

## COALITION HEALTH AND SOCIAL CARE POLICIES

### SOME INITIAL REACTIONS FROM NATIONAL VOICES

#### Overview

This paper is a point by point commentary on government policy as so far expressed in the coalition agreement, Queen's Speech and the recent Andrew Lansley speech. This overview section offers some high level observations and questions.

On NHS reform, Andrew Lansley has set out six priorities:

- make a cultural shift. From a culture responsive mainly to orders from the top-down, to one responsive to patients, in which patient safety is put first.
- devolve power through the unleashing of meaningful information to patients. Comparative data about standards and patient experience will drive up standards, as the data will influence patient choice. A transparent NHS is a safer NHS.
- engage people in their care so that, "no decision is made about me, without me", and give patients the opportunity to provide feedback in real time, reflecting the experience of their care.
- embrace leadership by setting NHS professionals free from a target-centred and bureaucratic system that compromises patient care, to one focussed on the quality, innovation, productivity and safety required to improve patient outcomes.
- adopt a holistic approach by looking at the entire patient pathway from preventative health and well-being measures, through to hospital and community care.
- align payments in the NHS to drive up the quality of care that patients receive. In the first instance, through introducing payments which encapsulate a more integrated care pathway by giving hospitals responsibility for a patient's care for 30 days after they are discharged.

The broad thrust of the vision is great. All governments have struggled to translate policy intent into improvement on the ground. We think embedding patient and citizen voices into the translation process is vital. So, more broadly is the role of the voluntary sector. We stand ready to help and we can offer solutions.

How it will all work out is greatly uncertain at present. What is proposed is actually more revolutionary than the comforting rhetoric suggests. Some of the emerging detail is cause for concern. Some targets – most notably the 4 hour A&E and 18 week waiting time targets are also, from a user perspective, really important outcomes. There are huge dangers of perverse incentives. Andrew Lansley has already shown himself to be pretty "top down".

**Funding.** There will have to be some cuts and significant changes, even with NHS spending rising. How will this debate be conducted, and how will patients be involved?

In a time of resource constraint, systems will be under more pressure to cut corners. How will the Government protect safety, quality and patient-focus in these conditions?

**Social care** Social care funding is not ring-fenced. Many of those we represent have both health and social care needs – and not all are elderly. How will social care be protected and better integrated with healthcare? What news on the social care commission?

**Patient voice** We think the NHS has tended to turn “patient and public involvement” into a bureaucratic tick box exercise. We favour a more human, immediate, communicative approach.

Mr Lansley has said Local Involvement Networks will have a new incarnation as local HealthWatches and that there will also be a national Healthwatch. We want to be involved in shaping this.

**Patient control:** we strongly support moves to give patients more control in managing their conditions. We want to see effective shared decision making and self-management approaches mainstreamed. This means that attitudes among some professionals will need to change.

**Communication** A consistent theme among the service users we work with. Much more emphasis is needed on how we recruit, train, support and hold professionals to account for their communication and social skills, and compassion.

**Quality** How will the new arrangements for commissioning ensure that resources are properly matched with needs?

How will you promote strong leadership in health and social care?

How will doctors be scrutinised and held to account for their performance?

**Equalities and rights** How will the Government’s concern for equal opportunities translate into health and social care? Many groups get a relatively poor deal from services – not only in access but in the quality of treatment and experience. There is discrimination, not only against ethnic groups, but also against people with particular conditions. Cuts could reinforce inequality – what are the safeguards? Whither the NHS Constitution?

**Health and work:** helping patients, people with disabilities and carers get into and stay in work is a vital part of empowerment

## **The NHS**

### **Health spending increases in real terms each year**

Strongly welcomed, but does not remove the significant efficiency challenge as the Secretary of State has already indicated. We favour honesty about the implications and public involvement in the trade-offs entailed.

Resource constraints create pressures that could affect safety, quality and patient focus. That strengthens the rationale for:

- Simpler, more accessible and more responsive feedback and complaints handling
- Meaningful public involvement in local service change
- More shared decision making between doctors and patients.

Social care spending is not ring-fenced and will be under huge pressure in the short term as local authorities make significant in-year cuts right now. In the slightly longer term a fair and sustainable funding settlement for sharing the costs between state and individual must be sorted. We look to see early progress with the new Social Care Commission

### **Stop top-down reorganisations of the NHS**

It depends what you mean by “top down”. In fact, a fair reading of the government’s plans is that a complete revolution is planned in the commissioning landscape. A new national commissioning board, scrapping SHAs, almost all funding being routed to consortia of GP commissioners, a major expansion of personal budgets. An uncertain future for PCTs.

History tells us that organisational change on this scale never goes smoothly, costs more than expected and hugely distracts people from the day job of designing and delivering care.

### **Cut the number of health quangos/Cut the cost of NHS administration by a third and transfer resources to the front line**

We applaud the intention. The challenge is to avoid unexpected costs and unintended side effects. Easier said than done

Parts of “NHS administration” are essential – eg the collection and sensible use of good data, and above all strong managerial and clinical leadership

### **Stop centrally dictated closures of A&E and maternity wards**

The Government has said that NHS service changes must: focus on improving patient outcomes; consider patient choice; have support from GP commissioners; be based on sound clinical evidence

We support these principles and would add that there must be meaningful and early involvement of patients and local communities in these decisions. It is also important that institutional vested interests do not trump quality and patient considerations.

In GP commissioning the government has created a potentially powerful quasi-market mechanism for making certain DGHs unviable. How will that pan out?

### **Strengthen power of GPs as patients’ expert guides/commissioners**

The government plans more than strengthening the commissioning role of GPs – the vast majority of NHS funding will be routed through consortia of GP commissioners. This is in fact a profoundly radical overhaul of commissioning.

How will it work? It is a risky venture and there needs to be greater clarity about:

- what must continue to be commissioned by other means to ensure that needs are met – especially for those who are not necessarily on GPs' radar
- what is done about GPs that are not willing or able to perform this role
- how the commissioning role sits alongside the GP provider role: this is an area rife with potential conflicts of interest
- how GP consortia are supported to do the job well – Mr Lansley has announced that there will be no automatic role for PCTs here
- how GPs are held accountable for their commissioning

**Ensure a stronger voice for patients locally through directly elected individuals on the boards of their local primary care trust.**

A good move in principle that could strengthen accountability. Except that it now looks as though the democratic deficit will be addressed in a part of the system that will wither and possibly disappear. In any case elected PCT members are not a substitute for:

- good engagement mechanisms connecting communities with their health and social care services
- simple and effective channels of communication for patients and families

**Local PCT to act as a champion for patients and commission those residual services that are best undertaken at a wider level, rather than directly by GPs.**

Good – but again sits oddly with the overall landscape of commissioning reform which seems to make PCTs much less important. And “residual” is not quite the right word for services that need to be commissioned on a sub-regional level.

**If a local authority has concerns about a significant proposed closure of local services, it will have the right to challenge health organisations and refer the case to the Independent Reconfiguration Panel.**

How will this mechanism sit with Overview and Scrutiny Committees, the new local HealthWatches and the new GP commissioning consortia? A lot more to be done on local accountability mechanisms

In particular, beware of bypassing patients and communities. A test of a good process for redesigning services must be the quality of the dialogue with patients and communities.

**Give every patient the right to choose to register with the GP they want, without being restricted by where they live.**

We support this

**Develop a 24/7 urgent care service, including out-of-hours GP services, and make care more accessible by introducing a single number for every kind of urgent care and by using technology to help people communicate with their doctors.**

We support this. We want the NHS to make more use of channels of communication which are commonplace in other walks of life – eg texting, emailing.

**Renegotiate the GP contract and incentivise ways of improving access to primary care in disadvantaged areas.**

Many disadvantaged areas are underdoctored. We strongly support moves to narrow the access gap.

**Extend best practice on improving discharge from hospital and where possible enabling community access to care and treatments./Help elderly people live at home for longer through solutions such as home adaptations and community support programmes.**

A strategic and holistic approach is needed to improving the management of long term conditions. This needs to involve working with patients, carers and their organisations.

**Seek to stop foreign healthcare professionals working in the NHS unless they have passed robust language and competence tests.**

Good

**Give front-line staff more control of their working environment.**

Empowered professionals deliver better care. But they must also be held accountable for their practice.

Professionals are more empowered in open working cultures that encourage their participation in decisions; rather than the autocratic, hierarchical cultures that prevail in parts of health and social care. This requires good leadership

We support the Government's plan to strengthen protections for whistleblowers, but hope that more open working cultures will reduce the need for whistleblowing

**Strengthen the role of the Care Quality Commission. Develop Monitor into an economic regulator that will oversee aspects of access, completion and price-setting in the NHS.**

We support the retention and strengthening of the CQC. It needs a well defined remit, which is patient-centred. It needs strong mechanisms for engaging with patients and families as part of its intelligence gathering and to inform its practices. In a period of resource constraint, the CQC must be able to:

- identify early warning signs of poor care and intervene swiftly where necessary
- have good, relevant data, including user feedback, and intelligence shared with the professional conduct regulators

**Enable patients to rate hospitals and doctors according to the quality of care they received; hospitals to be open about mistakes and always tell patients if something has gone wrong.**

We support easy and accessible channels for patients and families to voice opinion, concern and complaint, with the assurance of an appropriate response. We think that involves:

- good and swift local resolution of issues everywhere
- much greater use of online channels, with providers expected to be online too
- a single phone number
- mediation of significant complaints with a focus on genuine contrition and learning, and avoiding expensive litigation

**Will measure success on the health results that really matter – such as improving cancer and stroke survival rates or reducing hospital infections/ Will publish detailed data about the performance of healthcare providers online.**

We are in favour of much greater transparency about results that really matter. We support the general intention of the government on transparency to “ensure that all data is published in an open and standardised format, so that it can be used easily and with minimal cost by third parties”

Health data needs to be relevant and presented in a form that is understandable. We are keen to work with the Government on this.

It is also important that the NHS collects, uses and makes available key data on patient experience – without this turning into a bureaucratic exercise.

Primary care is relatively unscrutinised. There is huge variation in performance and quality. People need to know more about how effective their local surgeries and doctors are.

**Put patients in charge of making decisions about their care, including control of their health records.**

We strongly support both. Access to health records should be routine.

There is a need for a systematic approach to incentivising the take up of known good practice in shared decision making. This includes recruiting, training and supporting clinical staff to be good communicators and sharers of information.

People need more help to manage minor health complaints themselves. We have lost the art of self-care. It would take pressure off the NHS and save money.

**We will reform NICE and move to a system of value-based pricing, so that all patients access the drugs and treatments their doctors think they need.**

There needs to be a fair, transparent and publicly understandable process for deciding what treatments will and will not be funded by the NHS.

**Commit to the continuous improvement of the quality of services to patients, and to achieving this through much greater involvement of independent and voluntary providers./ Give every patient the power to choose any healthcare provider that meets NHS standards, within NHS prices, including independent, voluntary and community sector providers.**

We support this. The voluntary sector has value to add through service provision, advocacy, the encouragement of volunteering, and providing a bridge between communities and statutory agencies.

### **Public health**

**The Government will create a new public health service led by the Department of Health, in which:**

- **public health funding will be protected through ring fenced budgets;**
- **allocations will be weighted towards the most disadvantaged areas through payment of a health premium;**
- **local NHS organisations will hold the budgets and will be tasked with improving the health of their residents. They will work closely with local authorities, voluntary organisations and local business to deliver this. And they will be paid according the outcomes they achieve; and**
- **there will be revised incentives for GPs to prioritise preventative measures.**

**We will work in partnership with businesses and the third sector, and use innovative approaches based on behavioural science. The plans for the new public health service will be published in due course, and will be followed by consultation on the detail of the public health ring fence and the outcome measures to be adopted.**

We think this is an exciting agenda and hope to work with the government on it.

We hope this is an opportunity to build on the best examples of current practice of connecting disadvantaged communities with their health and with their health and social care services.

## **Social Action**

**Train a new generation of community organisers and support the creation of neighbourhood groups across the UK, especially in the most deprived areas.**

There is a clear potential read-across between this and the public health proposals above.

**Take a range of measures to encourage volunteering and involvement in social action.**

Including in the health and social care field

## **Social Care and Disabilities**

**Will establish a commission on long-term care, to report within a year, to consider ideas including both a voluntary insurance scheme to protect the assets of those who go into residential care, and a partnership scheme as proposed by Derek Wanless.**

We look for a sense of urgency and momentum and a strong user input into the process.

**Will break down barriers between health and social care funding to incentivise preventative action.**

Good, but in the short term social care funding is being cut.

**Will extend the greater roll-out of personal budgets.**

Mr Lansley has indicated that he is keen to see a major expansion of personal budgets for health and social care and sees them as a significant engine for driving health and social care integration.

This should be done informed by evidence of what works and taking care to ensure that the empowerment of budget holders is not at the expense of non budget-holders.

**Will improve access to respite care by direct payments to carers and better community-based provision.**

We support this

## **Jobs and Welfare**

**Will re-assess all current claimants of Incapacity Benefit for their readiness to work. Those assessed as fully capable for work will be moved onto Jobseeker's Allowance.**

This has raised some concern among National Voices members. Many of those on Incapacity Benefit have long-term conditions which are deteriorating over time. We fear that re-assessment will cause anxiety and stress for many. The process needs to ensure the right balance between economic necessity and protecting privacy and well-being