

NHS Listening Exercise

Summary of AHPF key points

4th May 2011

The following headings and questions are taken from the Department of Health document:

Working together for a stronger NHS: NHS Listening Exercise: Pause, Listen, Reflect, Improve

<http://healthandcare.dh.gov.uk/files/2011/04/NHS-Listening-Exercise.doc>

Choice and competition

Q1 Which are the types of services where choice of provider is most likely to improve quality?

The AHPF response to this question challenges to some extent the premise underlying this question

- Competition and patient choice per se do not drive improvement.
- Standards and expectations drive quality improvements (quality used in the commercial sense of delivering the expected standard for a given price)
- High level of knowledge is required to set appropriate high level expectations - need for involvement of appropriate clinical expertise – one solution to ensure this is for AHPs to be involved on Commissioning Consortia Boards
- The NICE guidelines will ultimately set standards to be used to support patient expectations and inform the outcomes framework that will become the basis for commissioning decisions. The AHPF has a concern that the timescale for completion of this work is 2015. This stretches well beyond the target date for GP led commissioning going live. This strengthens the need for AHP input directly to the Commissioning Consortia Boards as the early commissioning decisions will need to be undertaken without the benefit of the full set of NICE standards.

Q2 What is the best way to ensure a level playing field between the different kinds of provider who could be involved?

- The values of the NHS and the NHS Constitution should be built into all organisations providing services and not just organisations from or still in the NHS. This needs to apply to 3rd sector and private sector organisations entering the provider landscape.

Q3 What else can be done to make patient choice a reality?

- Patient choice is not and unlikely to be in the short to medium term a reality for the majority of users of (currently publically provided) health and social care services. Fostering informed patient/clinician collaboration around choice is more realistic. This mandates for a greater

emphasis of collaboration between appropriate clinicians and their patients and for overt emphasis that an AHP might be that appropriate clinician

- Increased numbers of service providers driven by commissioning against care pathways and the AQP model leads to potential fragmentation of sustainable services. Cherry picking of pathways to optimise profit leads to 'less attractive' pathways forced into national commissioning, or sink organisations squeezed on price, ultimately leading to reduced quality of patient care as funding for an organisation reduces without the opportunity to leverage productivity from the more profitable pathways.

This could be minimised by the Bill overtly recommending some form of multiple pathway provision being built into the scope for each provider organisation. Bundling of pathways protects providers (by reducing the ability to cherry pick) ensuring appropriate numbers of providers in the longer term hence maintaining opportunities for patient choice

- Integration needs to be the key word in describing the new cultural landscape over and above choice and competition
- There is evidence from multiple industry sectors not just health that quality improvements are best initiated and delivered by motivated staff. The AHPF has concerns that developing smaller providers working to a commercial or financial emphasis puts pressure on terms and conditions thus potentially eroding morale at a time when maximum commitment to change is needed
- There needs to be overt reference to the importance of self referral as a means of increasing patient choice. Entry into health and social care should not be predicated on GPs being the automatic initial contact

Public accountability and patient involvement

Q1 How can we ensure commissioning decisions are made transparent to the public, and that commissioning consortia engage fully with patients, carers and communities?

- Conflict of interest is always a potential issue in a commercial model, GPs both provide and commission services and private companies are involved in mapping exercises and setting up services. There needs to be clearer and more overt recognition of this as an issue and clearer methods outlined to ensure that conflict of interest is declared

Q2 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 Health and Wellbeing Boards based in local authority structures will be vital to ensure that appropriate health and social care provision in line with the Joint Strategic Needs Assessment is planned and provided for as well as providing scrutiny to local budget allocation.
- The AHPF has a concern that the HWBBs will not have the capability and expertise to fulfil their partner role effectively, at least not in the early days of the process (which hold the most risk of

inappropriate decision making). To reduce this risk a small cadre of local clinicians could be mandated to train and develop each HWBB and provide a pool of specialist knowledge. This group would include an AHP. In the longer term to maintain the appropriate levels of expertise within the HWBB this group could be absorbed into the HWBB structure. This gives each HWBB ongoing access from an integrated AHP.

- Given the important role of Allied Health Professionals in so many aspects of care including improving public health and wellbeing, reablement, management of long term conditions, providing integration across health and social care and delivering care within the education and justice contexts, the AHPF believes that the Health and Social Care Bill should be amended to ensure AHPs are represented at all levels in the new NHS structures, on the NHS National Commissioning Board, on the GP Commissioning Consortia and on the Health and Wellbeing Boards.
- Top level accountability to government must remain the remit of the Secretary of State for Health

Q3 Are we doing enough to make sure the NHS at local level has the freedom it needs to take locally-based decisions?

- To have freedom there needs to be initial structure
- Central diktat needed on boundaries and board composition (adds to level playing field). Note this is not a suggestion to create new 'PCTs' but if the Bill aims to integrate health and social care without some form of boundary management then the task is magnified inappropriately
- Coterminosity and an AHP on each commissioning board are potential solutions

Clinical advice and leadership

Overview question: How can we ensure that advice and leadership from NHS staff themselves on improving services and tackling patient needs are at the heart of the health service?

- In the current DH structure the senior AHP role (Chief Health Professions Officer) reports to the CNO putting AHPs under the nursing umbrella. The new National Commissioning Board will play a vital role in ensuring effective collaborative local commissioning and therefore in itself needs top level AHP input to ensure optimum decision making. It is inappropriate that top level AHP representation remains under nursing for a number of reasons:
 - Nursing and AHP roles have diverged over the years and now occupy very different niches within health and social care with different professional needs and capabilities
 - The sheer volume of nursing related activity driven by staff numbers could inadvertently take priority over AHP professional initiatives

Q2 How can commissioning consortia best engage and take on views from across the range of health professions in taking their commissioning decisions?

- Boards of commissioning consortia are selected for very specific knowledge and competence – a profile of total board capability would be required; for example the Board needs someone who brings to the table the overview of the service provision possible from AHPs and AHP led services. The likely individual competence that describes this is *having current experience of being the lead point for an AHP network*

Q3 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?

- Coterminous boundaries between Commissioning Consortia and HWWB and social care providers will make the whole process of leading integration easier. Note previous comment that this is not a request to reform PCT equivalent organisations
- Other key partners also need to understand the complexity of AHP provision across health and social care boundaries and as key components of a number of care pathways especially important in many long term conditions where a socio-medical model provides a more QIPP related sustainable long term approach rather than the traditional bio-medical model. This points towards the specific requirement for top level AHP engagement and the need for an AHP presence to be mandated for the HWWBs
- The new central Department of Public Health will provide vital input to the overall well being of the nation. It will require AHP input at the highest level and consideration should be given to mandating an AHP Director at the same level as the Nurse Director already announced.
- Local Public Health Directors will also require access to AHP expertise and input.

Education and training

Q2 How can health professionals themselves take greater ownership of the education and training of their own professions, whilst meeting the needs of healthcare employers?

- There is nothing to guarantee release time for ongoing professional development. If anything this is exacerbated by a larger number of smaller providers where pressure on release time is greater and providing cover more challenging both in terms of staffing capacity and cost
- There is a need to guarantee placements in the new provider landscape. A drive towards more fragmented smaller providers under the AQP model reduces the opportunity for placements unless overt recognition of this need is put into the bill

Q3 How can we ensure that the values of the NHS are placed at the heart of our education and training arrangements?

- An overt statement that all organisations must build in the principles of the NHS and the NHS Constitution into their people development would go some way to guaranteeing that education in all of its forms is resourced effectively for all staff. Note that this is another area where a GP undertaking commissioning may not understand the pressures as traditionally time and funding

for education has always been available to doctors. Once again this points to an AHP on the decision making boards

Q4 How can we best combine local and national knowledge and expertise to improve staff training and education?

- There is an overall concern that the proposed model will result in fragmented commissioning and a risk to sustainability
- AHP career progression is often through nationwide relocation and this is difficult to monitor and manage when the primary focus is local
- There needs to be some form of centralised control providing a long term viewpoint. Providers do not have a sufficiently strong financial incentive to look beyond a three year horizon at best. This is insufficient to ensure that the right level of AHPs and doctors is maintained on a long term basis and could see a system characterised by under then over supply. However, HEIs would find it difficult to work to such a model and there is a risk of HEIs reducing their capacity to train qualified AHPs. This would place an overreliance on staff trained overseas which for AHPs causes a particular challenge because, unlike doctors and nurses, overseas approaches and qualifications vary widely leading to challenges to the process of HPC registration
- Continue the high profile of AHPs in what is currently the AHP Professional Advisory Board and will become part of Health Education England. Structural linkage between HEE and local skills networks would facilitate the overall planning process.
- There is an opportunity for professional bodies to have a greater role in providing a national view of the profession and on quality, education and training requirements