

Royal College of Nursing Response to NHS England Consultation on Investing in Specialised services

Introduction

With a membership of around 420,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

Background

This consultation seeks views on the proposed principles and process by which NHS England will make future decisions about investment in specialised services. The RCN welcomes the opportunity to feed-in to this consultation. The focus on consistency, quality and effectivity, efficiency and equality as described in the consultation document, is appropriate.

Our members have a vital role in shaping specialised services provision. Nurses provide expert clinical care and continuity from first diagnosis, and have a good understanding of the whole patient pathway.

General comments

We are mindful of the impact that recent proposals regarding the commissioning arrangements for kidney care had, both on patients and for those working in nephrology services, and of how the debates that surrounded the proposal quickly turned to the nature of specialist services themselves.

While acknowledging that specialist services do have some designation underpinning their provision, we are concerned that there is still a lack of a consistent definition of what constitutes specialised services. We would wish to see consideration being given to the impact of re-designation on recipients of specialised services, particularly in the event of structural change or any future devolution of commissioning responsibilities.

It may even be helpful to provide further or additional guidance on the circumstances under which such a consideration may be made, and on the process by which a service or treatment would be de-designated from being a specialised service.

Responses to specific questions

Q1. Do you have any comments on the principles that we have proposed to underpin the process for making investment decisions about specialised services?

We broadly support the general principles for prioritisation and welcome the focus on transparency and engagement with patients. We hope that these principles contribute

towards reducing anomalies in the system and inequalities within service provision. However, as described above the RCN is concerned that even with the principles, there is still a lack of clarity about what constitutes specialised commissioning.

The RCN presumes these core principles contribute to sustaining and improving equitable and fair access. We have some reservations about any changes that may result in those with rarer conditions less likely to access treatment options. We welcome the provision for the possibility of according priority for treatments or interventions for rare conditions even when there is limited published evidence. In relation to this, nurses can provide valuable data, nurses have up-to-date information about the success of the variety of treatment options.

We are concerned that part *IV* of the proposed principles “is the treatment or intervention a reasonable cost to the public” has the potential to result in inequities in provision and also potentially hamper innovation. For example making it more difficult to make the case for research. In understanding the cost-benefit of treatments, we would like assurances that the process for assessing reasonable cost takes into account the potential cost saving benefits of more innovative approaches that may require more spending at the beginning, also that any measure captures the value of wider holistic and preventative based treatments. We are also concerned that the cost-benefit measures used to ascertain whether a treatment or intervention is a reasonable cost to the public often factors in a person’s ability to contribute to the economy through work, this excludes and disadvantages certain groups, for example older people. The RCN would welcome any future opportunities to feed-into the development of the process for deciding if something is a “reasonable cost”.

Q2. Are there any other principles that you think NHS England should adopt as part of its process for making investment decisions about specialised services?

We believe that the headline principles outlined in the consultation document are sufficient and sensible, but as mentioned above, the content of these could be adjusted to further protect equitable and fair access.

Q3. Do you have any comments on the proposed process for making investment decisions about specialised services?

The RCN supports any process which provides for greater consistency and transparency within the commissioning process. We welcome the proposed process for prioritising interventions and treatments and approve of the position of NICE recommended treatments at the forefront of this process.

There is a need for the process to be transparent and user friendly, to consult with patients at key decision making events as well as harness multi-professional involvement. We are encouraged that the process in place appears transparent with meaningful routes for patients, public and professionals to shape commissioning. We would caution that any changes to the process should be evaluated for whether they add further complexity and bureaucracy and if such changes have the potential to make the process more opaque to patients, public and professionals.

There is a need for effective resourcing at the Clinical Reference Group level to ensure that these groups are equipped to deal with the volume and variety of commissioning. Multi-professional involvement, including the involvement of nurses is important at this level.

The RCN would value the opportunity to be consulted on the development of a scorecard methodology bearing in mind some of the challenges associated with such an approach and the fact that the methodology in its previous incarnation was considered to be not fit for purpose. If a new approach is to be introduced, a full consultation with stakeholders is necessary. A reflection by NHS England of what went wrong previously and how the new approach addresses those challenges, would be useful.

Q4. Are there any additional stages in the process that we should consider introducing?

We would have concerns if any additional stages resulted in the process becoming more onerous for patients and individuals in the system and obstructing timely decisions. More important is that the system in place is accessible and transparent for stakeholders and the public.

Q5. Are there any additional stages in the process, where engagement with patients and the public should take place?

The process described appears to be reasonable, with opportunities to engage with patients and public at significant stages. We believe that quality rather than the quantity is important when it comes to engagement opportunities. The process for engagement should be transparent, not complicated or overly burdensome, and also ensure that the opportunities provided are meaningful for patients and public.

Q6. Please provide any comments that you may have about the potential impact on equality and health inequalities which might arise as a result of the principles and process that we have described?

We are concerned that the principle of “reasonable cost” has the potential to undermine equality for the reasons stated in our response to question 1.

The definition of equality of provision must be broad enough to allow for additional adjustments for certain groups (for example those with a learning disability). It is also important that the system provides for effective advocacy for children, people with severe and enduring mental health illness, capacity issues and other complex health problems.

We would also seek assurances that a young person’s transition from specialist paediatric services and treatment to specialist adult services and treatment should be supported to be as smooth as possible without a reduction in services resulting in a “cliff edge” for the patients.

Q7. Are there any other considerations that you think we should take into account when developing the principles and process for investing in specialised services?

As outlined in the sections above, we would like to see assurances that prevention and specialist services are secured, particularly in relation to meeting the “reasonable cost” principle.

On a broader point, as the numbers of people living with specialist and acute conditions is rising, and with the potential for change in the way commissioning is structured, we believe it is necessary to undertake a detailed risk-analysis of the proposals set out in the consultation. Risk management could include risks relating to demographic change as well as any future system instability and transformation. This should include any future devolution of commissioning powers, for example in Manchester.

Q8. As well as hearing your views on which treatments and services NHS England should prioritise for investment, we are also keen to hear your views on NHS England’s rolling programme of service reviews on how specialised services are delivered. If you have any views on which services should be prioritised for a service review in 2015/16, please tell us.

We have no comments to make at this time on specific services.

**Policy and International Department
Royal College of Nursing
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