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PARLIAMENTARY BRIEFING

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NATIONAL HEALTH SERVICE AND COMMUNITY CARE BILL

REPORT STAGE

Amendment 2

Page 3, line 11 [Clause 3], at end insert:-

'In order to carry out its primary functions, a District Health Authority, having carried out an assessment of the needs of the resident population of its district for health services, shall publish a list of services which shall be provided within its district by:-

(a) in the first schedule of the list, bodies directly managed by that authority; and
(b) in the second schedule of the list, any National Health Service Trust, within the meaning of section 5 below, within its district.'.

The White Paper "Working for Patients" draws a distinction between 'core' services and 'other' services. Core services must be provided locally. However, locally in this context may mean that services are provided in a neighbouring district. Given the size of many existing districts and given the White Paper's expectation that a significant number of District Health Authorities will merge in the coming years, this implies that the distance patients will need to go to reach a "local" core service may be quite large.

It will be for each DHA to determine what should constitute the core services for its district. Other services, by definition, will be likely to be provided further afield. The implication of this is that patients will have to travel to services outside their districts much more frequently than is currently the case.

On this basis it is clear that some services must be provided locally. For example, one of the aims of the child health service is to monitor the development and health of all children. This is only going to be achieved if it is easy for parents to have their child seen by a doctor or a nurse, and implies a locally-based health visiting service.

Similar arguments apply to screening services aiming to cover 100% of some group within the population. The greater the ease of access to the service, the better the coverage. If all the women in a District has to travel to a particular hospital for a smear test, fewer women would have smear tests.

We would argue that mental handicap services should be provided locally if they are to be effective. Similarly, services for elderly people need to be locally-based, if elderly people are to be enabled to live at home.

Follow-up care following surgery is also best provided near to people's homes. This may involve continuing treatment and/or monitoring and it will lead to real difficulties for patients if they have to travel long distances to get this support.

Detailed consideration will need to be given to each service area. The decisions taken on which services are to be provided locally and which are not are crucially important for the patients who use them. If patients are to travel further to receive a service then they or their representatives should be consulted about the proposal. The benefits gained by travelling further afield should be spelled out, so that it can be shown that they outweigh any inconvenience caused. This amendment by requiring that schedules of service be published will enable patients and their representatives to comment on the plans of their local health authorities.

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NATIONAL HEALTH SERVICE AND COMMUNITY CARE BILL

Amendment Clause 3, Page 3, Line 11, at end insert:-

"(1A) In addition to carrying out its primary functions, a District Health Authority shall publish each year a document setting out its assessment of the state of health of the inhabitants of its district and their need for health services.

(1B) Prior to publishing the document referred to in subsection (1A) above, a District Health Authority shall seek the views of Community Health Councils within their district on the document, and shall also seek the views of such other persons as seem to them to have an interest in the matter or to be representative of the interests of patients in their district on the document, and shall take account of any views or representations received on the document."

A key element of the Bill is to make District Health Authorities the 'acquirer' of services for their resident population. The Department of Health in its paper "Contracts for Health Services: Operational Principles" indicates that the first step for DHAs will be to assess local health needs, so that decisions can be taken on what services need to be purchased. This amendment has the effect of requiring that DHAs shall produce this assessment in the form of a document and seek views on it from local Community Health Councils and other organisations.

Assessing the health needs of the local population will be a new

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NATIONAL HEALTH SERVICE AND COMMUNITY CARE BILL

Amendment Clause 3, Page 3, Line 11, at end insert:

"(1A) In order to carry out its primary functions a District Health Authority shall ensure that, subject to subsections (1B) to (1E) below, services necessary to meet the health needs of the inhabitants of their district shall be provided within their district.

(1B) Subject to subsections (1C) to (1E) below, where the provision of services outside their district appears to a District Health Authority to be expedient, having regard to the interests of, and any inconvenience or hardship which may be caused to, patients in their district, subsection (1A) above shall not apply.

(1C) Where, by virtue of subsection (1B) above, subsection (1A) above does not apply, a District Health Authority shall each year publish a document setting out a schedule of categories of service, a substantial part of the provision of which they propose shall not be undertaken within their district, under subsection (1B) above.

(1D) In association with the document referred to in subsection (1C) above, a District Health Authority shall publish a document setting out the reasons for which, in their opinion, the benefits of providing a substantial part of the service outside their district outweigh any inconvenience or hardship which may be caused to patients in their district.

(2) Services whose effectiveness is unlikely to be affected, but for which there will be no benefit to patients (ie those services for which there is sufficient 'demand' at District level to sustain a viable unit and a unit could be provided locally).

(3) Services for which a loss of geographical accessibility may be traded off against other benefits to users (ie a more clinically effective service or shorter waiting times).

(4) Services for which an attempt to provide them locally would lead to a loss in effectiveness, perhaps because of a shortage of relevant expertise or the relatively low incidence of the condition (eg regional or supra-regional specialties).

On this basis it is clear that some services must be provided locally. For example, one of the aims of a child health service is to monitor the development and health of all children. This is only going to be achieved if it is easy for parents to have their child seen by a doctor or a nurse, and implies a locally-based health visiting service.

Similar arguments apply to screening services aiming to cover 100% of some group within the population. The greater the ease of access to the service, the better the coverage. If all the women in a District has to travel to a particular hospital for a smear test, fewer women would have smear tests.

We would argue that mental handicap services should be provided locally if they are to be effective. Similarly, services for elderly people need to be locally-based, if elderly people are to be enabled to live at home.

Follow-up care following surgery is also best provided near to people's homes. This may involve continuing treatment and/or monitoring and it will lead to real difficulties for patients if they have to travel long distances to get this support.

Detailed consideration will need to be given to each service area. Some comments from one RHA strategic plan are attached to this briefing as Appendix Two.

Decisions taken on which services are to be provided locally and which are not are crucially important for the patients who use them. If patients are to travel further to receive a service then they or their representatives should be consulted about the proposal. The benefits gained by travelling further afield

APPENDIX ONE

Some comments on "core" services

"Whether the market is simple or complex, we are clear that it cannot be unrestricted and "free" - the fact that NHS is publicly financed and the Secretary of State has a duty and a responsibility to secure health services for all, means that the Government is duty bound to impose constraints on, or otherwise regulate, the market." (para.2.94)

".....perhaps the major constraint is its requirement that certain "core" services will be provided locally, which could, if it works, mitigate some of the worst potential effects of a market in health care." (para. 2.95)

"There should be a national policy on which services should be provided locally from which DHAs may diverge if they can make out a sufficient case to the Management Executive."

(Recommendation 7.17 (c)(vi)
Social Services Committee
Eighth Report

"The Council is concerned about the specification of "core" and "non-core" services..... Although it is stated that it is not intended that the list of core services should be definitive, there are several important omissions, including maternity and paediatric services. Decisions on core services should not be made at a local level without advice being sought nationally, for example, through relevant professional bodies.

"The Council believes it would be a retrograde step to introduce a system which obliged patients to travel long distances for treatment. Competitive provision of "other services" could lead to some services being no longer available within a district, which could mean the end of the concept of the district general hospital."

BMA

"....the imprecision in definition of core services...will make it difficult to ensure that people have access to appropriate locally-based services when they need them. In particular, we are concerned about the continuation or development of geriatric and psychogeriatric services."

Age Concern

Dr. Ian Haslock, President of the British Society for Rheumatology, called for rheumatology to be included as an essential services in all DHAs.

"Independent" 24th Aug. 1989

The British Paediatric Association, the Cystic Fibrosis Trust and the Voluntary Council for Handicapped Children criticised the Government for not including paediatrics as a core service.

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APPENDIX TWO

Some examples from a Regional Plan of acute services that may need to be provided locally

West Midlands RHA Strategic Plan comments on some of the acute services that should be provided by each District in the Region. The summary below is not exhaustive but gives some indication of the range of issues that need to be addressed.

Each District should have in-patient beds for:
general medicine; general surgery; gynaecology; trauma & orthopaedics; accident & emergency; and communicable diseases.

Ophthalmology: each district should provide out-patient facilities, an A & E service and facilities for day case treatment. Specialist in-patient facilities (e.g. detached retinas) should be provided on a sub-regional basis.

E.N.T. : some Districts provide aural services as a basic DGH service; six do not. All districts provide an out-patient service. The region specifies the minimum size for a viable unit providing all in-patient and out-patient facilities: 2 consultants, 32 beds and a nominal population of 300,000. Some Districts are therefore too small for such a unit.

Urology: all Districts should have out-patient clinics and there will be designated in-patient beds in most districts.

Rheumatology: It would be desirable for each District to provide this as a basic DGH service. However, because of the previous low level of development within the Region, it is a designated regional specialty to be provided in 7 main centres.

Gastro-enterology: there should be one consultant physician with an interest in gastro-enterology per 150,000 population. "Rapid developments in the investigation and treatment of disorders of the gastro-intestinal tract make essential the development of gastronenterological service in each DGH." The plan even specifies what investigation should be available in each District.

Diabetes & endocrinology: it is accepted that not all Districts need have a diabetologist, although they should all have a diabetes liaison nurse.

Dermatology: though each District should have out-patient clinics, the Region does not aim to develop this as a basic DGH service.

Genito-urinary medicine: there should be a special clinic at each DGH.

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NATIONAL HEALTH SERVICE AND COMMUNITY CARE BILL

Amendment Clause 3, Page 3, Line 18, at end add:-

'(3A) A district health authority may only cease to provide or to guarantee the provisions within its boundaries of, the services specified in (2) above after:

(a) consultation with such bodies as the Secretary of State may recognise as being representative of medical or dental practitioners, nurses, midwives or health visitors, registered pharmacists, opthalmic and disensing opticians or representatives of such other professions as appear to him to be concerned; and:

(b) securing the agreement of the local community health council.'.

The White Paper "Working for Patients" draws a distinction between 'core' services and 'other' services. Core services must be provided locally. However, locally in this context may mean that services are provided in a neighbouring district. Given the size of many existing districts and given the White Paper's expectation that a significant number of District Health Authorities will merge in the coming years, this implies that the distance patients will need to go to reach a "local" core service may be quite large.

Follow-up care following surgery is also best provided near to people's homes. This may involve continuing treatment and/or monitoring and it will lead to real difficulties for patients if they have to travel long distances to get this support.

Detailed consideration will need to be given to each service area. Some comments from one RHA strategic plan are attached to this briefing as Appendix Two.

Decisions taken on which services are to be provided locally and which are not are crucially important for the patients who use them. If patients are to travel further to receive a service then they or their representatives should be consulted about the proposal. The benefits gained by travelling further afield should be spelled out, so that it can be shown that they outweigh any inconvenience caused. This amendment provides an opportunity to do this, by requiring that the local CHC has to agree any such proposal.

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NATIONAL HEALTH SERVICE AND COMMUNITY CARE BILL

REPORT STAGE

Amendment 3

Page 3, line 18 [Clause 3], at end insert:-

'(2A) In addition to carrying out is primary functions each District or Special Health Authority, and each Family Health Services Authority

(a) shall, within such period after the day appointed for the coming into force of Part III of this Act as the Secretary of State may direct, prepare and publish a plan for the provision of services other than services provided from within hospitals which complement the community care services within the meaning of section 41 below, provided by local authorities whose areas fall wholly or in part within its district; and

(b) shall, prior to the publication of their plan under sub-paragraph (a) above, consult the local authorities whose areas fall wholly or in part within its district, and such other persons (including voluntary organisations) as seem to them to be representative of the interests of the users of their services, or to be providing complementary services, or to have an interest in the matter, on the contents of the plan; and

(c) shall, at such intervals as the Secretary of State may direct prepare and publish modifications to the current plan, or if the case requires, a new plan.'.

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NATIONAL HEALTH SERVICE AND COMMUNITY CARE BILL

HOUSE OF LORDS : COMMITTEE STAGE

Amendment in the name of Lord Ennals

Clause 3, page 3 line 38 at end insert-

("(4A) It shall be the duty of the Secretary of State to give to each health authority and each Family Health Services Authority such directions under Section 17 of the principal Act as it appears to him necessary for the purpose of securing that:-

(a) patients shall have access to free and confidential advice independent of any health authority or Family Health Services Authority and to support whilst processing a complaint;

(b) patients shall have access to a complaints investigation services independent of any health authority or Family Health Services Authority;

(c) all employees of health service bodies as defined in Section 4 (2) of this Act and all medical practitioners who are providing general medical services in accordance with arrangements under section 29 of the principal act shall cooperate fully with such a complaints investigation service in an investigation of any complaint;

(d) patients who have complained shall receive from such a complaints investigation service a full explanation of the outcome of any investigation within such time

limits as the Secretary of State shall determine.

(e) such steps are taken for publicising the arrangements made under this Section as the Secretary of State shall require and that the arrangements shall be known as "the unified complaints system for health service users."

(4B) Nothing in sub-section 4A above shall preclude an investigation under part V of the principal Act in respect of any matter.

(4C) Nothing in sub-section 4A above shall preclude any award of compensation made to a patient under law or by any other procedure.

(4D) Nothing in sub-section 4A above shall preclude any disciplinary action being taken against an employee of a health services body as defined in section 4(2) of this Act or against any medical practitioner who is providing general medical services in accordance with arrangements under Section 29 of the principal Act").

The existing system for investigating patients' complaints in the NHS is bureaucratic, cumbersome, long-winded and strongly biased in favour of the medical profession. The attached report demonstrates the short-comings of the existing system. These are summarised below: The existing NHS procedures are -

* INVISIBLE - people do not know how to complain and the NHS does not encourage comment.

* INACCESSIBLE - there are currently at least seven possible channels for a complaint and it is often unclear which route is appropriate.

* SLOW - it is not unusual for complaints to drag on for months or even years.

* UNFAIR - many people who go through the system believe that it is beholden to the medical profession. Serious allegations are investigated by other professionals.

* INEFFECTIVE - the outcomes of the different procedures are unclear and often unsatisfactory.

Complainants are usually seeking an explanation, an apology and a reassurance that the incident will not be repeated. Existing procedures clearly fail to meet these basic needs.

The amendment would go some way to remedying these problems. It would require the Secretary of State to give directions to health authorities to ensure that a more "user-friendly" complaints

"DHAs will need to pull together information about GPs' preferences, about the nature, cost and quality of services available, together with their plans for contract placement, in a form which will enable all local GPs to express their views before final decisions are taken. Local circumstances will determine the best arrangements for this purpose, but the objective will be to devise machinery which will command GPs' acceptance and support. DHAs should also discuss these arrangements with the LMC."

However, decisions on contract placement are going to be extremely significant and it is important that views are canvassed more generally. This amendment requires that the material, which will be circulated to GPs and to the Local Medical Committee so that they can express their views, will be produced in a form which can be circulated more widely. The amendment also requires that the views of the local Community Health Councils, as the representatives of service users, and of other organisations be sought on the general plans for contract placement in their districts.

It is, of course, the case that the views of GPs are extremely important in deciding what contracts are needed for a particular district. However, the views of patients and their representatives should also be taken into account. It is certainly not acceptable to accept the views of GPs as necessarily being a proxy for the views of their patients.

The amendment should not involve any significant increase in workload for District Health Authorities, as the Department of Health already envisages that they will be consulting all GPs and the Local Medical Committee on general plans for contract placement. It will not be a major task to extend this to local CHCs and other relevant organisations.

In many ways the NHS contract is the core of this Bill. The Government's intention is that NHS contracts should be much more than mere commercial documents. Indeed, the idea is that NHS contracts should be the mechanism by which standards of service provided to the patient are to be specified.

The concerns about contracts can be summarised as follows:-

(a) inconvenience to patients. The implication of the encouragement for DHAs to place contracts outside their districts is that patients will have to travel to services outside their districts much more frequently than is currently the case. If this were true, this would inevitably cause inconvenience and hardship to some people, particularly those who are elderly or disabled, those with small children, and those without cars.

(b) freedom of choice. Patients may have less influence on where they receive a service. At present, patients are usually referred to a hospital via their GP. Ideally such referrals are made by the GP in consultation with the patient, taking account

of his or her needs. This will continue, but in future GPs will be responsible for ensuring that any referral they make is covered by an appropriate contract. By and large (except for fund-holding practices), these contracts will be placed by the local DHA. This is not even provider choice, let alone patient choice. Clinical freedom for the GP is likely to be undermined unless there is guaranteed substantial provision for extra-contractual referrals.

(c) cost-cutting and quality. There will be strong pressure on the hospitals to reduce their costs so that they can win contracts. This may, for example, lead to pressure to discharge patients even earlier than at present so as to cut costs, but liaison with local community services will be more difficult as the distances involved may be greater. An increased emphasis will need to be placed on the quality of service, but it is not clear that there will be much incentive on a hospital to spend money to improve quality, if the result is higher costs.

The DHAs and providers of service will have to agree what standards of service should be included in the terms of NHS contacts. It is important, if patients' interests are to be protected, that the specification of standards is as detailed as possible. Rather surprisingly, the Department of Health paper "Contracts for Health Services : Operational Principles" places "the onus generally on providers rather than purchasers to put forward detailed specifications of the services that can be provided."

The emphasis of this is surely the wrong way round. Hospitals will specify to DHAs the levels of quality and efficiency they can provide, rather than DHAs setting out what they expect, if patient needs are to be met. Placing the onus on providers rather than purchasers is a recipe for marginalising patients' interests and for services to be run for the convenience of consultants. Although some negotiation is expected the Department paper clearly envisages that standards will be specified on a take it or leave it basis.

CHCs are concerned that, once the contracts are agreed, it will only be possible to resolve concerns about the quality of service if the service provider has breached a contract term. It is important therefore that the standards set are widely accepted by CHCs and those organisations representing service users and that there has been proper consultation about the standards to be specified in NHS contracts.

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DRAFT AMENDMENT ON COMPLAINTS FOR REPORT STAGE

In clause 3, page 3 line 32 insert at end:-

"(4A) It shall be the duty of the Secretary of State to give to each health authority and each Family Health Services Authority such directions under Section 17 of the principal Act as it appears to him necessary for the purpose of securing that:-

(a) patients shall have access to free and confidential advice independent of any health authority or Family Health Services Authority and to support whilst processing a complaint;

(b) patients shall have access to a complaints investigation service independent of any health authority or Family Health Services Authority;

(c) all employees of health service bodies as defined in Section 4(2) of this Act and all medical practitioners who are providing general medical services in accordance with arrangements under section 29 of the Principal Act shall cooperate fully with such a complaints investigation service in an investigation of any complaint;

(d) patients who have complained receive from such a complaints investigation service a full explanation of the outcome of any investigation within such time limits as the Secretary of State shall determine.

(e) such steps are taken for publicising the arrangements made under this Section as the Secretary of State shall require and that the arrangements shall be known as "the unified complaints system for health service users."

(4B) Nothing in sub-section 4A above shall preclude an investigation under part V of the principal Act in respect of any matter.

(4C) Nothing in sub-section 4A above shall preclude any award of compensation made to a patient under law or by any other procedure.

(4D) Nothing in sub-section 4A above shall preclude any disciplinary action being taken against an employee of a health services body as defined in section 4(2) of this Act or against any medical practitioner who is providing general medical services in accordance with arrangements under Section 29 of the principal Act"