

Church of England – Mission and Public Affairs Council

Response to the White Paper: ‘Equity and Excellence: Liberating the NHS’

The Mission & Public Affairs Council of the Church of England is the body responsible for overseeing research and comment on social and political issues on behalf of the Church. The Council comprises a representative group of bishops, clergy and lay people with interest and expertise in the relevant areas, and reports to the General Synod through the Archbishops’ Council.

While referring to a specific White Paper that gave rise to the current shape of NHS structures, this document gives a good indication of the Church of England’s views on NHS Reform.

1.1 The Church of England understands health and wellbeing to encompass all areas of individual and corporate life: physical, mental, spiritual, psychological and social. The provision of health care ought to address each of these areas in an integrated manner, not dealing with any in isolation from the rest. In particular, when significant changes to healthcare are being considered it is essential that a holistic approach is taken in order to minimise the risk of solving certain problems at the cost of introducing new ones.

1.2 Inevitably, when changes are proposed, some will view the prospect enthusiastically, seeing it as presenting opportunities, while others will view the process with greater caution or even with misgivings. It is essential that the proposed changes are clearly and accurately presented with their rationale adequately explained. It is important that aspirations are measured, not raising hopes that are unlikely to be fulfilled; realism ought not to be sacrificed on the altar of rhetoric.

1.3 We welcome the ongoing commitment, in the White Paper, to upholding the principles of the NHS: ‘*a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay*’. We recognise the value of developing a health service that is ‘*genuinely centred on patients and carers*’ and that is free from ‘*political micromanagement*’. We also acknowledge the need to simplify NHS administrative structures and costs, giving greater decision-making powers to

health professionals, in cooperation with local authorities. We do, however, have a number of reservations with regard to the ways in which the White Paper seeks to achieve these goals.

2.1 Limitations on Patient Choice: while recognising the pivotal role of shared decision-making ('no decision about me without me'), it is important to acknowledge that there are restrictions on patient choice as well as limits on the ability of patients to make decisions with regard to their own treatment. 'Patient-centred' care ought not to be interpreted as 'self-centred' care, with each individual patient believing that he or she can make decisions without regard to the wider context in which care is provided.

2.2 Health professionals ought only to propose care that is both clinically appropriate and deliverable; patient choice will be, necessarily, restricted by these conditions. If, for example, certain services are not commissioned in a particular area or they are commissioned on a restricted basis, patient choice will be correspondingly affected. Similarly, under GMC guidelines on End of Life Care, doctors cannot be forced to provide treatment that they consider to be futile or burdensome, even if patients or their families wish such treatment to be given. Equally, NICE guidelines and requirements cannot be set to one side because of pressures arising from patient choice. While much of this may be self-evident to health professionals, this is not necessarily the case for many patients. It is important that the promotion of patient-centred services is grounded in reality, not rhetoric.

2.3 Similarly, the aspiration that patients may choose where they may receive treatment and also determine who treats them has the capacity to undermine a care-provider's viability. GPs cannot, realistically, be expected to provide cover for patients who live beyond a certain 'catchment area'. Equally, hospital consultants ought not to be subject to a form of popularity contest, leaving some over-burdened and others under-utilised, with attendant effects on operating lists.

2.4 The promotion of 'the expert patient' in recent years has recognised the need for patients to be well informed with regard to their existing medical conditions and the range of possible treatments and interventions that may be appropriate for them. A

renewed focus on the role of the patient can only be meaningful if patient-education is effective, as has been recognised in the movement within healthcare towards ‘empowered partnering’. In addition, promoting patient choice may result in inequity: skewing treatment towards the articulate and well-resourced sections of society, disadvantaging individuals and even communities that are ill-equipped to engage effectively with the healthcare system. In order to avoid additional inequalities in care arising, while seeking to provide an effective patient-centred health service, patient education services would need to be supplemented with patient advocacy services. Such services would, of course, carry significant resource and cost implications. The White Paper does not address the need for these services.

2.5 It is also important that the principle of patient choice does not become a burden for those patients who do not wish to be ‘over-consulted’ with regard to their health care and treatment. Many patients simply want to be treated effectively and efficiently and do not want to be presented with what they might perceive as a new set of questions to be answered or problems to be solved when they go to their GP.

2.6 The White Paper does not consider what additional GP training may be needed to make effective patient-centred services a reality. In the absence of training and monitoring, it would be all too easy to see the provision of patient-centred services being reduced to a box-ticking exercise.

3.1 Commissioning Proposals: the White Paper views ‘*GPs and their practice teams*’ as ‘*the healthcare professionals closest to patients*’ and on that basis proposes that the majority of health services ought to be commissioned by GP consortia. In spite of this reference to ‘*practice teams*’, in the main, the White Paper speaks of GPs becoming commissioners in the restructured NHS. While GPs, undoubtedly, play an essential and respected role in promoting and delivering patient care, other health professionals also play pivotal roles. A community nurse, for example, may well be the health professional closest to a number of patients on a GP’s list while, for others a community pharmacist may be their effective point of contact with the health care system. Correctly, much has been made, in recent years, of multi-disciplinary team-working in providing optimal care for patients. The White Paper appears to have set this to one side, in favour of giving GPs new commissioning powers. While the

principle of health care professionals being closely involved in commissioning services is a good one, it is unclear why GPs are considered to be *uniquely* positioned to do this.

3.2 Similarly, in the context of commissioning services, it is far from certain that GPs currently have greater skills or a more developed knowledge-base than other health professionals. Given their role as the ‘gate-keepers’ of the health service, GPs ought to play a central, but not an exclusive role in commissioning services. Giving other health professionals a statutory role to play in commissioning services would help to ensure that patients’ needs are fully explored, assessed and addressed. The danger of a new ‘post code lottery’ emerging, based on whether or not GP consortia took an inclusive approach to other health professionals’ involvement in needs assessment and in the commissioning of appropriate services, would also be minimised if other health professionals were given a statutory commissioning role.

4.1 The Importance of Good Management: while there is little doubt that the NHS is ‘over-managed’, with administration costs more than doubling in the last twenty years, care ought to be taken that ‘Liberating the NHS’ does not degenerate into a ‘management cull’. Management of personnel and services is a pre-requisite for the effective running of the NHS. It is essential that management skills are not lost and that effective managers are not removed from the health service. Little will be gained if, in effect, experienced managers are replaced by GPs or other health professionals who have to leave front-line delivery of services in order to become managers under the proposed new structures.

4.2 The comment in the White Paper that ‘*The headquarters [of the NHS] will be in the consulting room and in the clinic*’, is an unhelpful ‘sound-bite’ and would, in fact, be detrimental to patient care. It is essential that ‘the bigger picture’ is understood and acted upon by commissioners; it is difficult to see how this could be achieved without appropriate management.

4.3 The White Paper does not distinguish between management, administration and ‘decision-making’. A careful critique of these functions within the NHS is necessary for its effective operation; without such a critique ‘the baby may well be thrown out

with the bath water'. Giving health professionals, for example, a central decision-making role in commissioning does not mean that current management should be rendered obsolete or that health professionals ought to become managers. The share of resources allocated to administration within the NHS needs to be lessened, but this will not be achieved simply by taking a 'broad-stroke' approach to reform.

5.1 Social Care: the White Paper points out that better co-ordination between health and social care is required if patients are to receive optimal care. Individual patient wellbeing often requires that both health and social care needs are assessed and met. In the wider frame, the provision of social care is a factor in the overall health of a population.

5.2 The consultation paper, 'Local Democratic Legitimacy in Health', proposes to address the need for integrated services through a complex set of relationships between GP consortia, Local Authorities and newly established Health and Wellbeing Boards. Under government proposals, GP consortia will be ultimately responsible for commissioning Health Care, Local Authorities will be responsible for Public Health and Social Care, while the Health and Wellbeing Boards are to provide a forum for members of GP consortia, Local Authorities and others. They are tasked with the goal of promoting integrated care and influencing commissioning decisions. The mechanisms for achieving integrated care (even with a proposed 'mediation' layer in place) are unclear and unnecessarily complex. The fact that GP consortia and Local Authorities will not be coterminous is likely to add further complexity to the commissioning process.

6.1 Simplifying the Structures: the White Paper seeks to 'de-layer' the NHS, but there is a real possibility that the proposals in the White Paper will result in the NHS being 're-layered' and becoming more, not less, complex. While abolishing or amalgamating a number of 'arm's length bodies' will remove some tiers of administration, their functions will be carried out by remaining bodies who will have to subsume some of their staff. Abolishing Primary Care Trusts and Strategic Health Authorities is counter-balanced by the creation of GP consortia, Health and Wellbeing Boards and an over-arching NHS Commissioning Board. Local Authorities, Monitor and NICE are to be given enhanced roles, which will, no doubt, require additional

staff. It is difficult to see how the proposed structures will simplify the running of the NHS, even though they may result in a greater role for GPs within it.

6.2 An integrated model for commissioning health and social care would be more effective in ‘de-layering’ the NHS. Such a model exists in Northern Ireland in the form of ‘Local Commissioning Groups’ whose work is overseen by a Health and Social Care Board. The Local Commissioning Groups consist of seventeen members, drawn from GPs, other health professionals, Pharmacists, Social Workers, District Councillors, and service users, with GPs being given a leading role. In the context of proposing a major restructuring of the NHS in England, exploring a similar model might result in a less complex, more integrated and more effective structure than the one proposed in the White Paper and the attendant consultation papers.

7.1 Care Providers: the White Paper proposes to encourage greater competition between healthcare providers by enabling GP consortia to commission services from any group or organisation deemed to be competent. Assessing and monitoring a range of prospective providers will, of course, involve additional administration, but, in principle, increasing the number of potential providers available to commissioners does not raise problems. In practice, however, providers that focus on a restricted range of services and who are commissioned to deliver those services may undermine the viability of other providers who offer a wider range of services. Given the nature of the links between various medical and surgical services, a Hospital Trust that ‘loses’ one service may discover that other services are affected or even rendered unsafe. It is unclear, under the proposed reforms, how such concerns might be effectively addressed.

7.2 The White paper and the consultation papers do not make it clear which services are considered to be front-line services and which are ancillary or administrative. In seeking to cut administrative costs, both commissioners and providers may find themselves under pressure with regard to diagnostics, allied health professionals and chaplaincy services. Levels of care would suffer if laboratory services were to be curtailed because employees working in these services were deemed to be less essential than ‘front-line staff. Holistic care is essential for good health outcomes; the

expertise of allied health professionals and chaplains ought not to be minimised in delivering such care.

7.3 End of Life Care is a particular concern for many, with the provision of good palliative care services unevenly distributed throughout the country. The consultation paper, 'Transparency in Outcomes: a Framework for the NHS' sets out five 'domains' of care, but does not specifically address End of Life Care. This is a vitally important area of healthcare provision and ought to be addressed as an additional domain. Similarly, the provision of holistic care, which includes spiritual care, ought to be reflected as a 'cross-cutting' theme in all domains.

8.1 We welcome the overall aims of the White Paper that seek to give patients and health professionals greater decision-making powers in the commissioning and delivery of services and that also seek to simplify NHS structures. Nonetheless, we believe that issues highlighted in our response need to be examined further and satisfactorily resolved in order for the government's aspirations to become reality.

Brendan McCarthy 13th September 2010