Leeds Hospital Alert

CONFERENCE 19th MARCH 2011

A CHANGED NHS FOR LEEDS?

Chair's Introduction to the Morning Session: Michael McGowan

Michael McGowan explained that the purpose of the Conference is to provide information about the forthcoming changes to the NHS in Leeds.

Leeds Hospital Alert has a long history of campaigning for the NHS in Leeds, and in 2008 had led a large celebration of the NHS' 60th birthday.

Leeds Hospital Alert had invited Andrew Lansley, Secretary of State for Health, to be keynote speaker at the conference, but he was not able to attend. He did, however, send his best wishes for the conference.

Unfortunately, Louise Miller, workshop leader, and John Lister, afternoon session speaker, are both ill and unable to attend the conference.

Presentation: Samuel Forbes, Executive Lead for the H3+ Consortium in Leeds

Introduction

The presentation covers an overview of the NHS White Paper and GP commissioning, and how this will work in Leeds. Introductory points:

- This is not a defence of government policies.
- We love the NHS and its values.
- The presentation will be jargon-free.
- It is important for the public to engage with what is happening.

Samuel Forbes is Executive Lead with the H3+ GP Consortium, and also Business Partner with the Robin Lane practice in Pudsey, which has 11,000 + patients and is setting up a Health and Well-Being Centre.

Main Points of the Address:

- Core principles
- Commissioning
- The White Paper
- H3+
- Examples

Core Principles

The three founding principles of the NHS in 1948 were:

- To meet the needs of everyone
- To be free at the point of delivery
- To be based on clinical need, not on the ability to pay.

These remain the foundation of the NHS.

Commissioning

Commissioning is a response to these three principles. Commissioning exists "to provide services to meet the needs of the population" (Department of Health).

Commissioning is a purchasing relationship. It is currently carried out by the Primary Care Trust (PCT). The Labour government introduced Practice-Based Commissioning, in order to involve GPs in commissioning.

The White Paper

The White Paper Health Bill (July 2010) introduces the biggest shake-up in the NHS since 1948. Key themes:

- To give the NHS independence – there will be an independent NH Board
- To abolish Primary Care Trusts and Strategic Health Authorities
- To transfer NHS budgets to groups of GP practices (consortia). Consortia will be fully functioning in shadow form by March 2012, and fully or conditionally authorised by March 2013.

Why change from commissioning by Primary Care Trusts? A report from the King's Fund has evaluated the strengths and weaknesses of different kinds of commissioning:

- GP Fundholding: *strength*: input on referral rates; *weakness*: lack of scale.
- Practice-Based Commissioning: *weaknesses*: very few new services appearing; doctors' objectives have not been met; GPs have no decision-making powers.
- Primary Care Trusts: *Strengths:* size; relationships with public health and with the local authority; strategic oversight. *Weaknesses:* limited effect on hospital services; poor clinical involvement by GPs.

The question for commissioning therefore is: How to turn GPs' clinical aspirations into real change?

The H3+ Consortium

The H3+ Consortium was founded in March 2008. It involves 33 practices in South, West, and inner-city Leeds. There are 150+ GPs and nurses. It covers over one-third of the city.

Responsibilities of Consortia:

- Planned care – e.g. referral on for a skin problem
- Unplanned care – e.g. an urgent hospital admission
- Accident and Emergency
- Mental health services
- Community services – e.g. District Nurses
- To improve the quality of primary care
- To follow guidelines for primary care prescribing

Accountability

Consortia will be accountable in the following ways:

- The NHS Commissioning Board, an independent body, will set all the outcomes which patients can expect, and will monitor these
- The Health and Well-Being Board will be led by the City Council and will link to Adult Social Care services and to public health. A steering group has been set up for this.
- Members of the public will be involved through the Patient Public Advisory Group (PPAG) and through Health Watch. Consortia will also involve members of the public.
- The Care Quality Commission will monitor standards of care
- Monitor (government body) will ensure the appropriate spending of funds. Guidance is awaited on this.
- Doctors and nurses will be accountable through their professional status
- H3+'s first principle is patient involvement.
- There will be an equal mixture of clinical leadership, management support and patient as partners.

The H3+ Commissioning Group has four key principles:

- Patient involvement
- Workforce education
- Practice development
- Commissioning (statutory duties).

Patient involvement embodies one of the key themes of the White Paper: "no decision about me without me".

<u>Some Examples</u>

- Planned care: clinical pathways are being developed, for example with musculo-skeletal problems: GPs meeting with hospital consultants.

- Moving from general practice being acute practice to being pro-active: for example, weekly ward-rounds in nursing homes, trying to catch problems early. This has resulted in a 25% drop in hospital attendance.

Final Thoughts

- The White Paper will not turn GPs into managers
- The GP is the main route to NHS services
- Commissioning is to ensure that services meet the needs of patients
- GPs are the overarching care co-ordinators.

Questions from Conference Attendees on the Presentation

- Question about accountability: Answer: there will be a separate board of directors, and accountability processes as outlined in the presentation.
- A report in The Guardian has spoken of GPs earning £300,000 per year. What mechanisms will there be to ensure that money stays in the NHS? Answer: the practice and the commissioning board will be two separate organisations. The Health and Well-Being Board will have a say too.
- Practices will be offered £55,000 to become a commissioning group. Answer: funds will be in different bank accounts.
- The NHS will be run by private firms. GPs do not have any choice about joining consortia. The real problem is underfunding. Once the market is let in, the NHS will be destroyed from within. Answer: GP consortia will be statutory bodies.

Reports from Morning Session Workshops

Workshop: Patient Involvement. Led by Jane Westmoreland from Leeds Primary Care Trust

Issues for the consortia:

- Better publicising of opportunities for involvement, to make people more aware.
- Involve the "Cinderella services" as well.
- Real engagement: people really influencing services, not just comments or views on proposals put forward. Patients to shape services at early stages.

For Health Watch and other bodies to be effective, they should have statutory powers.

Workshop: Adult Social Care. Led by Mick Ward from Adult Social Care Department

Main points:

- The scale of the cuts to Adult Care Services in Leeds (£20 million) will have a major impact on NHS services. If the local authority has to pull out of services which it jointly funds with the NHS, there will be problems.

- The promotion of "any willing provider" for NHS services will mean that the NHS will just become a badge. The large number of NHS providers will create a problem of co-ordination for Adult Care Services.
- How will the consortia have a city-wide approach? Key service areas such as dementia may slip off the agenda.

Workshop: NHS Staffing Implications. Report by Rob Demaine and Ian McAleer

Main points:

- Effects on staffing levels of cuts in support staff – e.g. consultants doing their own photocopying.
- Terms and conditions: moving on from national terms and conditions – e.g. on unsocial hours.
- Privatisation: NHS trusts could be social enterprises, opening the way to involvement by Tesco and Virgin. These will not be interested in the "non-sexy" parts of the NHS such as dementia services.
- Staff awareness.

Chair's Introduction to the Afternoon Session: Dr Martin Schweiger

Health is everyone's business.

Every proposal should be considered in the light of Gandhi's question: "How would this affect the poorest person I have ever met?"

Presentation: Dr Amanda Robinson, Chair, Leeds Local Medical Committee

Introduction

Dr Robinson is a GP working in Leeds. She has been a GP in Leeds for twenty years, and has spent twenty seven years in general practice.

The Local Medical Committee is part trades union, part professional body. The presentation will give a flavour of what GPs are thinking in Leeds.

The White Paper

The White Paper was issued in June 2010, with three months' consultation. The key points are:

- Commissioning for patients
- Local democracy
- Freeing providers
- Transparency in outcomes
- NHS information

- Provider-led education.

GP consortia: the main points are:

- Statutory bodies
- Overseen by the NHS Commissioning Board
- Will commission most services
- The existing GP contract will continue
- Regional services will continue
- All practices must join a consortium.

GP Consortia in Leeds

Some considerations:

- In Leeds, GPs representing 80,000 patients have not yet joined a consortium. Will they join one of the present three consortia or form a fourth one?
- Will consortia need a commissioning support unit? The hospital trusts are huge, and consortia will need support in negotiating big contracts.
- Increasing patient and public involvement: this is not done well at present.
- £20 million has to be saved – a 45% cut in management costs is needed. To have cuts and changes at the same time is not a good idea.
- Consortia will be paid for high quality outcomes. They will need to look at profit in terms of each consultation.
- What happens if consortia fail?
- Targets will be replaced with 1,500 "outcome goals".
- Measures of quality will be effectiveness of treatment, safety of treatment, and patient experience. These will be developed by the National Institute for Clinical Excellence (NICE).
- "Patient Reported Outcome Measures" (PROMS) will be used.
- The information revolution will mean quality accounts, staff feedback being publicly available, and patients controlling their own records.
- Patient choice: there will be "any willing provider"; choice of consultant-led team; choice of maternity, mental health, long term and end-of-life care; being able to register with any practice; promotion and regulation of competition by Monitor.
- Training and education will be overseen by consortia.

Risks

These include:

- Damage to the patient-doctor relationship. This will be affected by having different providers.
- GPs will be blamed for cuts and excessive profits.
- Lack of continuity of care due to the abolition of practice boundaries.
- Privatisation by the back door. The NHS has better outcomes and cost-effectiveness than any other health service in the world except that of New Zealand.
- The funding formula is not accurate.
- Are there enough local leaders with the right skills?

- Involvement of enthusiasts without a mandate.
- Too many changes too often.
- There will be a gap between the “implosion” of the Primary Care Trust (PCT) and the setting up of the consortia, but the consortia will not be able to employ PCT staff in this period.
- Competition versus collaboration: practices will now be rivals.
- Learning the lessons of previous mergers may not happen.

Opportunities

These include

- Clinical leadership.
- Reduction of bureaucracy.

Major Concerns

These include:

- 40% redundancy costs - £1 billion so far.
- Accountability arrangements.
- The role of the private sector.
- What happens to training?
- Saving £320 billion: how to square that with choice.
- Fragmentation.
- Too much change at once.
- Will it work?

Presentation: Dr Chris Bem, Consultant, Bradford

Introduction

Dr Bem is a front-line worker in the NHS. He is a Christian Marxist.

The NHS

The NHS is beautiful and moral. It is not ruled by the immediacy of financial considerations. Business, by contrast, has a cynical take on humanity.

Rulers have two strategies:

- Divide and rule
- Forget the past.

There are three sources of power: professionals, manager, and patient. Of these, the patient is the weakest. We are all patients.

We need to offer an alternative vision of life and health. We need to understand three things:

- Commodification: buying and selling seen as covering all human transactions, with the need to gain more than we put in. This introduces a lack of trust. What we need is the economy of the gift.
- Individualisation: this can be a good thing or a bad thing. It depends on the type of individualism.
- Consumption: children and old people are seen as a handicap, a strain on the economy. We are no longer the resource, we have become the problem.

There is a need for social and ethical governance as well as financial and clinical governance,

Concluding Session: Messages to Take Away

In the discussion which followed, the following points were made:

- There is no democratic basis for the proposed changes.
- People are resisting – e.g. in Bradford. It is like Vichy France (Chris Bem).
- Subvert the process – encourage GPs to use their control of resources to support public, not private, services.
- Write to MPs – note the recent Liberal Democrat concerns about the changes.
- Support for the British Medical Association in their fight to alter the changes.
- The need for people to know about what is happening – a large-scale publicity operation – e.g. leaflets in hospitals.
- There will be a legal case concerning the involvement of a private healthcare firm which supported Andrew Lansley in the election.
- Learn from recent successful campaigns, e.g. on the forests. Saving the NHS is now the top concern for people involved with the campaign group 38 Degrees.
- Take part in the GP patient involvement process.
- Raise the issues through pensioner groups – e.g. Belle Isle Elderly Aid.
- Go to the Council Scrutiny Board.
- Stand together – solidarity.