Feedback Summary

White Paper: 'Equity and excellence, liberating the NHS' consultation event

6 September 2010, Berkshire East and Berkshire West

Putting patients and the public first

Feedback

1. **What are the most important changes needed to enable patients to fully take part in decision-making?**
    - Build on the NHS constitution rights / responsibilities of patients to take greater control over their care.
    - Need good quality information and give patients greater control over their health records.
    - Behavioural change could make a big difference - complaints show that patients like GPs to over talk. In line with this, address the fact that GPs have 10 minutes max to discuss a condition with patients. Choice and efficiency are not necessarily good bed fellows. GPs want to give choice – but there is a limit to choice and how to get efficiencies. Need to manage patient expectations accordingly and this needs to come from the top.
    - Make sure that there are solid / robust processes in place with regards to tough choices to ensure that it works for all sections of the community.
    - There is a need for positive, successful real life case studies, as we are good at criticising ourselves.
    - Need to ensure patients understand that there are finite resources and the system should be used in the most appropriate way.
    - Understand consequences – have we had a conversation with the public on what 'any willing provider' means? We need to be explicit about this.
    - Engage at all levels – be open and transparent and target hard to reach groups. However, understand the level at which patients and the public want to be engaged and the fact that some people do not want to take part in conversations.
    - This is a unique opportunity to create something sustainable, but it needs a 12 month conversation. We need to build trust as part of consultations and work with people prior to them.
    - We need to create organisations with memories, whilst understanding it takes time to see changes through.
    - Out of 14 GP practices, three or four may have good patient groups for capturing patient feedback. This is an area GPs are going to have a grip on and a better system is needed.

- Need to work with front line staff to empower them to make the right decisions.
- We need to remember that we are the experts and the fact that most people want the expert decision.

2. **How can patients be enabled to gain greater control over their health and care through information?**
   - Transparency and sharing of good quality information in the public domain is essential to make informed choices. Where there are problems around choice; information can get muddled. We need to have a sensible mechanism for facilitating choice.
   - Extend the degree of choice and range of treatment options.
   - Review the Choose and Book system – one third of patients do not use it, as it is a difficult and slow system.
   - There is jargon in the NHS including on NHS websites – we need to provide information that patients can relate to.
   - Most people are the 'worried well ' – what do we offer them?

3. **How can information be used to support clinicians and providers in delivering better health and care outcomes?**
   - Capture patient feedback and improve the time for capturing it so services can make good decisions.
   - Need to address the fact that doctors do not use Choose and Book, as it is not quick enough and is dependent on hospitals getting it right.

4. **How can LINks evolve to become local HealthWatch organisations?**
   - There needs to be a national specification for HealthWatch, which councils can use.
   - There should be a process for people to become paid members.
   - The HealthWatch Board should have NEDs, who are not paid.
   - If HealthWatch is expected to operate on a national perspective, it should be given help to undertake this role.
   - Surprise was expressed that CQC will be the host for HealthWatch. Why is this so and why not Monitor? If local authorities are commissioning, then they would be more appropriate. Local authorities are better at picking up the public voice. If not trained, funded or have infrastructure, it will be hard for LINks to take on this role as an existing unpaid and voluntary organisation.

Questions raised

- Do patients have a real say on providers and pathways?
- At what level is ‘No decision about me without me’?
- What is the role of HealthWatch? A check and balance or to drive up quality? How will this be followed through?
- Where will the work of LINks go?
- Efficiency and tight financial operating mean choice is at the margins. If you live in Reading you want Reading to be really good. What conversation do we have with the public about what this means and how do we involve the public in really difficult decisions?

Key points for Putting Patients and the Public First

- Extend patient choice in terms of treatment and providers.
- Systems are awash with information – the challenge is to provide patients with improvements they want to know about.
- Ensure information is transparent and in the public domain.
- Give patients greater control over their health records and more chance to provide feedback.

Regulating Healthcare Providers

Feedback

1. **What support do we need to provide to NHS Trusts in order that they are all able to make the shift to FTs by 2013?**
    - Need to determine if there should be mergers of Trusts first.
    - It depends where they are on the journey in terms of the support needed.
    - Need to make sure that there is a good business plan.
    - Trusts need early notice if they are getting FT status or if they need to make an alliance with another FT.
    - There could be a buddying scheme. However, a successful FT does not want to make its competitor better.
    - Need to determine how to help Trusts understand the market – what will they commission?
    - A particular service may not get enough numbers – this poses internal and external challenges.
    - When bringing in any willing provider model, need to ensure understanding of the whole health economy.
    - Need to ensure choice for patients – choice of provider or choice of hospital to go to. Patients are not worried about separate businesses and want quality care near to their home.
    - In terms of Vascular surgery, clinicians are using the network model. Clinicians organise a rota beneath the structure, which gives organisations economies of scale and provides good quality care. One site undertakes a speculation on a regular basis, which could potentially be developed for local access.
    - Need to determine who will regulate for equality of access.
    - Need mechanism to fix prices and competition, but not for regulation. This is why reforms are more far reaching than we have begun to imagine.

2. **What can we do to ensure that providers compete on a level playing field?**
    - Berkshire FTs are fighting each other and the business, but they can not all do everything. There should be collaboration rather than competition.
    - What is not clear is the appetite of the private sector to provide services.
    - Obvious barriers are estates, technology and infrastructure:
        - Who owns the estate when opening to market? Difficult in FTs, but easier in community services.
        - Infrastructure in A&E poses a barrier to other entrants into the market.
    - What would be amenable to other players coming in? There are not many providers already waiting, however, there are a small number wanting to provide small, discreet area services rather than for whole area pathways.

- It is a waste of energy to create a level playing field, which does not exist at current. Need to find experience we may want to commission in.
- Individual providers commissioning private care in the community do not always provide value for money or good quality care.
- Providers will want to make a profit. The expectations will have to include registering with CQC and access to NHS Pensions.
- Need to get existing NHS organisations to operate more commercially.

3. **What can we do to ensure effective economic regulation without imposing excessive burdens on providers?**
   - Clinical engagement is key to understanding financial issues. We will not get anywhere without the buy-in of clinicians.
   - Need to implement a robust and responsive regime very quickly which needs testing:
     - early warning systems need to be good.
     - need to set tariffs and get tariffs to reflect particular healthcare streams.
   - There is a mismatch between the size of the funding available – will there be too many FTs dipping into it, even before they are created?
   - Economic regulations need a plan for when FTs run into difficulty with debt:
     - Need to know the early warning signs.
     - Regulator needs plans in place to deal with continuity and ensure early intervention before Trusts close (pre-failure).
     - In the private sector there is a pre-step – the administrators are brought in and it is a viable concern.
   - It should be helpful, not people 'crawling all over you'.
   - Balancing books should not hinder work or be a burden.
   - Ensure good business sense.

4. **What should we do to ensure that Monitor, CQC and the NHS Commissioning Board work effectively together?**
   - Hold a risk summit every week.
   - Merge Monitor and CQC, however, it would be good if CQC is separate to up the ante on patient safety and hold organisations to account.
   - CQC needs to be seen as important as Monitor.
   - The Board of Monitor does have a sense of what it is about, however, quality might conflict.
   - Monitor needs a solid plan to secure services when it is obvious an FT is going to fail.
   - Encourage joint working.
   - Separation is a problem for the patient pathway - there is always a tendency for organisations to concentrate on finances first and patients second. It is difficult to ensure pathways are adhered to against guidelines, especially by more than one provider.
   - Why are there 3,000 ways to commission cataracts? There should be three, two or one, as with specialist commissioning.

- Need to look at lessons learnt to date about the way service is delivered and how this will be disseminated in the new landscape.
- Good practice documentation is very important.
- Are politicians going to interfere as they have done since 1948 or are they going to stand back and let Monitor, CQC and the NHS Commissioning Board act? If a system is created and they do not interfere, then that is fine.

Questions raised

- Who is paying for the prevention agenda? Is it public health?
- Is there going to be a switch off day for commissioned services?
- How much freedom will there to be commission? Will there be constraints to both providers and commissioners?
- Who is regulating GP syndicates? It is not just about money – it is also about the quality.

Key points for Regulating Healthcare Providers

- We need to be clear about who will make FT status, in particular organisations about to merge. Size and viability need to be considered and good business plans should be in place.
- For aspiring FTs, a buddying system is suggested, however, due to competition, the buddying may need to be further afield.
- Need to define 'level playing field'.
- Not sure the private sector would want to provide services, however the voluntary sector, social care and small providers may want to.
- Monitor needs to be better – it needs a responsive regime and early warning systems.
- Need to define the impending future and end autonomy – if organisations are capable, back off and if struggling, provide support. Need to get clinical buy in for this.
- There are dangers with dissociating money and quality.
- Monitor and CQC could perhaps join together or work closer together. Unsure how the NHS Commissioning Board fits with all this – clarity is crucial.
- Need to determine how commissioners should be replaced in the new world.
- Patients on a pathway moving from the old to new system need continuity.

Commissioning for Patients

Feedback

1. **How should GP consortia and local authorities collaborate to ensure NHS, public health, social care and children's services are commissioned in an integrated way and meet the needs of local people, individuals and families?**
    - Need to combine health and social care needs in one body to enable it to happen.
    - Need to determine who will take the lead and how it will be defined - 'leading' versus 'influence' is unclear.
    - There may be a risk that GPs will take FT view compared to local authorities.
    - Need to influence funding and determine how best to utilise it for health and social care, as there is pressure on local authorities to cut budgets.
    - Need to remove boundary lines. We should utilise available resources to facilitate this.
    - Councillors versus GPs – it will be interesting how this will work.
    - Need to move away from a democratic structure for commissioners.
    - Need to look at new behaviours and maintaining / building new relationships, particularly in terms of governance, communication and infrastructure. There is concern that relationships that have taken years to build will unravel.
    - Need to keep the good things and be careful about what you get rid of.
    - There are currently 11 consortia across Berkshire – this needs resolving.
    - Need to look at how the Health and Wellbeing Board will work with local authorities.

2. **How can GP consortia, the NHS Commissioning Board and Local Authorities best involve patients and those using services in improving the quality of health and care services?**
    - We cannot assume it 'just happens' – we need to continuously engage and have background information to triangulate as those with a voice will come from their own slant.
    - There is a danger that only those who want to be engaged will be engaged.
    - Need to ensure that the public and patients are involved and are able to feedback on the impact of commissioning decisions – a democratic voice is really important here.
    - Need to educate patients in how they can help and how they can express views on primary care. Councillors and existing patient groups could be used here.
    - HealthWatch will be significant for advocacy, but who will it represent?

3. **What support might commissioners under the new structure need to allow them to take on their new and expanded role?**
    - Need to look at how GP Consortia will ensure safeguarding issues and out of hours forensic paediatric work are managed.
    - It will be difficult to make decisions because of cross local authority boundaries – need to look at how this will be resolved and ensure accountability.
    - Infrastructure/governance arrangements should be built around statutory responsibilities.
    - Learn from FT governance model and members.

4. **What support might commissioners (including GP commissioning consortia) and local authorities need to resolve any local disputes that may arise?**
    - Look at current models in terms of resolving relationship issues.
    - Need to ensure difficult decisions are made locally. This was particularly a concern for organisations dealing with specialist/rare disorders – how will these be ensured a voice in terms of priorities?
    - Use a mutual arbiter when joint decisions go wrong / fail.

General points

- Should consortia look to have members like FTs?
- Care for the Future work should continue.
- Major acute providers would want a lead commissioner, which is currently being thought about.

Key points for Commissioning for Patients

- Communication is key. Need to ensure that good relationships are maintained.
- Need to effectively engage patients and the public and ensure that they are educated in what commissioning decisions are made.
- Accountability and democratic structures are key.
- There are fundamental questions around resources in terms of money, assets and people.

Health Outcomes

Feedback

1. **Do you agree with the proposed principles that should underpin the NHS Outcomes Framework?**
    - It does not say what the proposals are.
    - Definition of quality should be in the hands of consumers not the NHS.
    - Somewhere in the system, judgement about what patients want / need should be taken. The referring clinician needs to have this discussion to be sure patients understand and expectations are managed, but also to gauge an understanding of what patients want. We should not just be driven by what medics and clinicians believe, however, we need to appreciate that consumer views are not always right.
    - Patients want to be treated with respect, but not necessarily picked up.
    - Keeping patients out of the NHS increases pressure on social care and will create issues on budgets.
    - Draw a distinction between patient reported outcomes and patients' experience of care / feelings about the way they have been treated.
    - How do we measure outcomes? Currently we measure what is easy to measure, rather than what is really important. How do we measure outcomes from psychiatrists and GPs for example? We have to be careful deciding on what we measure and what we are trying to improve. Further clarity on this would be useful.
    - The impact on the whole economy has to be measured here.
    - There was a fear of potentially having 'an enormous army of managers and statisticians' measuring these outcomes and the associated cost of this.
    - We can not expect to see the impact of this immediately – it will take many years, however we need to establish the principles now.
    - It is important that outcomes should be internationally compatible, however, you must be able to compare like with like and how much value will this really give us? Need to be careful as comparisons could be meaningless. Services in Berkshire may differ to those in neighbouring systems, let alone internationally.
    - Small clusters of GPs will commission locally and the postcode lottery will get worse.
    - It is vital that local democracy is taken in spending decisions.
    - The Outcomes Framework needs to be clear and understandable and linked with patient expectation.

2. **Do you agree with the proposed structure and approach that could be used to develop the Framework?**
    - Is this not what quality is? This is what we would expect from a quality service.
    - The five domains are nicely phrased.
    - It would be good to describe what we mean by 'avoidable harm' – this would be an interesting public debate. Some clinicians are still not comfortable that we do 'harm'.
    - There are grey areas between this and public health.
    - We must focus on outcomes once people are treated in the NHS.

3. **How can the proposed Outcomes Framework support equality across all groups and help reduce health inequalities?**
    - Need to have a greater voice to promote public health and wellbeing.
    - Need to have crossover and linkage between public health and the NHS agenda –
        - This needs to be a two way process with public health and social care delivering improvement for healthcare.
        - Every frontline clinician should include preventative activity / messages in what they do. This is fundamental and should be in job descriptions and subject to personal assessment. We need to determine how best to measure this.
        - The whole point is to ensure people are as healthy as possible.
    - Need to change from reactive to proactive. A percentage of primary care income should be used for resources to give preventative advice.
    - Need clarity on whether the Outcomes Framework is only for ensuring the treatment of ill health and not public health.
    - The proposed Outcomes Framework needs greater emphasis on individual health promotion and a fully engaged society.
    - The NHS must encourage personal responsibility.
    - Need to look at how to adjust outcome measures based on pre-existing factors, for example measuring schools based on the mix of children.
    - The NHS dos not effectively screen patients out of treatment; therefore need to look at meeting certain criteria for accessing treatment.

Questions raised

- How do we make difficult decisions within this policy framework and how do GPs and local authorities make local decisions? Everyone has a local agenda - how do we manager this?
- How, when strengthening local democracy, do we maintain a national NHS, national view and standardised treatments?

Key points for Health Outcomes

- Expression of needs versus wants. Will the Outcomes Framework be able to discern between the two. For example, meeting the criteria for secondary care treatment before being offered choice of care.
- Link between public health and the Outcomes Framework.
- Personalisation of care - what is the measure of added value? This is not in the Outcomes Framework.

Public Health

Feedback

1. **How can the Public Health Service and the NHS work together to improve outcomes for patients and communities?**
    - Ensure that the GP commissioning process has public health advice and skills at the core so that it can take population level issues into account.
    - Governance of GP consortia needs a public health and local authority overview.
    - Engagement of the new public health service and GP consortia is key. There is a feeling that GPs are still focused on secondary care and there will be a risk of a medical model approach and no focus on wider public health issues at a population level. Plus, there will be GP conflict between provision and commissioning.
    - There is already co-operation across Berkshire, eg childhood immunisations. Need to consider what currently works and what is local.
    - Need a shared rather than a divided approach.
    - This is an opportunity to reintegrate public health and bring health protection back in, but we do not want to lose economies of scale.
    - The Health and Wellbeing Board needs to drive and influence.
    - Need to look at the public health workforce and associated skills mix and gaps across Berkshire to avoid duplication. Need to be clear about functions rather than posts.
    - In terms of achieving outcomes, need longer term targets of three to five years, not one year.

3. **What role can the NHS play - now and moving forward - in delivering and promoting public health?**
    - The national Outcomes Framework should hold GPs to account.
    - Need to be able to exert influence – what independence will the Director of Public Health have within the local authority, for example if it shuts down sports centres or sells off playing fields? How can the Director of Public Health challenge this?

General comments on Public Health

- Joint commissioning has shown some really good work and we do not want to lose it.
- There was a feeling that the Public Health White Paper will not be prescriptive about the form of Health and Wellbeing, which could be an opportunity.
- The job description for the Director of Public Health needs to include advocacy and influence.
- There was a desire for public health to act as a co-ordinator and ‘glue’ across authorities.

Questions raised

- What does the 'Director of Public Health and Health and Wellbeing Board holding GP commissioners to account' mean?
- Will Directors of Public Health be responsible for environmental health?
- Public health is proactive and reactive – what about health protection and where does that sit? Will the Director of Public Health have health protection responsibilities and how will this be discharged?
- Berkshire is very different to the rest of the country – will there be a Director of Public Health for every local authority (there are currently six in Berkshire)? What does this mean for corporate governance arrangements?
- If this is a Government focused on outcomes, who will be accountable for not delivering and how? (eg smoking – the actions are very widely distributed amongst GPs, primary health care team and public health.)
- Will GPs buy in public health services externally?

Risks / concerns associated with Transition and Public Health

- There are concerns about skills to guide and support GP commissioning – this is where the majority of current public health work is.
- What will be held at a regional level is not well defined. There was concern about what this will be and where overview, supervision and governance will sit.
- GPs are very individually focused and need someone to bring in the population level perspective.
- There was concern that the Healthy Schools service will go.
- There was concern around the independence of Directors of Public Health and the independence of critique services. It is a challenge to keep 'six plates spinning.'

Key points for Public Health

- Need clarity on what roles could exist at the regional tier level - it is unlikely that there will be six Directors of Public Health. Need to create a matrix to get it right.
- Accountability and independence are unknown quantities and further clarity is needed on public health provisions, ie budgets and Directors of Public Health up to the Public Health Service.
- Governance is needed for commissioning.
- Public health and population skills should be passed on to commissioners. There should be Health and Wellbeing clinics for this, which are run from the population perspective.
- Expectations on GP consortia – there needs to be consortia that are coterminous with local authority boundaries and large enough for financial risks.
- It is difficult to define the new responsibility deal.