

Rural Forum response to Greater Choice and Control consultation

Greater choice and control: Annex A. Consultation questions

*Q1. How should people have greater choice and control over their care?
How can we make this as personalised as possible?*

There is a delicate if not critical balance to be achieved here. It would be a wondrous outcome if, by offering the public more choice over the range of health care services available to them, that we could also achieve a reduction in service costs through provider competition. The counter argument might be that it is easier to control NHS costs by limiting choice to a range of fixed cost services. Given that the Government appears to be committed to reducing in real terms the funds available to GP commissioners it is more likely that health services for patients will have to be more tightly rationed. This is more likely to mean less choice for patients as some existing services have to be axed. Many localities will have limited service provider choice particularly rural areas. In many remote areas the reality may be that there is in effect no choice at all. Enabling patients to register with any GP and attend any secondary care provider, regardless of location, will favour only those who can afford to travel and are physically fit enough to do so. There is a real danger that the government is raising patient's expectations to a level beyond what is achievable with the available resources irrespective of who commissions services.

Q2. Which healthcare services should be our priorities for introducing choice of any willing provider?

There is no one size fits all prescription or solution. Priorities will need to be locality determined, building on what works well and seeking to improve those services that are not. A discussion amongst the GP members of the Rural Forum Steering Group revealed significant variation on what was considered priority services to reform and improve. For example Mental Health services in some rural areas seemed to be well regarded whilst in others they were regarded as extremely poor.

Q3. How can we offer greater choice of provider in unplanned care?

This is simply unrealistic in most rural areas and unachievable in remote areas. It would be more sensible and more cost effective to improve resources and incentivised funding to those areas that are struggling to provide an adequate service.

Q4. What would help more people to have more choice over where they are referred?

For the system not to favour the wealthy the Government will need to be prepared to fund the inherent transport costs for patients to be able to attend far off preferred service providers. For remote and rural patients this would also entail funding requirements for overnight accommodation.

Q5. Which choices would you like to see in maternity services and which are the most important?

There is a fine balance here between increasing patient choice and increasing risks to pregnant women and the unborn child particularly with regard to home births but also the risks of increased travel to a preferred more distant maternity unit. GPs need to be included in the information loop to avoid fragmentation of care. We need to ensure that where current arrangements work well that the choice agenda does not hinder rather than help.

Q6. Are these the right choices for users of mental health services, and if not why not?

We agree that patients should have more choice over their mental health treatment for mild to moderate anxiety and depression. That choice should include access to a self help approach using internet and literature based services but also for a personal face to face service for those that prefer this. Making service provider choice available may well prove a driver for service improvements in localities where current provision is poor. In some areas there is currently no choice available due to local restrictive arrangements. In remote rural areas there may be no realistic alternative but perhaps outreach services could be provided where there are local service delivery problems.

Q7. When people are referred for healthcare, there are a number of stages when they might be offered a choice of where they want to go to have their diagnostic tests, measurements or samples taken. At the following stages, and provided it is clinically appropriate, should people be given a choice about where to go to have their tests or their measurements and samples taken:

- At their initial appointment - for example, with a GP, dentist, optometrist or practice nurse?*
- Following an outpatient appointment with a hospital consultant?*
- Whilst in hospital receiving treatment?*
- After being discharged from hospital but whilst still under the care of a hospital consultant?*

These questions should be answered at local level with no central prescription. A key consideration is whether a provider can provide investigation results electronically.

Many GP surgeries have laboratory service contracts based on single provider service in conjunction with sample collection and 24 hr electronic return of results. Providing choice to service providers where such arrangements are not in place might be desirable. Having different tests done at different hospitals and clinics can be problematic in terms of collating results and ensuring they are appropriately acted upon.

Q8. Are there any circumstances where choice of where to go for diagnostic testing would not be appropriate, and if so what are they?

It might be more appropriate to have a line of investigation for a given condition to be followed through by a single provider for continuity and accountability.

Q9. Would you like the opportunity to choose your healthcare provider and named consultant-led team after you have been diagnosed with an illness or other condition?

This may be helpful and appropriate depending on practicality and whether the patient has access to enough information to be able to make an informed choice.

Q10. What information and/or support would help you to make your choice in this situation and are there any barriers or obstacles that would need to be overcome to make this happen?

Patients would need accurate data about service providers experience, adverse event record etc. When a distant provider is chosen issues about follow up and who deals with complications need to be addressed. For rural patients in particular they would be issues over access, transport etc for the patient and visiting relatives.

Q11. Is there anything that might discourage you from changing your healthcare provider or named consultant-led team - for example, if you had to repeat tests, wait longer or travel further?

Distance of travel will be of particular concern to rural and remote patients.

Q12. What else needs to happen so that personalised care planning can best help people living with long term conditions have more choice and control over their healthcare?

Personal care plans should be restricted to those in need where there is clear benefit to be derived and not simply become a bureaucratic paper exercise requirement.

Q13. What choices are most important to people as they approach the end of their lives? What would best help to meet these?

Q14. We need to strengthen and widen the range of end of life care services from which patients and carers can choose. How can we best enable this?

Q15. Carers may sometimes feel that they themselves have no choice when the person they care for chooses to die at home. How should the respective needs and wishes of patients and carers be balanced?

There are no simple answers here. Answers will depend on individual case circumstances.

Q16. What sort of choices would you like to see about the NHS treatment that you have? Treatment could mean therapy, support for self management, medication or a procedure like surgery.

Q17. How can we encourage people to take more responsibility for their health and treatment choices?

We need to ensure that accurate and appropriate information is made available for those that are able and motivated to take more responsibility over their health care choices.

Shared healthcare decisions

Q18. How do we make sure that everyone can have a say in their healthcare?

There will always be some who do not have the mental capacity to make informed choices about their healthcare and these decisions will continue to have to be made by next of kin guided by the supervising healthcare professionals.

Q19. How can we make sure that people's choices can reflect their different backgrounds - whether ethnic, religious or any other background that could affect their healthcare preferences?

Q20. How can we make sure that carers and the families of patients and service users can have a say in decisions about the healthcare of the people they support, where appropriate?

GPs are well used to consulting family members and carers about healthcare decisions regarding the cared for where appropriate. It is not clear to us that there is a need to formalise this. It would not be helpful if a formalised process led to conflicting views leading to indecision due to lack of consensus. It is essential that we do not create an over bureaucratic time consuming process as this could prove costly in health profession time.

Q21. How can we support the changing relationship between healthcare professionals and patients, service users, their families and carers?

Q22. What needs to be done to ensure that shared decision making becomes the norm? What should we do first?

Q23. Should healthcare professionals support the choices their patients make, even if they disagree with them?

It would be inappropriate to be prescriptive here. Clearly the healthcare professionals would have to use their judgement according to the particular circumstances of the case.

Q24. What sort of advice and information would help healthcare professionals to make sure that everyone can make choices about their healthcare?

Q25. How can we encourage more people to engage in advance care planning about their preferences for the care and support they receive - for example, when they are approaching the end of their life?

Q26. Would you welcome a chance to engage in advance care planning before you become ill – for example, when you go for your mid-life Health Check – rather than after a diagnosis of a life-threatening condition?

We do not feel it would be a sensible use of scarce resources to spend time planning for the end of life event prematurely as any decisions made may well be reversed when the eventuality arises. It could prove a very poor use of the healthcare professions time given the priorities and times constraints that face them. It could also prove harmful for many people making them over anxious about their health by confronting them with issues about their mortality prematurely. A better use of time would be to focus on preventive healthcare.

Q27. How could training and education make choice and shared decision making a part of healthcare professionals' working practices?

Q28. How can we help people to learn more about how to manage their health?

Q29. What help should be available to make sure that everyone is able to have a say in their healthcare?

Q30. Who would you like to go to for help with understanding information and making decisions and choices about your healthcare, or that of someone you support?

Q31. How can we make sure that carers' views are taken into account when the person they support makes a healthcare choice?

Q32. What information and support do carers, parents, guardians and those with powers of attorney or deputyship need to help others to make choices or to make choices on others' behalf?

Q33. What information and support do voluntary sector and patient-led support groups need so that they can continue to help people to make choices about their healthcare?

Q34. How can people be encouraged to be more involved in decisions about their healthcare?

Q35. Would decision aids be a useful tool for healthcare professionals and their patients and service users? Are there any barriers to their use?

Whilst we fully support the move toward increasing patient awareness and involvement in their healthcare decisions we would not be in favour of the Government seeking to produce formalised micro-management strategies. We feel some of the detailed line of questions set out above are in danger of being over prescriptive and suggest to us a lack of realisation that much of the principles are already practiced by healthcare professionals in an appropriate way.

Making it happen

Q36. How should people be told about relevant research and how should their preferences be recorded?

This is a rather over simplified question. Already there is a mass of research and health information available via the internet. The problem is to sift the good from the bad and it can be hard enough for health professionals to navigate through the literature let alone the general public. It would be helpful if there could be a universally accepted health professional toolkit that provided up to date relevant research and guidance on the full spectrum of healthcare topics. To a large extent NICE does seek to achieve this although sometimes the Guidance conflicts with the guidance of other respected institution's interpretation of the available research. One challenge will be to provide this information in a simplified form for the educationally deprived.

Q37. How can we encourage more healthcare professionals to use Choose and Book when they make a referral?

There is variability in the way choose and book has been rolled out and there is still an urgent need for vast improvements to the way the system works. In many surgeries, particularly in rural areas due to a lack of high speed internet access choose and book falls along way short of its objectives and cannot be used face to face during the consultation. The Government needs to invest heavily if it seeks to encourage wider use. It is noteworthy that Scotland appears to have an efficient e-referral system but does NOT have choose and book.

Q38. How can we encourage more healthcare providers to list their services on Choose and Book?

This will not be achieved until the current problems with Choose and Book are resolved. It is ironic that many departments in some areas are increasingly resorting to paper based referral proformas that have to be hand written instead of embracing electronic technology. Presumably this is a consequence of failing or incompatible IT systems.

Q39. How else can we make sure that Choose and Book supports the choice commitments in chapter 2?

Q40. Do you agree with the proposed approach to implementing choice of named consultant-led team? What else would you suggest needs to be done?

Named consultant referral was the historical norm but was replaced by unnamed departmental referral in order to remove waiting list bias. It is hard to see how the old problems of differing waiting times will be avoided by returning to named consultant led teams. Many DGHs have a number of consultants working as a team in each department to agreed standards and protocols and so named consultant referrals are perhaps less relevant and unnecessary with such working arrangements.

Q41. Do you agree with the proposed approach to establishing a provider's fitness to provide NHS services? What other criteria would you suggest?

We agree with the broad approach and we also agree it will take some time to set up accepted standard tariffs across the full range of services such that GP consortia can commission with full confidence. The commissioning service agreement specifications will need to be very detailed to cover everything from investigations, treatment, after care and follow up. Providers will also need to provide detailed evidence of their expertise, successes, complications rates etc.

Q42. Should this approach apply uniformly to all providers, no matter what size, sector and healthcare services that they provide? For example, should a small charity providing only one healthcare service to a very localised group of patients be subject to the same degree of rigour as a large acute hospital that delivers a range of services to a regional catchment of patients?

There may well need to be some rationalisation here so that a small unit with limited but specific service provision is not subject to inappropriate/unnecessary hoops. On the other hand this should not provide an excuse for lax standards of care.

Q43. Do you agree that an "any willing provider" directory should be established to make it easier for commissioners to identify providers that are

licensed and have agreed to the NHS standard contract terms and conditions?

This seems logical and should be made available electronically for ease of access and use.

Q44. The White Paper indicates that the Government will explore the potential for introducing a right to a personal health budget in discrete areas. Which conditions or services should be included in this right?

We feel this is a bridge too far to contemplate at this stage, if ever. We feel the Government should prioritise the development of a fair system for practice budgets by GP consortia. It is likely that GPs will have difficulty enough in managing a global practice healthcare budget and will find it far too time consuming and difficult to help patients develop personal health care budgets in the near future. We have serious concerns about the prospect of “no top up” personal health care budgets which could severely prejudice against the chronically ill, frail, elderly and the educationally deprived. A system of personal healthcare budgets could run a real risk of adverse consequences. How do you equate the budget requirements of the chronically ill with complex health needs against those who are physically well. Could the worried well feel they have a right to spend their unused budget for services that they might not otherwise have sought to get via the NHS such as physiotherapy, chiropody etc? What happens when the patient with complex needs uses up his/her budget?

Safe and sustainable choices

Q45. How can we make sure that any limits on choice are fair, and do not have an unequal effect on some groups or communities?

Q46. What do you consider to be the main challenges to ensuring that people receive joined-up services whatever choices they make, and how should we tackle these challenges?

We believe that too much choice might lead to fragmentation of care and lack of continuity of care. It is paramount that the registered GP practice be kept fully informed of any interventions by other providers. Sometimes catering to the patient’s choice and perception of need can lead to inappropriate treatment. A patient may insist on multiple referrals until he/she is offered the treatment they think they need even though this might be medically inappropriate.

Q47. What do you consider to be the main risks to the affordability of choice and how should we mitigate these risks?

It seems unlikely that increasing patient awareness about the availability and choice of treatments and treatment providers will lead reduced NHS spending. We believe it far more likely that costs will escalate both by increased up take by the public and in

the costs of administrating wider choice. As stated in our opening paragraph there is a strong argument that it is easier to control NHS costs by restricting choice and treatment options.

Q48. How far should we extend entitlements to choice in legislation and hold organisations to account against these?

Q49. Where no specific right to choice applies, how can the Board best encourage GP consortia to maintain and extend the choice offer?

We feel it would be wiser to pilot the effect of increased choice before resorting to legislation over choice.

Q54. What are the main risks associated with choice and how should we best mitigate these risks?

- Increased NHS costs and increased workforce demands
- Fragmentation of care with reduced continuity and accountability
- Potentially service over provision followed by financial collapse of some providers
- Increase in the number of unnecessary treatments
- Increased bureaucracy

The best way to mitigate these risks to extend choice over a limited range of services initially until the effects can be assessed. If deemed to have net positive outcomes then choice could be extended to a wider range of services.

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