# Community Glue:
# NHS Consultation Response May 2011

## Choice and competition

We are interested in your views on this area, including:
• Which are the types of services where choice of provider is most likely to improve quality?
• What is the best way to ensure a level playing field between the different kinds of provider who could be involved?
• What else can be done to make patient choice a reality?

## Community Glue Response:

Many people who work in the NHS (and in health and social care generally) see their jobs as a vocation and find the idea that they should compete (instead of collaborate) to help people inimical. The whole ethos of free public healthcare (now enshrined in the idea of 'co-production' of health) is intrinsically collaborative. By driving the NHS down the route of 'competition', this government risks losing the good will of front-line staff who are still currently accepting sub-market wages and conditions for the privilege of working in an enterprise that serves the greater good.

**Which are the types of services where choice of provider is most likely to improve quality?**

Choice is most important where people's experience has been poor, but it must be borne in mind that choice requires over-supply, and is therefore less cost-efficient than commissioning a single service that can provide economies of scale. Examples of where choice works best include services that are very widely available and highly specialist skills and equipment are not needed (most primary care services, community hospitals, maternity services, personal care, end of life). Choice works poorly in most secondary services, but the principle of receiving elective non-urgent in hospitals that are further afield than the local provider remains a good one. Budgets should be able to follow the patient, and commissioners should be able to 'pull the plug' on large contracts if enough people opt out of using them and go to neighbouring providers instead.

**What is the best way to ensure a level playing field between the different kinds of provider who could be involved?**

In answer to the second point, part of the difficulty of trying to ensure greater choice through competition stems from the intrinsic difficulties in trying to create a 'level playing field' between large private providers, the NHS, and small third sector organisations. 'World Class Commissioning' discriminated unfairly on the basis of size throughout the tender process, for example by assuming that larger providers have greater financial stability - something that our recent experience with the banks might suggest is untrue.

**What else can be done to make patient choice a reality?**

Patient choice starts at the interface between the potential service user and the service. Good impartial information is essential, all groups of clinicians still have a long way to go in terms of seeking genuine 'informed consent' (partly because of the unrealistic time pressure many are under). People need the right to advocacy support, a functioning complaints system and yes, some democratic control over NHS Boards (see below).

# Accountable to the public and patient involvement

We are interested in your views on this area, including:
• How can we ensure commissioning decisions are made transparent to the public, and that commissioning consortia engage fully with patients, carers and communities?
• How can we best ensure that the NHS commissioning budget, held by the new NHS Commissioning Board, is allocated transparently and used with proper accountability to the public at local level, and Parliament at a national level?
• Are we doing enough to make sure the NHS at local level has the freedom it needs to take locally-based decisions?

## Community Glue Response:

We believe that the premise is wrong. The public want control - transparency is merely a necessary precursor to this. The NHS is paid for with our taxes - why won't politicians give us proper control, fobbing us off with Boards of Governors and similar structures that have no control over anything?

**How can we ensure commissioning decisions are made transparent to the public, and that commissioning consortia engage fully with patients, carers and communities?**

The PCT and NHS Trust structure was fundamentally good, with a single omission: Boards need a majority of directly elected Non-Executive Directors. People with significant commercial interests, particularly in private healthcare, should be automatically excluded.

GP commissioning consortia are a bad idea. Most GP practices are private enterprises run for the benefit of the practice partners (and sometimes shareholders). In opposition the Tories were rightly critical of New Labour for handing over bags of cash to GPs in the form of the GP contract that allowed many to virtually double their salaries without doing any extra work. Why trust the same gold-diggers to run the NHS on behalf of patients? It didn't work in the 90s and it won't work now.

**How can we best ensure that the NHS commissioning budget, held by the new NHS Commissioning Board, is allocated transparently and used with proper accountability to the public at local level, and Parliament at a national level?**

The National Commissioning Board is a terrible idea; the potential for corruption is immense. Coupled with this government's pro-market, pro private-sector ideology, it leaves the whole of the NHS open to colonisation by large for-profit healthcare providers. As with PFI, the state will get the worst of the deal but by then it'll be too late.

**Are we doing enough to make sure the NHS at local level has the freedom it needs to take locally-based decisions?**

By reducing the budgets available for locally-based commissioning? Probably not! Collaborative commissioning frameworks may be effective for highly specialised secondary and tertiary care services, but the bread-and-butter GP and General Hospital services should be under the direct control of local people.

# Advice and leadership

We are interested in your views on this area, including:
• What early action is being taken in your area to improve quality of services through clinically-led commissioning? What is working well?
• How can commissioning consortia best engage and take on views from across the range of health professions in taking their commissioning decisions?
• What more could we do to ensure that commissioners collaborate to join up services to fit around the lives of patients and carers, and the particular circumstances of certain conditions?

## Community Glue Response:

Again, we reject the premise; commissioning needs to be patient-led (with significant involvement of clinicians), not clinician-led. Otherwise you don't get patient choice at all, just 'doctor knows best'.

**What early action is being taken in your area to improve quality of services through clinically-led commissioning? What is working well?**

We don't know of any.

**How can commissioning consortia best engage and take on views from across the range of health professions in taking their commissioning decisions?**

Healthcare profession representatives need to be involved in the Project Boards that oversee commissioning strategies, but shouldn't dominate them.

**What more could we do to ensure that commissioners collaborate to join up services to fit around the lives of patients and carers, and the particular circumstances of certain conditions?**

Invest more  in the structures that health people to participate in their own care, and in healthcare planning processes. Since New labour scrapped CHCs, the while thing's been a farce. The proposed HealthWatch service is just a watered-down version of what's already there. If you have proper democratic control, you could reallocate the resource to supporting people who represent patient groups on Trust  and Project Boards.

# Education and training

We are interested in your views on this area, including:
• Will the proposed changes to the education and training system support the aims of the modernisation process?
• How can health professionals themselves take greater ownership of the education and training of their own professions, whilst meeting the needs of healthcare employers?
• How can we ensure that the values of the NHS are placed at the heart of our education and training arrangements?
• How can we best combine local and national knowledge and expertise to improve staff training and education?

## Community Glue Response:

**Will the proposed changes to the education and training system support the aims of the modernisation process?**

Handing over power from SHAs to employers could be a huge own goal. With the odd exception, they've done an excellent job of managing workforce demand over the past decade. On the other hand many Foundation Trusts are now running their training arms at profit to subsidise patient care, and with the proposal to take the lid off profits they are likely to expand this area of activity. Shrinking the pot and passing it to employers is likely to mean less public money invested in training clinicians and more money going into inflated salaries for NHS managers.

**How can health professionals themselves take greater ownership of the education and training of their own professions, whilst meeting the needs of healthcare employers?**

Getting the right balance between professionals, employers and the patients they serve has always been tricky. Mental health services, for example, often suffer as a result of professional training that gives a low priority to mental health-specific learning compared to generic skills and competencies. Give too much power to employers, though, and you end up with problems such as the ones described in our previous answer (and professionals whose skills can't be transferred to other settings). The solution is to put patient interests at the fulcrum of these two sets of other interests.

**How can we ensure that the values of the NHS are placed at the heart of our education and training arrangements?**

I'm sure it would help if the government stopped trying to get rid of NHS values in its policies. High quality healthcare, available to all, publicly funded and free at the point of delivery. No  poor people dying while others get to live. It's a basic component of a free society. We are a broadly tolerant society, but the future of the NHS is a matter of life and death for everyone.

**How can we best combine local and national knowledge and expertise to improve staff training and education?**

Locally-based action research projects with patient involvement/user control would be a good counterpoint to national policy and research generated by professional, academic or commercial interests.