



**All Party Parliamentary Group  
Primary Care & Public Health**



***Were massive reforms necessary to save the NHS?***

Inquiry into the NHS Health Reforms

**January 2012**

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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 Kings Heath who is the current chairman alongside Kevin Barron MP and Julie Elliott 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)*	Baroness Masham (Secretary)
Kevin Barron MP (Co-chair)	Julie Elliott MP (Co-chair)
Baroness Gardner (Executive Officer)	

##### **Members of the Group:**

Baroness Hooper	Baroness Thornton
Baroness Fookes	Virendra Shamra MP
Lord Naseby	Grahame Morris MP
Dr Sarah Wollaston MP	Gavin Suker MP
Baroness Wall	Yasmin Qureshi MP
Caroline Nokes MP	Jim Dobbin MP

Bob Blackman MP	Baroness Pitkeathley
Nick De Bois MP	Andrew Love MP
Mark Garnier MP	Rosie Cooper MP
David Amess MP	Lord Harris
Oliver Colvile MP	Adrian Bailey MP
Lord Colwyn	Lord Rea
Theresa Villiers MP	Lord Rix
Margot James MP	Lord Stone

\*Disclaimer – Lord Hunt of Kings Health did not take part in this inquiry because of his role in leading the Opposition on the Health and Social Care Bill in the House of Lords.

**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 parliamentary 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.

Correspondence should be addressed to the secretariat: Libby Whittaker, [libby.whittaker@pagb.co.uk](mailto:libby.whittaker@pagb.co.uk), tel: 020 7421 9318, for further information on previous work go to <http://www.pagb.co.uk/appg/intro.html>

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





## **ii. Structure of the Inquiry Report and Acknowledgements**

This is the report of a five month inquiry into the NHS health reforms. 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.

For this inquiry, we wanted to examine the views of organisations and individuals that will be affected by the Coalition Government's huge programme of health reforms.

We wanted to find out first of all if the NHS needed major changes in order to stay true to its ethos of "free at the point of need". We also wondered if it was really necessary for such reforms and the heavy legislation which accompanies it or whether primary care was evolving this way naturally due to practice based commissioning, world class commissioning and, prior to this, fundholding.

In order to understand the views of those involved in primary care 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 hearing, those who attended and to

the organisations, and individuals that submitted written evidence to the inquiry (please see Annex i for details).

If you would like to receive any of the written evidence, please contact the secretariat.

The report has been given to Government for consideration and we hope to receive a response to the recommendations and conclusions.





## **1. Introduction**

Sustaining the NHS, as a health service free at the point of need is a challenge that all Governments face when in office. And, since we have an ever-increasing population that is living longer, it is crucial that we meet the challenge of sustaining the NHS long into the future, while at the same time, protecting its values.

The previous Government attempted to tackle this problem by moving towards a more responsible society, one where people look after their own health and their family's health and use health services responsibly. This was deemed necessary for the future of the NHS by Sir Derek Wanless in his 2002 report to the Treasury "securing our future health – taking a long term view."

The Coalition Government's answer to the challenge was announced in July 2010 and involved a reorganisation of the NHS, at the centre of which was commissioning.

Legislation is currently making its way through parliament but the reorganisation of the health system has already begun. It will mean that commissioning of most NHS services will no longer be the responsibility of management-led Primary Care Trusts but instead will be carried out by new groups of Clinical Commissioning Groups (CCGs) led by general practitioners. CCGs will take control of 70% of the NHS budget, which the Government believes, will result in a higher quality of care and a more

efficient health service because doctors have a better understanding of their patients' needs.

This reorganisation has not been without its controversy not least because it is the latest in a number of reorganisations of the health system since 1980, and the biggest programme of restructuring since the NHS was established. It is also speculated to be costing £2-3 billion (Kieran Walshe, professor of health policy at Manchester Business School) and comes at a time when Government is also expecting savings within the NHS of £20 billion.

However, the Prime Minister, speaking during the announcement of the Listening Exercise in June 2011, insists reforms are necessary 'changing the NHS today is the only way to protect the NHS for tomorrow' he said.



### **iii. Terms of Reference**

Our terms of reference for this inquiry were as follows:



**Was it necessary to re-design the health system with massive structural changes and legislation to make the NHS more efficient and sustainable, or was the system already heading this way as a result of practice based commissioning and world class commissioning?**



**How is primary care achieving QIPP (Quality, Innovation, Productivity & Prevention) targets and will this be different as a result of Clinical Commissioning Groups (CCGs)?**



**How is primary care engaging with patients and the public and will CCGs be able to do this better?**



**Is there sufficient emphasis on managing demand and referrals within CCGs' strategies and if not why not?**



**Is self-care as an effective mechanism to manage demand and referrals being given priority and if not why not?**



**How do we ensure CCGs are accountable to patients and the public?**





## **2. Summary and Recommendations**

### **Summary**

Overall, we concluded that the NHS did not need a wholesale restructuring. We were also concerned at the cost of the reforms, £2-3billion (Kieran Walshe, professor of health policy at Manchester Business School) in light of the Government wanting the NHS to save £20bn by 2015,

However, with much of the reorganisation underway despite the Health and Social Care Bill still being debated, our recommendations are to minimise the disruption to NHS patients and we hope that what emerges from the reforms helps deliver a more efficient, patient centred NHS that is sustainable long into the future.



### **Recommendations**



**2.1 Was it necessary to re-design the health system with massive structural changes and legislation to make the NHS more efficient and sustainable, or was the system already heading this way organically as a result of practice based commissioning and world class commissioning?**

Whilst we can see the advantages of moving towards a more clinician led commissioning health system, we feel there was no real need for Government to go to such lengths in order to restructure the NHS. This is especially frustrating since the system was moving towards greater clinical involvement in commissioning. There is concern too that there will be huge discrepancies in performance between CCGs which would impact on patient care, also raising issues around accountability.

To ensure there are no irregularities and all Clinical Commissioning Groups perform to the highest standards for the good of their patients there is a need to ensure structures and frameworks around their performance are carefully defined and the NHS Commissioning Board is strict in ensuring CCGs adhere to these frameworks

### **Recommendation i:**

It is crucial that CCGs are held accountable but that within this they should be able to exert some discretion in their activities.



## **2.2 How is primary care achieving QIPP (Quality, Innovation, Productivity and Prevention) targets and will this be different as a result of Clinical Commissioning Groups (CCGs)?**

There seems to be an enthusiasm to continue with the QIPP agenda and so health providers should be supported wherever possible to be able to make the most of these targets for the good of their patients.

**Recommendation ii:** We recommend that CCGs and others responsible for meeting QIPP targets in the NHS are given the freedom and space to focus on these without being overburdened by bureaucracy or matters concerning the restructuring.

**Recommendation iii:** We recommend that all providers of care in the population work together to deliver QIPP and avoid conflict or competition with each other and further recommend that public health expertise and input is given to CCGs and the NHS Commissioning Board to help meet QIPP targets.



### **2.3 How is primary care engaging with patients and the public and will CCGs be able to do this better?**

It is imperative that patients are engaged in their health and are aware of the health services that are available through primary care. CCGs must be encouraged to maximise this relationship with their patients and the public.

**Recommendation vi:** We recommend CCGs involve patients and the public in decisions about commissioning services by inviting them on CCG Boards which should also include others from the health community such as pharmacists, nurses, and practice managers to ensure services meet the needs of the whole population.



## **2.4 Is there sufficient emphasis on managing demand and referrals within CCGs' strategies and if not why not?**

Managing demand is clearly an issue that needs addressing and we hope that commissioning processes in primary care will help with inappropriate use of and referrals to secondary care. For this to happen it is imperative there are sound communications and better integration between commissioners and providers. We also recognise the need to have a dialogue with the public and patients on appropriate use of services to stop, for example, people visiting A&E with their common conditions.

**Recommendation v:** We recommend primary and secondary care work closely together in order to manage appropriate hospital admissions but that this is not achieved at the expense of patient care.

**Recommendation vi:** We recommend there is a national debate on health service provision, for patients and the public to understand when there is a need for medical intervention and when there isn't. The regional "choose well" campaign could be a starting point for a national debate. Health professionals can also help guide their patients.



## **2.5 Is self-care as an effective mechanism to manage demand and referrals being given priority and if not why not?**

Achieving greater self-care in patients and the public should be given a higher priority in order to empower people and manage demand.

**Recommendation vii:** We recommend that CCGs build mechanisms to support people and the public to self-care in their strategies and that this is central to all consultations.

**Recommendation viii:** We recommend the development of multi-disciplinary teams which include public health expertise and CCGs focus on strategies to turn around the dependency culture and enable greater support in their population for people to look after themselves.

**Recommendation ix:** We recommend school nurses are employed in every school to educate children in their health allowing this knowledge to help them become responsible healthy citizens equipped with the tools to take care of themselves and allow them to understand how to use health services capably.



## **2.6 How do we ensure CCGs are accountable to patients and the public?**

The health service belongs to us all and patients and the public deserve a say when decisions are being made about them and their health services.

**Recommendation x:** We recommend the NHS Commissioning Board holds CCGs to account on their systems and processes that demonstrate ongoing effective and appropriate public and patient involvement and influence.



### 3. Summary of Evidence

#### 3.1 Was it necessary to re-design the health system with massive structural changes and legislation to make the NHS more efficient and sustainable, or was the system already heading this way organically as a result of practice based commissioning and world class commissioning?

I feel it was necessary to re-design the health system as if it had carried on the old way, supply would have outstripped demand. This obviously comes with necessary, difficult and inevitable structural changes. It was in fact long overdue. As a clinician working in the community in primary care I felt we were powerless in changing anything in the massive health system. Practice based commissioning did not make any headway because clinicians were used as clinical information gatherers by PCT Managers and after being advised still did not take the direction which was given. **Dr Ranjan Adur, Clinical Lead, Havering CCG**

Massive structural change was not required and there is little enthusiasm for the reorganisation, but much general concern about its longer term impact. Changes could have been achieved without completely deconstructing the NHS. The reorganisation has caused an unnecessary upheaval at a time when we needed to concentrate on achieving savings towards the £20billion required, instead valuable time has been taken up in discussions about the reforms, causing considerable chaos and loss of

morale in itself. **Professor Carol Brayne, University of Cambridge**

Mostly respondents are of the view that such a wholesale restructuring of the NHS was not necessary. Dr Andrew Davies from Warrington Health Consortium believes there is no need for a legal framework for things that are already happening since CCGs are taking up the reins and SHAs and PCTs are dissolving under the current legislative framework. The King's Fund agrees that whilst there is logic in making a closer link between commissioning and clinicians, this could have been achieved without such a high level of organisational change.

#### Lost Interest

Dr Middleton from Mid-Cornwall and Dr Howard Stoate from Bexley have concerns that where there are examples of commissioning groups happening organically that that interest and commitment is now being lost because of the changes to phase out PCTs. Dr Hassan from NHS Suffolk agrees that once motivated and successful NHS managers are now disengaged and demoralised as a consequence of the restructuring. Dr Stoate worries about what will happen when the PCTs are wound up, what kind of commissioning support there will be and how much money there will be allocated for that. He feels there is a 'transitional organisational mess' and believes the way the government has gone about the reorganisation has caused a great deal of uncertainty for staff.

#### Local Infrastructure

Mike Beaman, pharmacist is concerned that the current reforms may not achieve improvements in commissioning and there will not be the local infrastructure to coordinate and support the new clinical commissioning groups. He wonders also if a National Commissioning Board can fulfil the

local direction provided by SHAs given there will be 500 CCGs across England.

### World Class Commissioning

The view by the Institute of Public Health at the University of Cambridge, is that World Class commissioning (WCC) was beginning to have a positive impact on efficiency and processes when it was abandoned and in their opinion would have improved health care planning with the required savings if it had increased public health input. On the other hand, the BMA felt WCC was overly bureaucratic and sees the authorisation process following the same path.

### Evidence Base

The Institute of Public Health at the University of Cambridge worries that the reforms have no evidence-base in favour of them and a great deal against. The Faculty of Public Health are also concerned by yet another reorganisation in the NHS. Their feeling is that reorganisations distract attention from real managerial efforts to increase efficient and sustainability and feels minimal intervention with structures and organisation would have meant the NHS could have devoted maximum attention to strategies for improving services and eliminating waste. A view shared by the BMA.

### NHS Staff

Many respondents, including Unite, RCN, RCM, QNI have concerns that the reorganisation and the need to save £20bn is having a detrimental effect on staffing levels which are impacting on patient care. The RCN commented that axing specialist community nurses is short sighted since they are invaluable at helping people manage their long-term conditions

and provide support to help people stay out of hospital. Dr Middleton agrees saying specialist community nurses are the doctor's "right hand".

### **3.2 How is primary care achieving QIPP (Quality, Innovation, Productivity and Prevention) targets and will this be different as a result of Clinical Commissioning Groups (CCGs)?**

To achieve QIPP there needs to be the ability to redesign and decommission from acute, manage referrals against agreed and evidence based criteria and a reduction of acute estate. CCGs will be more assertive in this than PCTs due to their clinical nature. By using public accountability mechanisms they will shine a light on the cost of maintaining acute care against the value of preventative population based health care and more to the NHS from its current focus as a reactive illness service to a pro-active health service. CCGs are formed of addition of individual General Practice. This will assist the process of QIPP being owned by the constituent parts as long as CCGs are allowed the flexibility to come up with innovative local solutions. **National Association of Primary Care**

All respondents see the benefits of delivering the QIPP agenda although there are concerns from the Faculty of Public Health and others that the preoccupation of reforms within the NHS will distract NHS managers from its focus on QIPP. The BMA worries also that contrary to Government's intentions, central control will still dominate the new system, and like the NAPC, they do not want CCGs to be overburdened by bureaucracy and unable to adopt a responsive approach to commissioning for local needs.

#### CCGs Recycling PCT staff

Whilst the chair of Warrington Health Consortium, Dr Andrew Davies doubted primary care was even aware of QIPP until the advent of Clinical

Commissioning Groups. A view also held by the Institute of Public Health at Cambridge University who believes CCGs are forming out of existing structures and recycling the same staff, so the CCG formation will probably neither hinder nor help the progress of QIPP.

#### Conflict or Competition

Others are more optimistic about CCGs delivering QIPP provided there is no managerial interference, and, says Havering CCG all providers of care in the population work together to deliver QIPP and avoid conflict or competition with each other.

#### Clarity Needed

The BMA want more clarity on the remit of the various bodies in the new structures, including the NHS Commissioning Board and associated regional structures. The increased complexity and number of organisations will now make decision-making more difficult, and together with a focus on internal re-organisation, achieving QIPP savings will be harder.

#### Public Health Role

There is a major role for specialist public health input to CCGs and to the NHS commissioning board if service redesign is to incorporate preventive measures that reduce the need for healthcare at all.

### **3.3 How is primary care engaging with patients and the public and will CCGs be able to do this better?**

Approximately 60% of GP practices across the country have established a Patient Participation Group (PPG) with which they work closely on matters related solely to the individual practice & the services provided. Since the proposal for GP led commissioning & the emergence of CCG's there has been a burgeoning interest from GP commissioners in the PPG model as a mechanism for collective patient & public engagement closest to the heart of general practice with the potential to gather patient feedback on services & priorities in the CCG locality. **National Association of Patient Participation (N.A.P.P.)**

There is unanimous agreement from respondents over the benefits of engaging patients and the public in decisions about primary care services. And the inquiry was pleased to learn of the toolkit offered to practices from the BMA Patient Liaison Group on how to effectively involve patients and the public in healthcare planning and delivery.

#### System Needed To Gather Opinions

N.A.P.P. believes the responsibility will lie with individual CCGs putting in place a system to gather collective opinions from all constituent practices and that Patient Participation Groups are the predominant mechanism through which individual GPs and their practices can deliver primary care engagement with patients about their services.

#### Patient Involvement Agenda

Dr Adur from Havering CCG told the inquiry that CCGs are taking the patient involvement agenda very seriously and getting them involved in decision making and local health provision. Dr Adur mentioned also that the CCG Board encapsulates views from, not only, the patient but also the

pharmacist, nurse, practice manager which is essential in order to ensure services meet the needs of the whole population.

### Dissatisfaction with Services

Furthermore, the BMA made the point that failure to engage patients can lead to misunderstandings, dissatisfaction and poor outcomes and advised commissioners and providers to be good at listening and responding and suggests collaborate working with CCGs and patient/community groups wherever possible.

### **3.4 Is there sufficient emphasis on managing demand and referrals within CCGs' strategies and if not why not?**

We are putting sufficient effort in our CCG to manage demand in primary care but clinicians should get freedom to deal with this. We need the message of patient education being directed especially from Politicians as to what is available on the NHS during this period of world recession. Sign-posting then becomes easier for the Clinicians in contact with the public. For example for Long Term Conditions like Diabetes or COPD (Chronic Obstructive Airways Disease) which take more than 60% of NHS resources. The NHS cannot sustain in its present form. If the patient's unnecessary demands are not curtailed and do not know how to use the limited NHS resources. The NHS cannot afford infinite healthcare. **Dr Ranjan Adur, Clinical Lead, Havering CCG**

Mostly respondents feel that managing demand in primary care is difficult and Cornwall, Devon and Plymouth and others believe there is a growing need to have an honest debate with clinicians and the public about prioritising what the NHS can afford to provide. Dr Adur from Havering

CCG is keen to have politicians begin this debate on using health services responsibly.

### Growing Emphasis on Managing Demand

According to the NAPC there is a growing emphasis on managing demand and referrals based on supporting GPs to improve the quality of the service they provide and to make better use of alternative ways of meeting the patients' needs.

### Consistency Needed

However, according to the NAPC this is not consistent throughout CCGs. Ideally CCGs need a "collective quality improvement network" to work through these issues, apply some design principles and then spread across at pace. Organisations such as NAPC are working to support the dissemination of best practice.

### Over-Provision of Urgent Care Causing Confusion

There was general agreement amongst respondents that the NHS had created a demand service rather than a service based on needs, and according to Dr Howard Stoate the greater the capacity, the greater the usage. The King's Fund's view is that an over-provision has been created in urgent care e.g. A&E, GP out-of hours services, walk-in centres, urgent care centres, NHS Direct, 111 etc. which is confusing for patients as they are not sure where to go. Patients may use more than one of the services and there may be overlap as there is not the integration to record which services individuals have been to. There is concern over lack of health service provision in some areas however, especially in rural parts where out-of-hours health services are not adequate and many people have to travel long distances to get to A&E.

## GPs Working in A&E

In Cornwall, Dr Middleton spoke about how some A&Es have GPs working in them with the aim of getting the message through to people going to A&E unnecessarily that they are still just seeing a GP.

### **3.5 Is self-care as an effective mechanism to manage demand and referrals being given priority and if not why not?**

Self-care has been shown to reduce numbers of GP appointments and hospital admissions, improve health status and increase choice for patients<sup>1</sup>. The Department of Health and commissioners should be promoting self-management both for the benefits to the patient and the easing of systemic and financial pressure. **British Medical Association**

Whilst there is recognition amongst respondents that self-care can reduce GP appointments and help with A&E admissions, as well as empower patients, in general, respondents' views are that self-care is not being given the priority needed. The reason for this admits the NAPC, is because priority *is* being given to improving clinical performance. They believe CCGs are increasingly aware of this and it will inform part of their strategies as they develop further towards authorisation. The South Essex PCT Cluster says it is also important to have careful cost benefit analysis to ensure savings can be achieved through self-care activities rather than just moving demand for scarce resources around the system.

## NHS A Consumer Service

Warrington Health Consortium's Chair is of the opinion that patients have been encouraged to view the NHS as a consumer service which will

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<sup>1</sup> <http://www.crd.york.ac.uk/CRDWeb/ShowRecord.asp?View=Full&ID=32006001556>

respond to demand rather than need. Dr Davies and others want Government to promote self-care nationally and make clear to the public the NHS limitations.

### The NHS – A Treatment Service

The Institute of Public Health at the University of Cambridge says the health system is built on treatment not prevention and the current reorganisation will not change this in any fundamental way. Their concern is that if we move forward with a demand bases system then it has the potential to move further away from prevention.

### Public Health Can Support CCGs

The Association of Directors of Public Health argue that public health expertise can support CCGs with moving to informed consent approaches enabling and supporting people to take responsibility for their health and supporting individuals to be people not patients.

### Fully Engaged

Recent report from the King's Fund concluded that 'we are not in a position yet where patients and individuals are really appropriately 'fully-engaged' in the decisions that they need to take about of their own health'. They insist until mechanisms are developed by multi-disciplinary teams for supported self-care, we will stay a long way from having the fully engaged scenario Wanless recommended in 2002 and a system that enables more people to live independently with less utilisation of health and social care services, and with better health outcomes and quality of care.

### Dual Accountability

There should be dual accountability between the patient and doctor and people should be provided with good information about their illness and can get involved with shared-decisions about their care so, they are more empowered.

### Change of Culture

The King's Fund, Dr Howard Stoate and Dr Alan Middleton agree there has to be a change of culture, changing people's mindsets about healthcare and patient behaviour so they are more engaged. Dr Hassan agrees and comments that educating patient to help themselves is a resource intensive activity. Nick Goodwin from King's Fund said more people have to stand up and say that self-care is a good thing. And, the RCN believe school nurses can play a vital role in teaching children about healthy behaviours, 'setting them on the right path' from a young age.

### **3.6 How do we ensure CCGs are accountable to patients and the public?**

We believe strongly that the best way to ensure that CCGs are accountable to women, patients and the public in general would be to involve service-user groups in the commissioning process. In maternity services, the RCM has previously advocated that commissioners should have a duty to consult maternity networks, made up of both providers and service-users. For users of maternity services, Maternity Services Liaison Committees (MSLCs) already play a significant role in influencing and guiding the development of maternity services and are a vehicle for change and improvement. They have the potential to contribute significantly to maternity strategy, guidelines and policies, patient information services, clinical services and commissioning plans.

In the absence of an established MSLC, other organisations that represent maternity services users, such as the National Childbirth Trust, Netmums and Mumsnet should be engaged. **Royal College of Midwives**

All respondents agree that to involve patients and the public in the discussions around health services is the best way to ensure their needs, wishes and perspectives are at the heart of commissioning decisions. Having their input on Boards and Groups will ensure the patient perspective is included. NAPP want to see CCG's held to account by the NHS Commissioning Board at a national level and for them to provide evidence to the Board that they have systems and processes embedded within their operations that demonstrate ongoing effective and appropriate public and patient involvement and influence.

#### General Practice Contract

The view held by Havering CCG is that the General Practice Contract includes commissioning processes that will ensure patients do not get a raw deal and the public are reassured that their needs will be met.

#### Health and Wellbeing Boards

And, the Association of Directors of Public Health believe local commissioning plans should be subject to scrutiny and comment by the Health and Wellbeing Board and even signed off by the Board and that health and wellbeing strategies should

- be asset-building, wide-ranging and thorough and include qualitative 'citizen' views (not just service-user or patient views);
- include preventative and health protection issues;
- be the basis for all local commissioning.



## ALL PARTY PARLIAMENTARY GROUP

### Primary Care and Public Health

#### Annex i

##### Written Evidence:

Dr Ranjan Adur - Havering CCG  
Association of Directors of Public Health  
Michael Beaman, pharmacist  
Dr Andrew Davies – Warrington PCT  
British Medical Association  
Cornwall of Isle of Scilly NHS Trust  
Dr Andrew Hassan – NHS Suffolk  
Institute of Public Health Cambridge  
National Association of Primary Care  
National Association of Patient Participation  
NHS Lambeth  
NHS Partners Network  
NHS Somerset  
Nuffield Trust  
Queen's Nursing Institute  
Royal College of Midwives  
South Essex PCT Cluster  
UK Faculty of Public Health  
Unite

##### Oral Evidence

Nick Goodwin, King's Fund, Senior Fellow  
Howard Catton, Royal College of Nursing (RCN), Head of Policy  
Dr Alan Middleton, Vice Chair, Mid-Cornwall Commissioning Consortia  
Dr Howard Stoate, Bexley Clinical Cabinet, GP Lead



# ALL PARTY PARLIAMENTARY GROUP

## Primary Care and Public Health

Were massive reforms necessary to save the NHS?

### **Annex i**

Oral Evidence Session

Wednesday 9<sup>th</sup> November, 12– 2pm - House of Lords, Committee Room 2a

### APPG Members

Julie Elliott MP

Baroness Masham

Nick de Bois MP

### Witnesses

Nick Goodwin, King's Fund, Senior Fellow

Howard Catton, Royal College of Nursing (RCN), Head of Policy

Dr Alan Middleton, Vice Chair, Mid-Cornwall Commissioning Consortia

Dr Howard Stoate, Bexley Clinical Cabinet, GP Lead

### **Moves to a more clinician-lead and sustainable health service could have taken place under the existing legislation**

The health and social care bill has provoked a huge amount of interest over the past year and formed a large part of MPs' workload. For the first time, the bill's passage was 'paused' for a listening exercise to take place. The health reforms have now proceeded to the House of Lords where they are being debated until February before going back to the House of Commons.

With this happening the APPG on Primary Care and Public Health wanted to examine some of the aspects of the reforms, in particular around commissioning.

The following questions were put to the witnesses:

**Do you agree the NHS needs saving in order to protect its values of “free at the point of need”?**

Dr Alan Middleton commented that the NHS doesn't need saving but that it needs to continue with modifications to keep up to date with changes.

The RCN response was that the NHS and its principles has 'overwhelming support' from nurses but they have had a strong reaction to the reforms as they believe it poses significant risks to those principles, including fragmentation, increasing bureaucracy and excessive marketisation. The fact that the proposed changes are being played out amongst a backdrop of £20 billion efficiency savings needing to be made has also raised major issues about cuts to jobs to the detriment of quality care.

Another concern was that, in particular, many specialist nursing posts, such as those working in the community, have been targeted to make savings when these nurses perform roles such as helping people manage their long-term conditions and provide support to help people stay out of hospital which is very cost-effective.

The incredible value of specialist nurses was echoed by Dr Middleton who described them as the 'GPs right-hand' and thought that more needed to be integrated into both primary and secondary care. In relation to commissioning, his worry was that the specialist nurses and community matrons would be replaced by lower-grade, less-skilled nurses who would not be able to perform the same duties.

**Do you believe these massive reforms were necessary, or were we already heading in the direction the Government is taking us with practice based commissioning?**

The Kings' Fund's view was that at the moment we have an 'unsustainable model' in terms of the demands that are being placed on the system. Hospital and nursing home-based care is very expensive and means the institutionalisation of people who don't necessarily need to be there. Mr Goodwin suggested that different ways of supporting individuals need to be developed, particularly for those people with the greatest individual needs such as elderly people, with a new type of approach that integrates care and brings together primary care with the specialist nurses.

He could see the logic in making a closer link between commissioning and clinicians but thought this could still have been achieved without such a high level of organisational change.

Dr Middleton spoke about his own experiences of practice-based commissioning where, for the past five years, he has been working with Primary Care trusts (PCTs) to set up a clinical commissioning forum on a reasonably large scale. Clinicians were becoming more involved whilst retaining the managerial skills of the PCT. He thought this was a good model which could have been expanded

upon but that interest and commitment was now being lost with the recent changes to phase out PCTs.

Dr Howard Stoate, chair of the pathfinder commissioning group in Bexley, also described how practice-based commissioning had been introduced in Bexley four years ago. A sub-committee (Clinical Cabinet) made clinical decisions which were then put to a Board for approval. The organisation has now been slimmed down (by 46%) at the government's insistence although a lot of uncertainty remains about what will happen when the PCTs wind up, what kind of commissioning support there will be and how much money there will be allocated for that.

Dr Stoate remarked that 'Constantly at the moment, we are getting a series of directives from the centre, telling us how things ought to run but no real clarity'. There is a lot of confusion and a 'transitional organisational mess'. While he agrees with the principles at the heart of the changes, he believes the way the government has gone about it has caused a great deal of uncertainty for staff. Also, a change in the law was not required as the changes were already taking place within the existing legislation.

The last point made by Dr Stoate was regarding conflict of interest; the government wants localism but doesn't want a postcode lottery. However, he argues 'you can't have both...you are guaranteed to get variations in quality'.

Baroness Masham then raised a question about the surgery near York that was promoting the services of a private company owned by the practice to carry out minor procedures. The panel agreed that this was 'shocking' and shouldn't have happened but thought that one of the real issues posed by the new system was going to be more conflicts of interest for GPs, as managing budgets may mean commissioning services to their own practice or partners.

**In 2001 Wanless was commissioned by the Treasury to take a long term view of the health service. He reported that the "fully engaged scenario" where people were informed to take responsibility for their health would empower people and save the NHS up to £30bn.**

**In 2009 the King's Fund told us we were in between the "slow uptake" and "solid progress" scenarios.**

- **Will the reforms truly engage patients, the public and health professionals in the behavioural change that is necessary for the fully engaged scenario?**

- **Is the King's Fund intending to do any further analysis on the Wanless scenarios?**

Mr Goodwin said the King's Fund had recently produced some reports that begin to address some of that question; a 2-year report on the quality of care in English general practice and a report on shared decision making and how patients make choices. Looking across the evidence-base, he summarised that 'we are not in a position yet where patients and individuals are really appropriately 'fully-engaged' in the decisions that they need to take about their own care'.

Going back to the patients with the greatest needs who put the major demand on the system, Mr Goodwin thought that we need to move to a situation where people are provided with good information about their illnesses and can get involved with shared-decisions about their care so, when they go back home, they are more empowered and able to self-manage their condition, with an understanding of the illness and who to contact when they need help.

Despite having a strong primary care system, Mr Goodwin thought there needed to be some kind of dual accountability between patient and doctor for making decisions about the patient's care, what he describes as 'real choice' around the care patients receive. He argued that until mechanisms are developed by multi-disciplinary teams for supported self-care, we will stay a long way from having the fully engaged scenario and a system that enables more people to live independently with less utilisation of health and social care services, and with better health outcomes and quality of care.

The King's Fund will be running some of the Wanless scenarios to look at how changes to the model would impact on costs and outcomes. It is also going to be developing a programme of work around integrated care and what happens to individuals in their interactions at a clinical and service level as there is a lack of evidence in this area. Mr Goodwin explained: 'We know that self-care can work when it's done well, often the evidence is equivocal because the interventions themselves haven't necessarily been the best'.

Baroness Masham also enquired as to the King's Fund's view on telecare. Mr Goodwin said the King's Fund would shortly be publishing the results of a 3-year project that has been trialling telecare. He thought that if you can get the case management right and target the appropriate patients safely and effectively then it can be positive and part of the solution. However, the panel agreed there would be cultural issues to overcome.

Debate ensued about how to change people's mindsets about healthcare and patient behaviour so they are more engaged. Dr Stoaite gave some examples of initiatives being run in Bexley with this aim, such as an expert patient programme, a communication and engagement group and one-to-one tuition to help people with diabetes manage their condition.

He added that people still think of 'hospital' when they think of the NHS, when going to hospital is a failure of care in many cases. Nick de Bois commented that politicians can get elected based on pledges to save a hospital and so any attempts to change perceptions about what is good quality care has to come from the medical profession; people would not trust politicians.

Helping people to understand the benefits of self-care and that it can be 'something more, rather than something less' is key explained Nick Goodwin, giving the example that increased use of technology such as telecare would lead to more contact with a healthcare professional. He added that more people need to stand up and say that self-care is a good thing. Mr Catton pointed out that school nurses also play a vital role in teaching children about healthy behaviours, 'setting them on the right path' from a young age.

**Written evidence we have received suggests that we have over-provided services in the NHS. Since we have a health service that is open 24/7 it means that patients have been encouraged to view the NHS as a consumer service which is responding to demand rather than to need.**

- **Do you agree and if so how can we get back to the culture where self-care was the default?**
- **Should this be a priority for Clinical Commissioning Groups (CCGs)?**

Dr Stoate considered that the greatest challenge for CCGs is the de-commissioning of services. He said that the only solution is for capacity to be reduced, with a planned, phased, withdrawal of services, in order to re-design services so that they are more about reducing the need.

This is very difficult politically and the CCGs' power to make radical decisions is being curtailed because of top-down worry. For example, rather than send someone for an angiogram, they could be sent for a less-invasive high-resolution CT scan. However, the CCG would still end up paying for both, not just the new service. The CCG could tell the hospital that they don't need such cardiology out-patient services anymore but only if they are allowed to, as CCGs have been advised not to de-stabilise the hospital or upset the health economy.

Dr Stoate said the evidence shows that the greater the capacity, the greater the usage. However, the media and politicians often see the re-design of services as cuts.

Dr Middleton noted he had seen a change in patients in that more people wanted to stay out of hospital and take greater care of their own health and that they should be consulted more to find out what they want. Dr Stoate disagreed and said that in Bexley demand had risen in the past year.

The King's Fund view was that an over-provision has been created in urgent care e.g. A&E, GP out-of-hours services, walk-in centres, urgent care centres, NHS Direct, 111 etc. which is confusing for patients as they are not sure where to go. Patients may use more than one of the services and there may be overlap as there is not the integration to record which services individuals have been to.

In Cornwall, Dr Middleton spoke about how some A&Es have GPs working at them with the aim of getting the message through to people going to A&E unnecessarily that they are still just seeing a GP.

The panel was asked about the 'Choose Well' programme that is designed to signpost people to the appropriate service and whether, if more widely promoted, it might lead people to be better informed about where to go? It was thought that it is possible but very difficult to actually change behaviour through such information campaigns. The issue of availability of services was also raised, as people often go to A&E when they are unable to access their doctor.

**Do you think the health reforms will harm the patient-doctor relationship and nurse-patient relationship and maybe even nurse-doctor relationship?**

The doctors thought the danger was that if patients start thinking their GP is making money out of them then it will seriously damage the patient-doctor relationship. However, if it is done right, patients will appreciate that the decisions are being made by people who know what they're talking about and it has the potential to be successful. It could go either way.

Mr Catton was concerned that issues may arise with other health professions if the GP was seen as 'controlling the purse strings' rather than a multi-disciplinary team. He also noted that coverage of nursing in the media has become a lot more critical.

With GPs having to make cost-conscious decisions at the point of consultation, Mr Goodwin believed a different type of relationship with patients and the local community was needed, one that allows for transparency and patient engagement in shared decision-making.

**How do you feel the NHS Commissioning Board is going to improve health services locally?**

The panel were uncertain about this. They thought, at the moment, there is a confused picture about what the architecture will be and how the relationships will play out between the different organisations. There could also be issues over accountability.

**Reforms are meant to strip out managers in favour of clinical leadership, do you believe this is likely to happen or will we see Clinical Commissioning Groups behaving like PCTs?**

Dr Stoate spoke about the difficulties of working within the 'cost envelope' that the government is set to allocate (this was debated but is expected to be around £25 per patient). His worry was that GPs would not be able to do everything that was expected of them within that budget; things could possibly be done adequately but not well.

He also argued that a budget per person was not a level-playing field as when the population is larger the budget can be used more cost-effectively.

Julie Elliott observed that some of the pathfinders were already millions over-budget and queried what would happen when these were rolled out on a larger scale? Dr Stoate's response was that they would either need to merge with other groups to become much larger or would not get authorisation and be told what to do by the national Commissioning Board.

Dr Middleton thought it would not necessarily be a bad thing if CCGs behave like PCTs, as we could have managed with the present structure but with GPs being involved in a greater way on PCT Boards.

Closing the discussion, Ms Elliott pondered that having gone through many months of debate about the reforms, and with a large amount of money having been spent, that perhaps we might end up with something very similar to what we had before!

