

**NOTE OF A MEETING WITH ANDREW LANSLEY
SECRETARY OF STATE FOR HEALTH
19 MAY 2011**

Professor Sir Neil Douglas, Chairman of the Academy, welcomed the Secretary of State and thanked him, Sir Bruce Keogh, Julie Moore and Dr Kathy McLean for attending the meeting as part of the listening exercise around the NHS Bill.

Sir Neil said that the Academy supported a number of the proposals in "*Liberating the NHS*" particularly the focus on outcomes as a measure of success and the development to the Outcomes Framework, the emphasis on clinical engagement and clinical leadership and patient involvement in health service design and funding decisions.

However there were a several areas of real concern where the Academy believed that the proposals could seriously undermine the ability of the NHS to deliver comprehensive, co-ordinated care. The areas of concern were

- The implications of increased **competition**
- Delivering effective **clinical commissioning**
- **Education and training**
- **Patient involvement**
- The **Public Health** proposals
- Delivering major change whilst making substantial **efficiency savings**

Sir Neil explained that Academy members would take each area in turn setting out the concerns but also providing constructive proposals on how to address the issues. The Secretary of State's or his colleagues' views would be welcome to respond on each of the issues.

The implication of increased competition

Sir Richard Thompson, President of the Royal College of Physicians (London) set out the Academy's concerns over:

- Risks to coherent, high-quality and co-ordinated healthcare services brought about through the promotion of increased competition and a market approach to healthcare provision
- Threats to organisational viability if services are taken from a hospital because effective healthcare relies on the interdependencies between services
- "Cherry-picking" of services by private providers
- Private sector providers must undertake or contribute to education and training.

Additional points made by Academy members were:

- There should be a duty to promote collaboration and co-operation and this should be included in Monitor's responsibilities
- The need to for commissioners to be able to define and identify quality standards if that is to be the basis of competition and the inherent difficulties in this e.g. in diagnostics
- The very considerable resources in terms of both time and money that will be expended in running a market system

- That whilst patients did appreciate choice, overwhelmingly their prime concern was to know they had high quality services available to them promptly in their local hospital or area. In areas such as emergency care, choice was not a relevant issue
- Choice was as much about treatment options and type of care as actual provider. Factors affecting choice can be very varied.

In response the Secretary of State made the following points:

- Competition was not about increasing the role of the private sector but was primarily about patient choice
- Patients and commissioners should be able to exercise choice
- Competition could not be excluded from the NHS but it was not an end in itself.

Clinical Commissioning

Iona Heath, President of the RCGP, stated that the purpose of commissioning was to ensure the needs of individual patients were met but the Academy concerns were that:

- It is not clear how the full range of clinicians and other health care and public health specialists will be involved in consortia and the process of commissioning. This wider involvement will produce more informed and co-ordinated commissioning and better services for patients. Current requirements simply to seek advice from professionals are not sufficient
- Accountability arrangements for consortia are inadequate
- Clinicians and public health specialists also need to be fully involved in the processes of the National Commissioning Board and any intermediate arrangements.

She stated that the Academy believed that:

- Mechanisms and processes for involving secondary care clinicians and public health specialists are required and the Bill must require effective involvement.
- Whilst GPs should be the majority of the board of the consortia and remain in control by virtue of their voting rights, consortia boards should include places for a range of locally determined clinical, public health and social care practitioners
- There is a requirement of all decision-making bodies, including consortia, to be public bodies, with boards meeting in public and publishing minutes, and the adoption of the Nolan principles by all relevant individuals
- Consortia must remain publicly accountable for all commissioning decisions, such that board minutes and financial decisions are open to public scrutiny, including details of payments made to GPs or practices for non-General Medical Services (GMS) work, taking account of payments to private companies in which GPs have a financial interest
- Health and Well Being Boards should be required to sign off the alignment of local commissioning plans with the Joint Strategic Needs Assessment
- It would be undertaking work with Colleges and the Health Foundation on a project to define how clinically led commissioning could work in practice.

Other points made by members of the Academy were:

- The value of networks
- How services could be commissioned on a “patch” basis i.e. beyond a single consortium but not at national level
- The need for consortia to be of a viable size to avoid excessive costs and bureaucracy.

In response Kathy McLean:

- Explained some initial thinking about ways to involve clinicians in commissioning groups at local and patch level through the concept of “clinical cabinets”
- Invited the Academy to engage in further discussions to develop the proposals.

Education and training

Sir Neil Douglas and Damian Roland, Chair of the Academy Trainee Doctors’ Group said:

- The Academy welcomed aspects of the proposals particularly the requirement for providers to engage in workforce planning and education and training processes and for the establishment of HEE
- There was a real opportunity for the proposals to define the funding available for education and training and set out how it should be used in the way that has occurred with research funding
- Although the active involvement of employers was welcome and important, the Academy firmly believed that Skills Networks cannot be responsible for the provision as well as the commissioning and quality assurance of post-graduate education and training. Responsibility for provision and commissioning/QA needed to be separated as elsewhere in the system
- Vital Deanery functions need to be retained. There were various possible models and the Academy had proposed clear accountability to HEE
- Whilst there must be close links with universities it would not be appropriate for them to be responsible for post-graduate medical education
- With the increasing difficulties of clinicians getting time to undertake education and wider activities for the NHS, it would be very helpful if the Bill included a duty on NHS organisations to support and facilitate work undertaken by their staff for the benefit of the wider NHS
- The importance of supervision of trainees was stressed.

The following additional points were made:

- The quality of trainers and the time for training
- The Academy supported the establishment and role of CfWI. While there had been considerable improvement, there were still concerns about the transparency of their work and assumptions
- The Temple Review recommendations should be implemented and a commitment to trained doctor delivered care and no diminution of the consultant role as “sub-consultants”.

In response the Secretary of State and Julie Moore said:

- There was full commitment to the implementation of the Temple Review
- As the education and training proposals were not part of the Bill there was more opportunity for more discussion and development and they would wish to engage further with the Academy and Colleges.

Public and patient Involvement

Sol Mead, Chair of the Academy Patient Liaison Group said

- The Academy welcomed full patient involvement in healthcare and endorsed the principle of “No decision about me without me”
- The proposals divorce patients from clinicians and there are no mechanisms that ensure clinicians and patients/carers representatives meet directly with each other to discuss health service related issues
- Healthwatch needs to be an independent Patient Liaison Group body which can speak freely on behalf of patients/ carers and local health community and there should be an obligation on GP consortia to engage with such a Group

- Any arrangements had to ensure that the voice of children is heard
- Whilst possibly not the intention, it seemed that doctors might be required to breach patient confidentiality in the requirements for the provision of information and there should be an absolute assurance in the Bill that doctors will not be required to breach their duty of confidentiality.

In response the Secretary of State recognised the issue around engagement between clinicians and patients but pointed out existing mechanisms had not to date achieved this successfully.

Public Health proposals

Dr Liz Scott, Treasurer of the Faculty of Public Health said:

- The proposals for moving public health responsibilities were supported. However, accountabilities for protecting and improving the health of the population are unclear. This puts the population at significant risk, especially in outbreaks and emergencies
- Professionals and the public will not have confidence in the quality and independence of advice informing national and local decisions if Public Health England (PHE), which provides that advice, is part of the Department of Health
- The DPH must have the skills, resources and authority to influence all aspects of local authority and health service activity, and more widely in the community. There is nothing in the current proposals to ensure that they are qualified, appointed at a sufficiently senior level, or able to support health service commissioning or provision
- Local authorities should be responsible for protecting, maintaining and improving the health of the population, supported by Public Health England
- All NHS funded health service providers should have a duty to cooperate on health improvement and health protection
- The DPH must be a qualified, registered and experienced public health specialist and the DPH must be accountable directly to the local authority chief executive, with direct access to councillors
- The role of the DPH should include responsibility for ensuring that local health services are appropriate, effective and accessible. The DPH's annual report should address the health needs of the population and the extent to which these are being met
- Public Health England should be constituted as an executive agency or, ideally, a special health authority. It should provide support in all three domains of public health: health protection, health improvement and health services
- There should be a requirement for all specialists in public health, including DPHs, to be on a statutory professional register.

In response the Secretary of State said he welcomed the support for the underlying principles of the proposals and recognised the need to create a national public health organisation with real expertise.

Delivering the change whilst making efficiency savings

Peter Furness, Vice Chairman of the Academy and President of the Royal College of Pathologists said:

- Major organisational change was inevitably disruptive
- The engagement of staff was essential in achieving change and there were threats to staff morale with re-organisation and the effect of efficiency savings
- There were issues on which central decision-making and guidance were required rather than devolution of decisions to local level.

Other points made by members were:

- The need to pilot proposals where possible
- The importance of getting the right balance between national and local decisions and that the Government should not shy away from DH decisions and guidance where it made sense
- Adequate time needs to be allowed in consultant job plans for training.

In response the Secretary of State said that he had not given away Departmental power and the proposals emphasise the national role and functions of the NHS.

Conclusion

The Secretary of State concluded by saying:

- Much of what he had heard were not matters simply about the legislation but wider issues around culture and behaviours in the NHS
- No change was not an option
- What was proposed was a legislative framework which would support the NHS
- Nothing in the proposals would extend the role of the private sector
- Nothing in the proposals would extend charging
- The issue of “cherry picking” will be dealt with.

Sir Neil thanked the Secretary of State for his attendance and assured him of the commitment of the Academy and Colleges to continue to work with ministers and the Department for the benefit of the NHS and patients.

Attendance

AoMRC

Prof Sir Neil Douglas, Chairman, AoMRC

Dr Susan Bews, Honorary Treasurer, AoMRC

Prof Sir Sabaratnam Arulkumaran, Honorary Secretary, AoMRC

Dr Pete Nightingale, President, Royal College of Anaesthetists

Prof Derrick Willmot, Dean, Faculty of Dental Surgery

Dr John Heyworth, President, College of Emergency Medicine

Dr Iona Heath, President, Royal College of General Practitioners

Dr Clare Gerada, Chairman of the Council, Royal College of General Practitioners

Dr Anthony Falconer, President, Royal College of Obstetricians and Gynaecologists

Dr Olivia Carlton, President Elect, Faculty of Occupational Medicine

Prof Harminder Dua, President Elect, Royal College of Ophthalmologists

Prof Terence Stephenson, President, Royal College of Paediatrics and Child Health

Prof Peter Furness, President, Royal College of Pathologists

Dr Richard Tiner, President, Faculty of Pharmaceutical Medicine

Dr Neil Dewhurst, President, Royal College of Physicians of Edinburgh

Sir Richard Thompson, President, Royal College of Physicians of London

Dr Sue Bailey, President Elect, Royal College of Psychiatrists

Dr Liz Scott, Treasurer, Faculty of Public Health

Dr Jane Barrett, President, Royal College of Radiologists

Mr David Tolley, President, Royal College of Surgeons of Edinburgh

Mr John Black, President, Royal College of Surgeons of England

Mr Sol Mead, Chairman, Academy Patient/Lay Group

Dr Damian Roland, Chairman, Academy Trainee Doctors Group

Dr Mike Tidley, Chairman, Academy of Medical Royal Colleges in Wales

Mr Alastair Henderson, CEO, AoMRC

Department of Health

Rt Hon Andrew Lansley MP, Secretary for State for Health
Sir Bruce Keogh, Medical Director for the NHS
Claire Bache, NHS Listening Team

NHS Futures Forum

Julie Moore, CE Birmingham University Hospitals Trust, Chair Education and Training work stream
Dr Kathy McLean, Medical Director NHS East Midlands, Chair Clinical Engagement work stream