into a single, unified and professional Public Health Service, in a White Paper later this year.

5. If not, what should be done to increase productivity in the NHS?

The proposals set out in the White Paper are a coherent set of reforms which will strengthen incentives for efficiency over the long term, cut bureaucracy and place the NHS on a sustainable footing for the future.

Implementing the proposals will take a several years. The timescales are set out in the White Paper. Subject to Parliamentary approval, the majority of the reforms will come into effect in April 2012, including the establishment of the NHS Commissioning Board, the new local authority health and wellbeing boards, Monitor as the economic regulator and HealthWatch. According to our proposals, GP commissioning will be fully operational by April 2013.

In the meantime, the current drive to improve quality and productivity in the NHS in a priority. We know that local teams must find local solutions, because inevitably they know what will work best with their local services. The Department of Health will continue to support local teams to do this. In addition, the Department has set up national workstreams in 13 initial high impact areas, each with its own dedicated lead, to help drive the quality and productivity challenge across local organisations. There is a need to work at scale and pace to deliver the level of efficiency savings that are required by 2013/14.

Through the national workstreams, the Department of Health is supporting the NHS to improve productivity in two ways. The first is to drive out inefficiencies from the current system, whether in procurement, pharmacy, or the way staff are deployed (technical efficiencies). The second is through creating significant improvements to the way services are currently delivered to patients, finding new and better ways of providing care (allocative efficiencies)

Increased quality and productivity will be best achieved through organisations working collaboratively throughout the system, sharing ideas and cooperating closely with each other and with key partners such as social services.

ALL PARTY PARLIAMENTARY GROUP
Primary Care and Public Health

The NHS White Paper & Patient Engagement

Annex iii –Write Up from First Oral Evidence Session

Oral Evidence Session
Tuesday 26th October 2010, 3.30 – 5.30pm, Committee Room 13

APPG Members

Lord Hunt, Chair
Kevin Barron MP, Co-chair
Baroness Masham, Secretary
Julie Elliott MP, Executive Member
Lord Warner

Witnesses

Jeremy Taylor, CE, National Voices
Dr Laurence Buckman, Chairman, BMA's GPC
James Gubb, Director, Civitas

NHS White Paper: some optimism for improving public engagement in health, but early days yet, experts tell MPs

Equity and Excellence: Liberating the NHS - the White Paper on the future of the health service published by the government in July - could potentially provide exciting opportunities to improve health outcomes by helping people become more involved in their own care. However, much more needs to be known about the government's plans, particularly against a background of the unprecedented efficiency savings which the NHS needs to make in the next four years, experts have told MPs.

Moreover, the pace of change planned by Ministers for this latest reorganisation of the NHS is of concern, they told the All-Party Parliamentary Group on Primary Care and Public Health (APPG), during an evidence session held on October 26 as part of the APPG's inquiry into the White Paper and public engagement.

From the patient perspective, the vision of "no decision about me without me" as set out in the White Paper is a "very compelling and powerful call to action," but how Health Secretary Andrew Lansley intends to implement it is not yet clear, said Jeremy Taylor, chief executive of National Voices, the coalition of national voluntary organisations in health and social care.

No decision about us without us?

He also noted that the Paper is "relatively silent" on the issue of "no decision about us without us" - methods of collective engagement in the design of health care service delivery. Giving local authorities a central role in bringing together joint working by the NHS, the new Public Health Service and social services, as it proposes, makes a lot of sense in dealing with the "enduring scandal" of health inequalities, he said, but added: "we need to see further papers from the government on public health and social care."
The British Medical Association (BMA) agrees that it is too soon to assess the implications of the White Paper, and is concerned at the destabilisation which is being created in the NHS in the three

years leading up to the legislative timescale, said Dr Laurence Buckman, who chairs the BMA GPs' committee. There is certainly potential to reduce health inequalities but nothing will become clear until the legislation is enacted, and maybe not for some time after that, he said, adding: "we should have had a planned transition – what we are getting is a chaotic transition."

Engaging and empowering

Engaging patients more in decisions about their care is empowering and promotes better care and more rational resource allocation, but both patients and health professionals will need help to achieve successful shared decision-making, said Jeremy Taylor.

Patients will need training in how to manage their conditions while GPs need to be trained in how to "coach," he explained, but the result will be more powerful and effective consultations - and not necessarily longer ones. "More confident patients take up less time. The evidence shows that these approaches lead to happier patients, better outcomes and often – by choosing more appropriate treatment outcomes – better value for money," he said.

Dr Buckman pointed out that training in consultation skills has long been compulsory for medical students, and while shared decision-making is central to every GP consultation, doctors need to recognise that it will become even more important in the future. "The next generation of doctors will have to be educated to work in a different world," he said.
"Myth" of 10-minute consultations

Moreover, it is a myth that GP consultations are limited to 10 minutes, he added; patients get the length of time they need, and the evidence shows overwhelmingly that longer consultations produce better outcomes.

But do patients feel that they are as involved as much as they want to be in their care? Surveys conducted over each of the last eight or nine years continue to show fairly stable results; around 70% of primary care patients and hospital outpatients say they feel satisfied with their degree of involvement in their care, but only about 50% of hospital inpatients agree and among mental health inpatients the satisfaction levels are even worse, said Jeremy Taylor.

Laurence Buckman suggested that if doctors were to look beyond what happens in their surgeries and out to the patient's entire care pathway, this could be "a terrific opportunity" in terms of educating both patients and GPs. Re-examining and rewriting care pathways could improve a good deal of chronic and most acute care, and also deter the "game-playing" of multi-referral for the same condition, which "infuriates GPs and is a waste of taxpayer money," he suggested.
The obesity epidemic – why have we failed?

The White Paper has appeared at a time when obesity and diabetes are reaching epidemic proportions in the UK. The implications for society are massive, yet public health initiatives seem to be having little effect on improving unhealthy lifestyles. So, the MPs asked the experts: how can the public become more widely engaged in taking responsibility for their own health?

And should this involve denying NHS care to people who don't look after themselves?
Care is already being rationed, and quite overtly, Dr Buckman responded; patients are already denied treatments because of their smoking and obesity issues, either through clinicians' decisions or because of where they live and, with the shrinking economy, this will happen even more. Certain serious kinds of care will have to be restricted and some very difficult choices made, and while it should be for society to make these decisions, he believes this responsibility will inevitably fall to GP consortia and other parts of the NHS. "The only way to stop this happening is through having a single NHS provider," he said.

He also warned that, under the White Paper's proposals, the difficulties which are created now when one PCT makes an expensive drug treatment available to its patients but another does not would get very much worse. All three political parties want there to be no boundaries in primary care, but under the proposals, as "all norms of geography disappear," the availability of a particular treatment – or lack

of it – would enable one GP consortium to take the patients of another many miles away, and this would happen across both primary and secondary care.

Currently, no-one would choose to be treated by a GP located a long way away, nor do people generally change their doctors. “But if you need an expensive treatment that is available not to your GP but to one 200 miles away and your life depends in it, you will change – you’d be mad not to,” said Dr Buckman.

Conflicts “inevitable”

Essentially, the White Paper is about making GPs responsible for their budgets alongside their patient responsibilities, said the APPG’s chair, Labour peer Lord Philip Hunt. He wondered: will this create conflict for GPs?

It will, inevitably, and doctors will have to manage these conflicts, said Dr Buckman. However, he emphasised that, as a GP his principal relationship in the NHS is with his patients, and if he has to advocate, it will be for his patients – not his consortium.

There are also potential conflicts of interest between GPs’ roles as commissioners and providers, said James Gubb, director of the health unit at independent think tank Civitas. One of the perceived advantages of Primary Care Trusts (PCTs) is that they represent patients independent of provider interests, but while GPs are the best guardians of patients’ interests they may also be the best guardians of producer interests. For example, why are there so many general practices in middle-class areas and not in poor areas? And why is there so much clinical variation? The conflict lies in getting the best deal for the patient, said Mr Gubb.

Reaching marginal populations

Engaging patients more in their own health care also includes those in marginal populations such as the homeless, added Mr Gubb, and he described the pioneering work being done by specialised medical professionals at centres in London such the Bromley by Bow Centre community group, the Great Chapel Street Medical Centre for homeless people in Westminster, and in a study conducted at University College Hospital (UCH). These professionals are working not only with patients’ medical conditions but also with wider issues such as their housing and work situations, they are engaging with them, finding out their needs and connecting them with the right services. This approach is cost-effective, he said; the UCH study shows it improves outcomes and reduces costs - there are fewer readmissions, for example.

There is potential in the White Paper’s proposed Health and Wellbeing Boards to look at these issues more widely, but in the end it comes back to the need for a profound culture change, he said.

Part of this culture change is about the communication methods which can help in promoting good public health, such as social networking and community engagement, added Jeremy Taylor. Many health professionals understand what is needed to deliver modern health care that has a public health focus; Professor Steve Field, past chairman of the Royal College of General Practitioners (RCGP), has pointed to the duty of modern doctors to reach out to individual populations and take a holistic interest in their needs, social care, housing and employment status. A large part of the medical population does get this, but the challenge is how to make it consistent, said Mr Taylor.

The issue of fairness is not just about whether a drug is available in one area but not another; we need to understand the needs of local populations, actively involve them in decision-making and commission against pathways, he advised.

Also, getting people to engage more in improving their health has to be about carrots as well as sticks. We need to give very active support to the many people who are trapped in unhealthy cycles and who want and need help to get out, Mr Taylor told the MPs.

In fact, said Dr Buckman, the biggest public health educators are celebrity magazines and television soap operas. “Whenever something terrible happens to a celebrity my surgery is full,” he said, but as “each wave of nonsense” results in two or three people who really do have the publicised condition, particularly in the cases of occult neoplasms and diabetes, lives are saved.

But one very significant exception to the general failure so far by public services to help people improve their unhealthy lifestyles has been the hugely successful smoking campaign, in which pharmacists have played a very major role, the inquiry heard.

Pace of change too fast?

The MPs were also told that the speed with which the government wants to see the new GP commissioning consortia established is worrying, given the requirement for the NHS to make unprecedented efficiency savings averaging 4%-5% a year over the next four years.

If the government is serious about “no decision about me without me,” then this has to apply during the transition process while the GP consortia are being established, Jeremy Taylor stated, while James Gubb warned that the upheaval involved in the wholesale restructuring of commissioning could move attention away from patients. Such restructuring is neither necessary nor desirable to improve health outcomes and it could lead to a return to rationing, he added.

GP consortia will form “fairly naturally and relatively easily,” and the government’s requirement that GPs join a consortium based on local geography, with no option for them not to join, will actually make things easier, said Dr Buckman. He believes that consortia will do a lot more than just commissioning and that they will share many activities rather than replicating them individually; “if they don’t, they’re just PCTs,” he said.

NHS management skills must not be lost

Management will be a major issue for the new consortia and Dr Buckman urged them to employ the talent that’s already there among the “vast majority” of NHS managers who do a good job. He wondered why the government is encouraging such “pathfinders” to go so early and warned that their skills must not be lost to the Service.

James Gubb was also concerned that PCTs could be replaced by GP consortia too quickly, and that as Trusts disappear over the next few months their skills and support will be lost to the new structures. A more sensible route, he suggested, could be to have GPs learning by “shadowing” PCTs and taking on responsibility for leading programmes such as Quality, Innovation, Productivity and Prevention (QIPP), for example. In Somerset, for example, the PCT is effectively a confederate for a number of consortia, but this opportunity will not exist in areas where commissioning is less advanced, he warned.

So, Lord Hunt asked: what went wrong with PCTs?

Over the many NHS reorganisations, relationships with GPs, which were once “cosy but effective and cooperative” became confrontational, adversarial and tense, said Dr Buckman. “PCTs have been seen as an instrument of government and, when you’re on the receiving end, it is very uncomfortable,” he added.

Some PCTs have been doing a “not bad” job in engaging patients and doing useful work on health inequalities and health promotion, but on the whole they have been weak in their commissioning functions, especially in terms of confronting vested interests, noted Jeremy Taylor.

James Gubb added that, too often, PCTs have had a confused purpose - are they a provider or commissioner, an instrument of government or an impartial commissioner, an advancer of collaboration or of competition? They should be impartial commissioners and the government should support them in their work, but this has not always been the case, he said.

“Macho” culture is counterproductive

Moreover, the “slightly macho” culture within PCT management, which involves seeing their role as “bashing providers as hard as possible,” is counterproductive, he said. But while this culture is “not particularly healthy…you do not have to rip them up; the best way to educate for cultural change is

through telling stories backed up with hard data, eg, “X person did this, and this was the result’,” he told the panel.

Collaboration or competition?

Is it possible to gain benefits from competition without the risk of breaking up collaborative relationships, of losing the natural tendency of people in the NHS to want to work together?

The BMA and Civitas hold opposing views on the desirability of increasing competition in the NHS, and James Gubb and Laurence Buckman explained their positions to the inquiry.

The BMA believes that the NHS should be the preferred provider – it is in the best position to collaborate across sectors with patients and create pathways which are best for patients, said Dr Buckman, adding: “we shouldn’t spend money on encouraging competition and giving NHS money, even indirectly, to shareholders of businesses.”
He believes the way to produce better care is through cross-sector collaboration. “The bulk of patient activity can be commodified into straightforward pathways – these need looking at carefully – and involving the patients. We should be commissioning community care for quality rather than cost,” he said.

But Civitas believes that increasing competition will deliver health improvements. “As a patient, if I want a service, I want the provider which gives high-quality care for the best cost – NHS or other, I don’t care which. Commissioners should be selecting the provider for me, based on these criteria,” said James Gubb.

Moreover, he pointed out that in sectors other than the NHS, innovation is typically provided by new entrants, who “don’t carry the baggage of operating systems in place, vested interests, a status quo and trying to make more efficient a process that has always been there.” He asked: “why should we exclude these opportunities from the NHS?”

For the patient, good-quality care is what matters, said Jeremy Taylor, adding: “as far as I can see, ‘any willing provider’ does not undermine the founding principles of the NHS.”
We can have both collaboration and competition, he said, and we mustn’t overlook the potential for organisations in the voluntary and, maybe, the commercial sector. In practice, the NHS is the preferred provider and there is room for “a little bit of competition - we are nowhere near the fragmentation that could lead to a free-for-all. Let’s give it a go, within the context of good regulation,” he suggested.

ALL PARTY PARLIAMENTARY GROUP

Primary Care and Public Health

Annex iv – Write Up from Second Oral Evidence Session

The NHS White Paper & Patient Engagement

Oral Evidence Session
Tuesday 9th November 2010, 1pm – 2.30pm, Committee Room 3a

APPG Members

Kevin Barron MP, Co-chair
Baroness Masham, Secretary
Lord Colwyn

Witnesses

1- 1.30pm
Jo Webber, Deputy Director of Policy, NHS Confederation
Frances Blunden, NHS Confederation
Dr Mike Bewick, Medical Director-Primary Care, NHS Cumbria
Dr Huge Reeve, GP Lead – South Lakes, NHS Cumbria

1.30 – 2pm
Earl Howe, Health Minister, DH

Incentives and drivers are needed to boost GP/public engagement in health, says Minister

Encouraging general practitioners to "look beyond the ill patient" and work with the their local communities to keep them healthy is probably not a matter for legislation but it certainly will require incentives and drivers, Health Minister Earl Howe has told MPs.
We are still some considerable way from true patient involvement in their own care and joint decision-making, he told an inquiry held recently by the All-Party Parliamentary Group (APPG) on Primary Care and Public Health.

The APPG has been examining whether the government's White Paper - Equity and Excellence: Liberating the NHS – goes far enough to encourage increased engagement by the public and health professionals in order to achieve the health improvements being sought by Ministers.

Ear Howe agreed that, as a standalone document, there is probably not enough about engagement in the White Paper, but he added that it is deliberately brief statements of the government's vision, filled out by subsequent documents which are now out for consultation.

"Without engaging and involving at all levels – public and patients, clinicians and other health care professionals – it won't be possible to achieve that vision," he emphasised.
Empowerment "leads to better outcomes"

The coalition government did not invent the phrase "no decision about me without me," but "it encapsulates what we think is the right way forward," said Earl Howe. Empowerment, leading to a greater sense of ownership of health and wellbeing, is the way to get better outcomes, but it needs the

right relationships and a change in the culture. None of this will happen overnight, but the White Paper "signals the architecture that we will try to put in place from day one to encourage it, including the duty of involvement," he said.

Much depends on giving people the right information, he added. "The way in which patients engage in the doctor's surgery, at home or in hospital will depend on the provision of good information on which they can base decisions and choices."
Whether or not patients actually want "choice" is much debated, but empowering them so that they understand their illness and the options for treatment does matters because the more people understand, the better are their chances of recovery.

NHS Confederation, GP consortia views

The APPG inquiry also heard the views of the NHS Confederation, which represents both commissioners and providers in the NHS, and from GPs in Cumbria representing a pioneer GP consortium.

Frances Blunden, senior policy manager at the NHS Confederation, told the panel that while the aspirations of the White Paper are "spot on" in terms of creating a patient-centred NHS, the Confederation has concerns about the detail. All health professionals have to be engaged, not just GPs - and especially public health specialists – in driving health improvement. "It is everybody's job," she said.

Another key concern is that ring-fencing the public health budget could led to the perception that health improvements happen "over there," ie, not an integral part of what you do, she cautioned.

Ms Blunden is also worried that it might be considered "enough" to simply publish information for patients, particularly on-line, when in fact around 15% of the population – largely the elderly and people in lower socioeconomic groups – do not have access to these resources. "We need to think about different sources of information and providing it at the right point - for example, when helping people to stop smoking - and ongoing support is vital," she said.

There also needs be greater use of social marketing initiatives, and targeting of population groups who have high levels of need and NHS usage but poor literacy, she added.

Self-care "comes at a cost"

Jo Webber, the Confederation's deputy director of policy, agreed, and pointed out that self-management comes at a cost, because delivering information in the right way for local populations must include giving the right support at the right point and time, and include a variety of approaches to reach the greatest number of people.

Transition fears

APPG chairman Kevin Barron (Labour) told Lord Howe that earlier sessions of the inquiry have heard concerns about the potential risks involved in the transition from Primary Care Trusts (PCTs) to GP consortia, in terms of costs, timeframe issues and potential risks to patient care. He asked the Minister: "are these concerns valid?"
"A transition of this sort carries costs and risks but these can be contained and managed and we are closely engaged in doing both of these things," Earl Howe replied. The cost of implementing the White Paper cannot yet be estimated – an impact assessment is due – but while there will be one-off costs there will also be downstream savings year after year, including £850 million annually from administration alone, he said.

Timeframe is "eminently achievable"

The timeframe is a challenge but it is "eminently achievable," he said. By 2012-13, GP consortia will be operating in shadow form, with the experience of the pathfinder consortia, and in April 2013 they will

go live. “We’ve got over two years and I believe that’s enough,” he said, and dismissed claims that that the timeframe is too rushed. In fact, he said, the risks of taking longer are greater, not least because some of the best people now working at PCT and Strategic Health Authority (SHA) level, who have the skills which are transferrable to the new world, will be lost. “The message to these key people is that they are wanted and we are grateful,” he said; “if we drag the process out, they will become disenchanted.”

“Organisational memory”

Ms Webber also emphasised the need to retain PCT and SHA management input where there is much “organisational memory.”

“We’re not saying things should stay the same – far from it – but there are many skilled and experienced managers with knowledge about what does and does not work, and this has to be held onto,” said Ms Webber.

The key is strong relationships and good leadership, she said, and an example of where this is happening is in NHS Cumbria where, since April this year, an increasing share of the region’s £850 million annual health budget has been directly managed by six GP-led boards. Two representatives from NHS Cumbria - Dr Mike Bewick, medical director for primary care and Dr Hugh Reeve, GP lead for South Lakeland and chair of an embryonic consortium – gave evidence to the inquiry, and while they praised the White Paper’s commitment to patient involvement, they added that much more detail needs to be made available.

The Cumbrian GP consortia were constituted in April, making them among the first in the country, but they have in fact been in formation for four years, said Dr Bewick, Therefore, the GP commissioning plans are nothing new for them and simply represent a natural progression, he said: “in fact, commissioners can do much more than the White Paper thinks.”

However, for some other GPs the future is “very frightening,” he added, and forecast that around only 20% of consortia overall will be place by the government’s target of 2012, while for the rest it will be a developmental process. “You can’t learn this on a course or by reading a textbook,” he said; “it takes a lot of time and, to be honest, a lot of pain.”

Failures “must be allowed”

Quite a lot of organisations might fail, and he urged the government to allow this. “You learn on the job, you can’t be taught it and certainly not by ticking boxes,” he said.
The degree of assistance and support received by GP consortia from PCTs as they establish around the country has been very varied, but Dr Reeve told the MPs that his PCT had been very supportive and extremely proactive about developing staff to consortia level over the last two years. “We will be very sad to see the PCT go, and this needs to be done in a phased way, with accountability and control handed over during the next one to two years,” he said. But where there is lack of trust between GPs and PCTs, he suggested that perhaps the Trusts should be “just got rid of – if you haven’t got a relationship now, you can’t suddenly create it.”

One of the problems with PCTs is that they are managerially-led with insufficient clinical leadership, said Earl Howe. “We want much more clinical leadership in the commissioning process and this will give clinical engagement,” he said. The government is not saying that every GP should become a commissioner or a manager but, nevertheless, “we need a sufficient number in each consortium to take the lead on commissioning and thereby set the policy for that consortium.”

“People think that commissioning is about a doctor buying the patient a service – it’s not,” he said. It is about identifying the health needs of the local population, what services are required to meet those needs and then fitting the needs of the patient in the surgery into that framework. When the patient is presented with the options that are open to them, this is when joint decision-making takes place, and this is proper commissioning, he said.

Ensuring quality

Work is underway within the National Institute for Health and Clinical Excellence (NICE) and at local level to ensure quality is inbuilt into commissioning. 'We're racing ahead on this, with lots of people working on care pathways in a way that hasn't happened before," and this work on quality will be sustained and maintained during the transition period, said the Minister.

And at individual practice level, GPs will be held to account largely by their own patients, and their consortia, while financial incentives already present in QOF (the Quality and Outcomes Framework) will be enhanced to encourage GPs to engage with patients more generally, he added.

Building the culture for greater engagement will be a mix of education, having the right systems in place and financial incentives in primary and secondary care, he said. There is also a huge role for technology such as telecare – which is "transformative" in getting patients involved in their own wellbeing.

"We also looking at ways in which patient engagement can be built into QOF, at least for the time being, to get GPs into the right habits."

Patients and the public must be involved in the design of services from the ground up. This will be a legal requirement set out in the Health Bill, but GP consortia also recognise that this is in their best interests, said the Minister.

HealthWatch

He also discussed the government's plans to establish national and local HealthWatch organisations, based on Local Involvement Networks (LINks), aimed at giving patients and the public a voice at every level in the system.

APPG member Baroness Sue Masham (crossbencher) regretted that HealthWatch will not be an independent body, and Earl Howe agreed that this had been a difficult issue for Ministers. While they could see distinct advantages to HealthWatch being independent, their final decision was that it should be co-located as an independent element of the Care Quality Commission (CQC).

The government is averse to setting up too many arms' length bodies (ALB), and the costs of creating HealthWatch as an ALB would have been greater, he said, but hoped the chosen solution will prove to be "the best of all worlds."

Rethink on OSCs

He also told the MPs that while the government had originally proposed that local Oversight and Scrutiny Committees (OSC) should be subsumed into the new Health and Wellbeing Boards (HWBs), it is now re-examining this plan following requests to do so.

"Our initial view was that you don't need both OSCs and HWBs and they could be usefully merged, but there are those who think there is a utility to having the HWBs overseen by the OSCs," he said.

Public health

The Public Health White Paper, coming soon, will set out what the government sees as the drivers to getting health improvements in lifestyle problem areas such as sexual health, use of alcohol and drugs, obesity and mental health issues.

"Patients taking ownership of their own situation has to be right and the solutions have to be locally-led and locally-driven – but with support," the Minister told the inquiry.
Drs Bewick and Reeve emphasised that self-care is a major priority for Cumbria.

Preventative care tackles health problems and inequalities early on, and is essential to support the NHS. “Once most GPs understand the public health issues, they embrace them,” said Dr Bewick.

Dr Reeve described one initiative, focusing on support for vulnerable elderly people, which has resulted in a 6% drop in emergency admissions in Cumbria - while they have risen almost 9% over the same period over the whole of England - and a 13% drop in Cumbria A&E visits, again compared to a rise of 5% in the rest of the country. Care and rehabilitation provided through community-based service and teams is much better than in an acute hospital, he said; segmenting aspects of care is more flexible and appropriate.

Unexploited opportunities

The witnesses were asked: are there any unexploited opportunities in the White paper for delivering health improvements?

Jo Webber responded that the document does not spell out completely how to incentivise delivery of health improvements, and she called for outcomes frameworks to come together in public health and social care, with everyone working along a single track rather than in parallel, to incentivise an integrated approach.

She added that the current difficult financial situation presents an opportunity to do things very differently and to be innovative, linking local organisations together more closely to provide better services in new way, saving money and with wider reach.
Dr Bewick agreed; “the pattern of unrecognised illnesses coming through the surgery door is the medicine of yesterday,” he said. One innovative development in Cumbria is a “local QOF,” which involves the proactive risk assessment and evaluation of patients at all points – by GPs, pharmacists, dentists and within A&E. “With no opportunity lost, you don’t miss things,’ he said.

Are NHS savings, productivity gains deliverable?

A previous evidence session of the inquiry had asked witnesses if there were any questions which they would wish to put to Earl Howe. One, put forward by health policy think tank Civitas, asked whether he really believed the NHS will be able to drive productivity to improve care by 4% while transforming commissioning, given that not only has the NHS never previously managed this, neither has the private sector.

Earl Howe responded that the previous Labour government’s response to the challenge of improving productivity within the NHS while making savings of £15-20 billion by 2014 was through the QIPP – Quality, Innovation, Productivity and Prevention – programme. QIPP is “alive and kicking and doing well,” and to the suggestion that high-quality care must necessarily cost more, he replied: “all I see from QIPP suggests the opposite.” There is a lot of poor care in the NHS at the moment – bedsores, falls in hospitals and care homes, MRSA, poor medicines management causing readmissions – but the QIPP “safe care” workstream can deliver several billion pounds’ worth of savings, “if we get that right,” he said.

GP commissioning is bringing together clinical decision-making and financial decision-making for the first time, there will be systems to record information “once and one time only,” and the NHS administrative burden is being reduced. The Service can work as well, and better, if decisions are taken at grassroots level by doctors and other health professionals without top-down direction, although there will be support and guidance, he said.

The 4% annual savings over the next three years have to be achieved, and in a structured way. “QIPP is about how to save money smartly, not through arbitrary salami-slicing or, even worse, removing services for no clinical reason,’ he said. Also, QIPP is not just about primary care but also hospitals, pharmacies, and social care; “it must be embedded everywhere, and this is the challenge.”

Finally the British Medical Association wanted to ask the Minister why the government is encouraging pathfinders to leave the system early, and “creating destabilisation” in the service in the three years

leading up to the legislative timescale. “We should have had a planned transition – what we are getting is a chaotic transition,” said the doctors’ group.

But Earl Howe rejected these charges. The transition is not chaotic, he said, and the “fantastic” pathfinder GP consortia which are already in place – in Cumbria, Cambridge, and East London for example – will act as pilots and exemplars to the rest

“We are doing our best for a structured, managed transition, which is not without risks, but we hope to convince the BMA that we’re on the right track,” the Minister concluded.