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THE NHS AS A NATIONAL ASSET

PUTTING PATIENTS AND GROWTH AT THE HEART OF THE NHS

The current Health Bill has much to recommend it and in many ways flows in the direction of travel of the NHS reforms that have occurred under previous governments. The main failures in the current Bill we think are in the unnecessary complexity and lack of context, dismissal of the need for good management support and the omissions that we believe are crucial to ensuring a continuing, universal service.

The key omissions that would drive improved health benefits and stimulate economic growth are adoption of technology to transform long-term condition management, extension of co-payments and incentivising personal responsibility in healthcare.

Any Health Bill will be opposed by any number of organisations as there are vested interests to keep things the same, prevent limitations to their power or expose them to greater scrutiny. However it is in the public interest that improvements in quality of care, safety and stewardship are strived for in the NHS. Good clinicians will know that accountability should be a sine qua non of receiving tax payers' money. Our recommendations come under three headings:

1. **Smarter spending**
2. **Improving the quality**
3. **Re-defining the caring experience**

1. SMARTER SPENDING

CLINICAL COMMISSIONING SHOULD BE RETAINED.

Without GP led commissioning those who are answerable for the vast amount of spending within the NHS will not be held responsible. Many will admit that they have had 'super-market' sweep to date and would be happy to be more accountable. Accounts and reasons for awarding contracts should be open to public scrutiny, so if a practice within the consortia is delivering services, it is clear from the tendering process that this decision was evidence based.

CONSORTIA - WE SUGGEST THEY BE CALLED **CLINICAL COMMISSIONING TRUSTS.**

This is to represent the broader primary care membership that should be included. Wider membership will enable GPs to draw on the expertise of all clinicians and the multi disciplinary team be held collectively to account. However hospital staff should not be included in the board. The involvement of hospital clinicians is vital in the redesign of pathways and there needs to be a formal process by which the Board works with them. The opportunity now is for the majority of clinicians in any community to take a renewed interest in what and how services are delivered in the interests of patients and obtaining value for money.

COMMISSIONING & LEADERSHIP SUPPORT IS VITAL

To become successful commissioners and actively engage and drive change, GPs need to be well supported. Detailed decisions on planning, contracting and financial management requires high calibre management support and this must be available from both the Department of Health as well as from the independent sector organisations who some will want to use. In leading boards, clinicians and particularly doctors must be given the authority and tools to manage members of the team to ensure that high quality care and value for money are achieved.

TECHNOLOGY ADOPTION IS URGENT

It should be expected that managers and clinicians alike adopt modern technology at scale into new pathways and this should be reflected in the reimbursement system. We know this isn't covered in the Bill but there has to be an urgent push to transform the way we deliver care. How we deliver care now is unsustainable in terms of the inefficient use of the workforce and the rising demand due to an ageing population.

COMPETITION

The NHS for too long has held a monopoly over the provision of health care and this has led to complacency and inefficiency in performance and productivity. The NHS is already engaged with the independent sector (most GPs, pharmacists, dentist, optometrists, many diagnostics, pathology, mental health, home care, all medicines and some elective surgery are all independently provided) and this should be encouraged. The 'anti-privatisation' rhetoric has been hugely damaging to the NHS and to economic growth and simply wrong – the Bill is not about the transfer of assets to the private sector. The independent sector has a strong record of innovation, scrutiny, efficiency and investment in technology and growth. Commissioners should determine locally where support is required, what role the private sector can play and how this might be enabled to enhance care. In some cases this may mean that services are provided wholly by the independent sector. Where the NHS is the monopoly provider we must ensure that they deliver value for money (VFM) and quality of service. Some hospitals already use their facilities well but others need to feel under pressure to improve the quantity and quality of what they do. Competition has to be real, there has to be the chance of failure – otherwise we will repeat the mistakes of the banking crisis where high risks were taken on the assumption that the bank would not be allowed to fail – only in this case it means poor hospitals will continue to survive while patients die due to inadequate care.

2. IMPROVED QUALITY OF CARE

STRATEGY AND CO-ORDINATION - RENAME AND REVISION OF SHAS.

It will be impossible for the National Commissioning Board to oversee the work of hundreds of consortia and NHS Trusts. It would seem sensible to put in place regional bodies, it would make sense to have these aligned with the regional public health departments. They must be significantly different from PCTs and SHAs. More of the same will not do, nor will moving the deck chairs around solve the problem. New blood is required. A regional body's role must be to scrutinise performance and co-ordinate strategy, not performance manage. They should advise the National Commissioning Board where problems exist.

CHOICE HAS ITS LIMITS

To meet demand and provide the public with what they should expect we have to adopt more effective ways of treating illness, targeting prevention and enabling simple choices. Choice cannot be universal and that there are limitations. We need to acknowledge that choice eats up management time and consumes too much money that is not available so our choices are limited. Where choice is available this should be made clear to the public.

Choice	
Should be optional	**Not optional**
Treatment of minor illness location / provider	Specialised surgery / treatment for rare conditions
When to receive diagnostics / treatment	Where to receive on-going long term condition care; Chopping and changing between complex elements within each pathway
GP location	
Upgrading to (co-payment for) new technology e.g. type of implant	
In-home monitoring	
Planned and managed medical or surgical intervention	Emergency medical and surgical intervention

NICE MUST BE IMPROVED NOT UNDERMINED

The Bill lays the foundation for changes to NICE, to remove its mandate over the universal availability of medicines. This will exacerbate the postcode lottery for obtaining medicines and would lead to perverse behaviours by both GPs (covert rationing) and patients (overt re-location to another consortium to obtain medication). It would be a hugely retrograde step which would both effectively demote a body of international renown and increase health inequalities. NICE isn't perfect, the "Healthcare Technology Assessment" process should be improved, but the mandate should stay.

INTEGRATION MUST BE POSSIBLE

Nothing in the Bill must preclude vertical integration where local commissioners want this to happen. Both the ICO and RCGP federated models illustrate this. Public choice remains at the point of GP and care pathway.

FAILURE REGIMES ARE VITAL FOR SAFETY AND STEWARDSHIP

There needs to be greater clarity on the failure regime for Commissioning Consortia and NHS Trusts. The current regime focuses on financial failure but clinical failure must be an explicit part of any regime. At present there is little come back for organisations where poor care is delivered other than changing the management. Thought needs to be given to imposing fines for poor care or taking away a licence. The service would then be tendered out. This would not necessarily mean relocating a service. There is no reason why a number of organisations could not run services out of one hospital or GP consortia. We already have franchised services in some hospitals. (see Competition above)

OUTCOMES

We need greater transparency over outcomes with easily accessible, understandable information. There must be less 'management speak' when communicating clinical performance to the public and greater clarity on what the outcomes mean. Health organisations can easily gloss over failures and focus on successes. We would not want to undermine public confidence unnecessarily, but communities need to

be better informed to enable them to exert influence to improve performance or exercise choice when practical. We welcome the need to refocus on quality within VFM rather than measuring process or overt competition on cost, which whilst having a place in determining the quality of care delivered is not the whole answer.

CQC AND MONITOR SHOULD MERGE

There is no financial sense in keeping Monitor and CQC apart. Taking into account the political response that Monitor is in an invidious position if it is expected to assess fiscal prudence and promote competition at the same time, CQC and Monitor should combine to be actively involved in assessing clinical pathways development to ensure real change and VFM is happening. Added to this, EU competition law already fully applies to the NHS and it is not necessary to gold-plate it through adding another competition law regulator in the form of Monitor. Where there is failure to undertake pathway redesign and capitalise on new ways of working consideration should be given to the future of the Consortia /Trust. Recent events have shown that appalling levels of 'care' have been tolerated for too long with few consequences for the poor performers. This is an unacceptable betrayal of the public's trust in the NHS. Safety must trump sentimentality.

Given CQCs inability to recognise and prevent breaches of standards a review of the assessment of Trusts is required. Currently, it is largely based on self-assessment, with triangulation being used to identify discrepancies. We suggest a more hands-on assessment be introduced using the previous HQS framework and that highly skilled, senior assessors site visit and review every Trust at least once every two years.

CQC/ Monitor should make robust recommendations to the National Commissioning Board as to where services can no longer be safely delivered.

PUBLIC ACCOUNTABILITY

Closer scrutiny at local level by non NHS bodies and the development of Health and Wellbeing Boards (HWB) gives an opportunity to develop a greater integration between services at every level and demand they give a better account of themselves. HWB's need to be empowered to take positive action where care is falling below par or there is a failure to adopt new models or new approaches to care and where VFM is not delivered. Access to the new NHS information centre and Map of Medicine to ascertain

variation in services will be essential. The new Consortia must be locally accountable and their Health and Wellbeing Boards as well as responsive to Healthwatch. Patients should also be able to register where they want for their care, and not be limited by geographical boundaries.

3. CARING EXPERIENCE

In exploring the caring experience there are three key principles

- **We must share the responsibility for our own health and the health of those around us**
- **Develop confidence in the services and those that deliver them**
- **Put community and kindness at the heart of care**

'PAYMENT BY RESULTS' FOR PATIENTS

In sharing responsibility for our own health new ways of engaging with the public must be found to enable a better understanding of the actions needed to prevent illness or self manage. We propose a 'Payment by Results' for patients whereby if you e.g. keep your blood sugars down, keep weight off, take on more self-care there will be a tax rebate or an end of year bonus. This could be monitored by the GP through QUOF. More money spent on making healthy choices rather than pursuing unachievable choices (see above) would be the best stewardship of NHS funds. Government must continue to work more closely with the food and drinks industry to reduce the burden of ill health cased by over eating and drinking. There are known addictive compounds used in processed food which should be banned. There needs to greater emphasis on education at all ages and levels of society.

HEALTHWATCH, PATIENT EXPERIENCE RATINGS AND ENGAGEMENT

Healthwatch is required to undertake a larger role than the current LiNKs and adequate provision of funding needs to be in place if it is to be successful without it becoming politically driven or over bureaucratic. Healthwatch should have its sole focus on the delivery of high quality care and the patient experience and advice on service provision and choice left to others. It too must be held to account for its actions achievements and effectiveness. Producing a patient experience rating could form part of the Healthwatch work.

Engagement of the public in scrutinising healthcare has largely been unsuccessful as a way of improving quality of care and outcomes for individual Trusts, or the early detection of major problems. We propose that each Trust has board of lay governors that is solely responsible for monitoring the quality of

care within hospitals and consortia. They should have some power to take action where care and outcomes fall below their expectation and be given direct access to the National Commissioning Board to enable them to raise legitimate, serious concerns. They must be given the power to assess the impact of pathway changes and developments or lack there of upon the local community. They should represent the population at large in discussions on pathway redesign, access and responsiveness. Healthwatch should also have the right to comment and offer advice to trusts on strategic direction

PUBLIC HEALTH

While we welcome the integration of Public Health into the Local Authority, Public Health is an important function at national and local level. Much of the demand on future healthcare will stem from public health issues. There needs to be a public health function within Consortia as well and this needs to be accountable and work closely with the Local Authorities. The JSNA needs to have greater weight and should be offered as information to the public through their GP and Local Authority to increase awareness of the impact of the health needs of the whole community.

CO-PAYMENT SHOULD BE EXPANDED

The presence of top-up payments in primary care has meant that dentists, opticians and pharmacists have been able to encourage self-care, personal spending on health and stimulate innovation in the medical devices industry. Despite the changes to legislature, 'top-ups' in the rest of the NHS to enable access to e.g. non NICE approved medicines have been severely hampered by the accompanying restrictions that don't allow payment for delivery of treatment. The benefits would be significant of allowing more co-payment: allowing more choice, stimulating innovation, encouraging people to invest in their health and ensuring new technologies are made available to all – as well as some honesty about what the NHS can actually afford.

BIG SOCIETY IN HEALTH

The concept of the Big Society is all about taking more responsibility, it's about "giving you the initiative to take control of your life and work with those around you to improve things". Applied to health there

should be an increasing sense of 'community' at the heart of health which encourages everything from informal partnerships in care (such as between those with the same long-term condition) to more appropriate use of A&E. We are about to produce a fact sheet on initiatives that can be copied by others, but stressing the importance of community in these reforms is also vital for sustainable healthcare.
Engaging the public in scrutinising healthcare is problematic. FTs have failed to engage the public in scrutiny of their work, the Board of Governors and the membership have had little appetite to challenge managers and clinicians. Scrutiny by the users of services needs to be about clinical quality rather than planning and strategy, and emotional attachments to buildings and services may drive participation rather than an understanding of the quality of outcomes.

NURSING

Details of inadequate care over the past few years have all too often highlighted the huge variability in nursing care in England. We think that a review of both training and employment terms is essential. There should be no tolerance of continuing poor performance. The holistic nature of the role should be stressed as well as an unremitting emphasis on the importance of kindness and caring.

NATIONAL VIABILITY REVIEW

Consideration needs to be given to providing treatments closer to home and in the home, at the same time providing specialist care where it is safe to do so.

We propose that the Government undertakes a National Viability Review. This would:

- Decide where services are viable in current settings and identify new settings that make greater use of internet and communications technologies. The adoption of telehealth and telemedicine over and above that currently envisaged is essential and the there needs to be leadership in the development of new pathways and roles as well as working in partnership with industry
- Review 'specialist' services to explore where care that requires high tech and skilled intervention should take place, identifying centres to deliver such care.

In considering where care is best placed, inevitably some facilities will be significantly reshaped. For much of the country little would be changed for geographical reasons. By far the biggest problem will be London and a pan London Strategy needs to be developed and owned at Government level.

ABOUT 2020HEALTH

2020health.org is a not-for-profit, independent grass- roots think tank for Health and Technology. Our vision is to shape the present and direct and influence future health, social and technology policy, putting community at the centre of all we do. We aim to ensure policy reflects the wisdom and experience of professionals, to broaden involvement and debate on key concerns to give value for money and build on the achievements of the present to create the vision for improved healthcare. Many of our reports and proposals have influenced the thinking of the main political parties.

For more information please contact us at:
83 Victoria Street,
London
SW1H 0HW
T: 020 3170 7701
E: admin@2020health.org
W: www.2020health.org