NHS WHITE PAPER:

"Equity and Excellence: Liberating the NHS"

RESPONSE TO CONSULTATION

October 2010

Introduction

Action against Medical Accidents (AvMA) is the specialist charity which focuses on patient safety and justice. We advise and empower over 3,000 people each year who have been affected by medical accidents, and work in partnership with healthcare organisations and the healthcare professions to improve patient safety and the way medical accidents are responded to. We have over 25 years' experience and expertise in this area. We have limited our response to those parts of the White Paper where we have relevant knowledge and constructive ideas to offer. We would welcome the opportunity to discuss our ideas with the Department of Health with the view to achieving our mutual goals of high quality, safe and effective healthcare.

We have divided our response under the title of each of the White Paper documents.

Equity & Excellence: Liberating the NHS

We strongly welcome the focus on "putting patients and public first" and in particular the commitment to

"require hospitals to be open about mistakes and always tell patients if something has gone wrong".

We would like to see this given much greater priority. There is a reference to it in "Transparency in Outcomes – a framework for the NHS", but as this is such a vital initiative, it must feature more largely. There are those who are already trying to dilute the commitment to "require" openness underpinned by statutory force, with a more general "exhortation, support and encouragement" approach. This approach has already been tried over many years and on its own is not effective. Such approaches need to be underpinned by a strong, unambiguous and enforceable statutory duty.

A more minor point of drafting is that for "hospitals", we should surely read "healthcare". To only require hospitals to be open would not make sense. Also, it is sadly often families of the patient to whom the requirement to be open needs to apply where the patient has died or lacks capacity.

Transparency in Outcomes – a framework for the NHS

We strongly support the emphasis on patient safety. See our comments on "commissioning for patients" for our views about ensuring this is effectively delivered through the NHS Commissioning Board, and our comments on "regulating healthcare providers".

Whilst we appreciate the focus on 'outcomes' as opposed to 'process', we think that implementation of patient safety alerts must be seen as part of the outcome framework. They are clinically based and evidenced and designed to avoid known adverse outcomes that are causing harm. Unless there is a robust system to ensure that the implementation of patient safety alerts is being carried out effectively and on time, lives are being put unnecessarily at risk. (See our reports on implementation of patient safety alerts February 2010 and August 2010). There should also be outcome measures covering the problems each patient safety alert was designed to help prevent, to show whether incidence has actually been

reduced.

Regulating Healthcare Providers

We are not opposed to more freedoms, but believe that increased freedoms must be accompanied by meaningful accountability to patients. NHS bodies must be transparent and act like public bodies, not profit driven businesses. Whilst there should be less red tape and less targets if they are not justified, there needs to be "must do's" over which every NHS body can be held to account. Implementing patient safety alerts would be a good example, as would being open with patients/families when things go wrong. There must be a much stronger requirement for representation of patients and the public – no trust should be entirely staff run and many Foundation Trust have a huge membership but no effective involvement in monitoring, and the development of policy and strategy. Effective public involvement prevents NHS bodies becoming self-serving and remind them that they are there to serve the public.

Increasing Democratic Legitimacy in Health

Healthwatch

We enthusiastically support the main thrust of the proposals to develop LINks into local and national Healthwatch. We believe that effective patient involvement, empowerment and advocacy are essential elements of any healthcare system which seeks to improve patient safety and treat its patients fairly. We have lacked an effective and credible mechanism for this ever since the ill-judged abolition of Community Health Councils (CHCs). This in no way reflects the quality and commitment of members of LINks and Patients' Forums before them, but rather the fact that they were working within a system with inherent weaknesses which were bound to fail. Healthwatch provides the opportunity to build on what was best about CHCs, whilst making further improvements based on experience. What we particularly like about the proposals are:

- Re-introducing the concept of a local 'one-stop-shop' where members of the public can get advice, information and support or get more involved.

- Introducing a national body that has potential to act on issues nationally that are identified locally, and to co-ordinate and support local Healthwatch organisations.

- The integration of support with complaints with the monitoring role of Healthwatch locally.

However, we do have some serious concerns about some of the current proposals as they stand:

- If Healthwatch is to be an effective movement it is vital that staff and members are all part of the same organisation and movement, with clear lines of accountability. A key weakness of the LINks system is the separation of LINks members and staff who in effect are 'hired help', from a variety of 'host' organisations who have successfully tendered for a contract to 'service' LINks.

- All staff, including staff responsible for providing complaints support (currently known as Independent Complaints Advocacy Services) should be part of the

Healthwatch itself. Another weakness in the current system is that it is so fragmented. LINks have limited or no actual connection with the complaints support function (ICAS). This means that vital opportunities for intelligence from complaints informing to monitoring work are missed. We strongly believe that had there been a more robust, connected system in place in Stafford, that the lid would have been lifted on what was going on there much sooner.

- Healthwatch must be independent and be seen to be independent. Given that Healthwatch is charged with monitoring social as well as healthcare services, it is highly inappropriate that it should be accountable to, commissioned or funded through local authorities. We strongly recommend that funding for Healthwatch is ring fenced and distributed from a central, national body (eg national Healthwatch itself) using a fair formula based on local need. Funding must be ringfenced if HealthWatch are to be successful and independent.

- National Healthwatch must also be independent and be seen to be independent. We have concerns about it being located within the Care Quality Commission – one of the very key national bodies of whom it may need to be constructively critical on behalf of patients. Ideally, Healthwatch should be completely separate from the CQC or any other body which it may need to monitor or seek improvements from. If the Department decides that it will go ahead with locating Healthwatch within the CQC, we believe the following conditions are absolutely vital:

  - National Healthwatch funding is ring fenced and CQC have no right to use it for other purposes.

  - CQC has no say over Healthwatch priorities, policy, or performance.

  - Healthwatch can, if necessary, criticise CQC with no fear of reprisals.

  - National HealthWatch is accountable to a board elected from Local HealthWatch.

- We believe that the current system of "commissioning" Independent Complaints Advocacy Services (ICAS) and 'host' organisation services for LINks as wasteful of resources as well as reinforcing fragmentation of the system. Much needed money is being wasted on commissioning processes, and in providing a margin for various organisations who successfully tender for these contracts. Centralised funding, together with robust quality standards, would be a far more effective way of resourcing Healthwatch.

- The new 'ICAS', or complaints support service should be an integrated part of the Healthwatch movement, delivered locally according to national standards overseen by national Healthwatch. Additionally, the National Healthwatch should retain a central budget from which it could commission specialist services to complement the generic complaints support and advice delivered locally. These arrangements would most likely be from specialist national advice organisations.

- Local Healthwatch geographic areas would be more appropriately geared to the areas covered by GP Commissioning Consortia rather than local authorities. Healthwatch should also have statutory rights to observer status wherever commissioning decisions are being made and, access to information and

obtaining responses from GP Commissioning Consortia.

Commissioning for Patients

NHS Commissioning Board

We understand that it is intended to absorb the functions currently carried out by the National Patient Safety Agency (NPSA) into the work of the NHS Commissioning Board. We have serious concerns about the loss of a body whose sole focus is patient safety, and what could lead to a dilution and diminution of this work. There will need to be strong safeguards against this happening, but we appreciate that there are also opportunities for giving the work on patient safety "more teeth". (A common criticism of the NPSA has been that despite its good people and good work, it has lacked powers to make anything happen). We suggest that for this to work effectively, the following measures would be needed:

- A clear identity and degree of autonomy for the patient safety arm of the Board.

- Commissioning decisions by the Board should be subject to a patient safety risk appraisal conducted by the patient safety arm.

- There needs to be representation of independent patients' organisations and HealthWatch on the Board and in the work of the patient safety arm.

- Some of the work currently carried out by the NPSA might be outsourced to specialist voluntary organisations.

GP Commissioning Consortia

We have serious concerns about the implications for patient safety of placing so much responsibility for commissioning on GPs, who do not necessarily have the skills, experience, expertise or desire to carry out these functions. We need good GPs, treating patients not acting as managers or commissioners. However, we do believe that a suitable half way house would be for GPs to be more formally involved in the commissioning functions of PCTs. We believe there are already some examples of this happening around the country. This would deliver the same outcomes without the unnecessary cost, disruptions and risk of losing experienced staff. If GP Commissioning Consortia are established as statutory bodies in their own right, we believe it is vital that Healthwatch have a statutory right to have an observer on the Board and on committees concerned with commissioning decisions, to access information, and to receive responses to recommendations they make to the Board.

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