JOINT MINISTERIAL COMMITTEE ON HEALTH

22 OCTOBER 2001

Conference Room A
Cabinet Office, 70 Whitehall
London

EXPECTED ATTENDANCE

Ministers

UK
Alan Milburn
Secretary of State, Department of Health

Helen Liddell or (Lynda Clarke)
Secretary of State for Scotland or (Advocate General for Scotland)

Paul Murphy
Secretary of State for Wales

Andrew Smith
Chief Secretary to the Treasury

John Hutton
Minister of State for Health

Northern Ireland

Dermott Nesbitt
Junior Minister
Office of the First Minister and Deputy First Minister

Bairbre de Brun
Minister of Health, Social services and Public Safety, Department of Health, Social Services and Public Safety

Scotland
Susan Deacon
Minister for Health and Community Care, Scottish Executive

Wales
Jane Hutt
Minister for Health and Social Services, National Assembly for Wales

Officials

UK
Alasdair McGowan
Special Advisor, No.10 Policy Directorate

Hugh Taylor
Director of corporate & External Affairs, Department of Health

Donald Henderson (Secretariat)
Devolution & Regions Division, Central Policy Group, Office of the DPM, Cabinet Office

Amy Nicholas (Secretariat)
Head of DH constitution Unit, Department of Health

William Jordan
Economic and Domestic Secretariat

Janet Lewis
Deputy Section Head, Department of Health

Simon Stockwell
Home and Social Division, Scotland Office

Sarah Canning
Head of Social Affairs Policy Branch, Wales Office

Adrian Mcmenamin
Special Advisor, Wales Office

Wales
Ann Lloyd
Director NHS Wales, National Assembly for Wales

Dr Ruth Hall
Chief Medical Officer, National Assembly for Wales

Mark Drakeford
Special Advisor to Jane Hutt, National Assembly for Wales

Scotland
Trevor Jones
Chief Executive of the NHS Scotland and Head of the Scottish Executive Health Department

Northern Ireland
Clive Gowdy
Permanent Secretary, Department of Health, Social Services and Public Safety.

JOINT MINISTERIAL COMMITTEE ON HEALTH
22 October 2001

AGENDA

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1. Winter Planning [Papers Enclosed]

2. NHS Modernisation Progress [Papers Enclosed]

3. Communication and Co-ordination [Paper may follow]

4. NHS Pay Modernisation for all Staff Groups [Paper to follow]

5. Free Nursing /Personal Care [Papers Enclosed]

6. Lessons from Bristol and Alder Hey [Papers Enclosed]

7. ECJ Rulings and Cross-border health care [Paper Enclosed]

8. Consumer Protection Act - High Court Ruling and Hepatitis C Compensation [Paper Enclosed]

JOINT MINISTERIAL COMMITTEE ON HEALTH

WINTER PLANNING

A Note by the Secretaries

Please find attached four papers by officials in the Department of Health, National Assembly for Wales, Scottish Executive Health Department and Department of Health, Social Services & Public Safety respectively. Each paper sets out the progress on preparations for winter planning and implementation.

This is for discussion at the Committee's meeting on Monday 22 October.

Summary

The four health departments are building on the experience of successful planning in recent winters, supported by additional investment. Comprehensive and inter-sectoral planning is being done on a continuous basis as there is all year round pressure on occupancy. There is recognition that Winter 2001/2 will be a major challenge.

A common issue is the impact of bed occupancy on delayed discharge. There are differences of emphasis in how this is being tackled. All four countries have been expanding bed capacity, including critical care to cope with year round demand. Wales is seeking to address the factors underlying constantly high levels of bed occupancy and delayed discharges and though there has been recruitment from abroad staff shortages remain a problem in critical care. Northern Ireland are reviewing ways of preventing inappropriate admissions and delayed discharges and are also reviewing community care, having boosted primary care by establishing early treatment schemes in the community to prevent admission. Delayed discharges too are a major operational risk in Scotland. Nursing home capacity is being targeted this winter and cross-sectoral work is in progress to develop long-term radical solutions. The whole-systems approach in England has led to targeting A&E trolley waits, (a problem in common with Northern Ireland), cancelled operations, waiting lists, outpatients as well as delayed discharges. Extra investment to stabilise capacity in the care home market in England is expected to help reduce delayed discharges. Flu immunisation is being repeated to reduce the pressure on hospital beds.

The Committee is invited to note the good progress made in winter planning in the UK countries and may wish to exchange views on the following:

a) Approaches to handling the major operational risks in each country.
b) Co-ordination of flu campaign timings.
c) Continuing exchange of information on developments in intermediate care and alternatives to hospital admission.
d) Lessons from recruitment overseas.
e) Media handling .

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1. WINTER PLANNING

1.1 WINTER PLANNING IN ENGLAND

Summary of Progress

1.1.1 We are building on the successful planning for the last few winters. The key change from previous years is that communities have been explicitly required to plan and map capacity for the whole of 2001/02 not simply the winter period. Successful planning for winter cannot be delivered in isolation from the rest of the year.

1.1.2 Acute Trusts and their commissioners have also been required to plan and profile elective and emergency activity as one (based on realistic predictions of in year emergency activity). Planning requirements have also emphasised the need to take full account of intermediate care and private health sector capacity. This fits clearly into the overall planning for the NHS Plan Implementation process.

1.1.3 In line with this approach Local Winter Planning Groups (Health Authorities, Social Services Departments plus other NHS and voluntary/private sector partners) were renamed Local Capacity Planning Groups and set up to operate year round.

1.1.4 Health and social care communities were required to ensure as a minimum that general and acute, intermediate bed capacity on 1 December 2001 is at or above capacity recorded on 1 December 2000. Critical care capacity is required to be at or above the level recorded on 15 January 2001. Predicted December capacity was reported at the end of September and indicates the NHS is on track to meet this requirement.

Major Issues

Access via A&E/ Cancelled Ops

1.1.5 Despite the overall robust performance on total time in A&E a minority of patients, usually those requiring admission to a bed, still spend far too long in A&E (trolley waits). While very long waits for admission (over 12 hour waits) have reduced by over 50% year on year over 4-hour waits continue to increase as a percentage of total admissions. This increase is on a relatively low base. Cancellations of operations on the day of the operation are also still running at unacceptably high levels.

1.1.6 Tight monthly profiles for reducing over 4 hour trolley waits and cancellations of operations have been set for all HAs/Trusts. In addition action is being taken to reduce occupancy in acute and general beds. While the causes of waits and cancellations are complex, successive studies have suggested a relatively strong statistical link between occupancy over 82% and a high risk of over 4 hour waits and cancelled operations for lack of beds. Further work is being undertaken on ways to reduce overall occupancy.

1.1.7 Diagnostic work has been carried out to identify Health Authorities/Trusts (hot spots) with particularly acute problems across a range of indicators (trolley waits/delayed discharges/waiting list/out patients). The

areas are subject to a Performance Improvement Process. The Chief Operating Officer will oversee the process – tight improvement targets are being set supported by input from the Modernisation Agency to facilitate change on the ground.

1.1.8 £300m (announced this month) has been invested (over 2 years) in improving care for older people in line with the NSF. The £300m will stabilise the care home market and reduce delayed discharges (freeing up about a1000 beds).

1.1.9 Immunisation of the over 65s was very successful last winter with 65% of the target group immunised and noticeably lower levels of flu in this age group than other groups (flu strains vary year by year however). Immunisation will again be offered and promoted to this group this year.

1.1.10 Staff immunisation (of front line health and social care workers) was more patchy with some ideological resistance on the ground. This year all health employers have been advised to offer immunisation to front line workers and crucially this is being done with the support on the ground from occupational/public health teams.

Conclusion

Activity/performance

1.1.11 Pressure on the NHS (as measured by trolley waits, cancelled operations etc) continues to rise yet overall emergency demand and elective activity has been relatively static over the first quarter of 2001/02. We are working to understand the factors involved here – thought to include a greater proportion of emergency admissions being admitted via A&E, and possibly increasing lengths of stay.

Putting management information into the public domain

1.1.12 The SITREP system collects comprehensive management information in England on a wide range of demand and performance indicators weekly year round. During the peak winter period (Dec-Jan) selected indicators are collected daily. Last year in England none of this information was routinely made public but selected demand and performance indicators were used in rebuttals or in response to specific requests for information. In other administrations (Wales) a range of indicators drawn from systems similar to SITREPs were routinely made public (via a web site). It is for discussion what approach administrations are taking this year.

1.2 WINTER PLANNING IN WALES

Background

1.2.1 The summer has seen the NHS in Wales come under consistent pressure with a weekly average of approximately 4,900 emergency patients being admitted as an emergency admission every week since December 2000.

1.2.2 The Assembly has again made available a recurrent financial allocation of £35m specifically for reducing waiting times and managing winter pressures. The Innovations in Care Team have extended their remit to include emergency pressures while NHS Direct now covers the whole of Wales.

Summary of Progress

1.2.3 The health and social care communities in Wales continue to look at emergency pressures on a "whole system" basis. Again this year nearly 6,000 copies of detailed Emergency Pressures Planning Guidance were issued to the NHS and it's partners.

Major Issues

Delayed transfers of care

1.2.4 These remain a significant obstacle to the smooth running of acute services. Wales has spent time developing a detailed national data collection system; the most recent data collection revealed nearly 800 delayed transfers of care in Wales (about 55% social care related; 27% health related and 18% patient/carer/family related). Work is on-going at a local level looking at the reasons for delay in detail, understanding those delays which are a consequence of system/process failures and those which require investment.

Critical care

1.2.5 20 extra critical care beds were opened for last winter, another 10 were funded but staffing problems precluded their opening. Lack of critical care beds remains a cause of cancelled operations although SITREPS information shows that the use of critical care beds is uneven. A group including intensivists has been set up to look at the optimal provision and location of critical care beds.

A&E & trolley waits

1.2.6 Although there have been isolated incidents these have not been a major problem in Wales; they are carefully monitored through weekly SITREPS.

Outliers

1.2.7 Medical outliers are a problem in Wales and they are now monitored through daily SITREPS. The Emergency Pressures Planning Guidance provide detailed guidance on dealing with this issue.

Bed numbers

1.2.8 An extra £3m has been invested specifically in developing capacity, the NHS is seeking to increase the number of acute beds available for

emergency admission this year by at least 130 compared with 31 May 2001. Bed management processes are the target of an improvement programme.

Staffing issues/numbers

1.2.9 Staffing remains a problem even though nurses have been recruited from the Philippines, return to work schemes run and training places increased. The lack of adequate nursing cover has affected the ability of the NHS in Wales to increase and sustain both acute and critical care bed numbers.

Cancelled operations

1.2.10 Better information collection last year highlighted the problem of cancelled operations; the planning guidance has focused on this area and continues to make Chief Executives responsible for intervening when urgent operations are cancelled.

Media

1.2.11 A Communication Strategy has been developed with the following objectives:

- to further develop systems to ensure robust and effective communication between the Assembly, NHS and local government;
- to ensure that the principle of "no surprises" applies to media work undertaken by partners:
- to achieve balanced coverage of emergency pressures issues in the media; and
- to respond to bad news/crisis effectively and quickly.

Flu

1.2.12 The "Keep Well This Winter" campaign is being run again this winter, this was launched earlier this month with the start of the flu immunisation campaign aimed at all those 65 and over and the at risk groups with chronic diseases, but extends to embrace other public health protection programmes.

Visits

1.2.13 A multi-disciplinary team will visit all health authorities, as will those localities with the most intractable problems; further visits be undertaken if problems persist or difficulties arise later.

Conclusion

1.2.14 Health Authorities continue to co-ordinate the local action teams based around LHGs/Local Authority areas. The NHS and its partners have planned, provided and prepared better than ever before and continue to work in partnership to tackle the inevitable pressures that winter will bring.

1.2.15 A small expert team will be available to assist the minister in monitoring arrangements through the winter. More schemes have been developed jointly to address pressure on the system, including rapid response and reablement. Local Health Groups continue to work with local authorities to identify alternatives to admission and introduce ways of facilitating early discharge.

1.2.16 However, discussions with the NHS, local government and in the expert advisory team show:

- increasing age and complexity of emergency patients;
- difficulties in recruitment – it is proving difficult to recruit staff to absorb recently raised spending allocations; one trust has heavily recruited nurses recently from the Philippines;
- tightness of margins – hospitals routinely now exceed 85% occupancy through the year; and
- delayed transfers of care remain an issue.

1.3 WINTER PLANNING IN SCOTLAND

Introduction

1.3.1 Winter 2001-02 will be a major challenge to the NHS in Scotland. Efforts to ensure that the NHS handles winter pressures effectively are being built on the base laid for 2000-01. Planning for winter began early, with Boards submitting first draft plans in August. Additional, ring-fenced resources were made available to Boards in mid-September. Key risks lie in critical care capacity and the number of delayed discharges from NHS beds. Detailed discussions have been held with Boards which are assessed as facing particular challenges in these two areas. Waiting times and waiting list numbers also represent significant risks, as does the recruitment and retention of key staff.

Summary of Progress: NHS Boards' Plans

Immunisation

1.3.2 The Scottish campaign was launched on 27 September along similar lines to last year's successful campaign, using posters and leaflets in local health centres and hospitals backed up by TV advertising. NHS Boards are carrying out more locally focussed campaigns that dovetail with the national message. The target vaccination rate for the population aged 65 and over is 65%. Arrangements have also been made to improve targeting and tracking of others in at-risk groups. To supplement local vaccine stocks, a central Scottish stock is being established.

Critical Care

1.3.3 The position on ITU bed numbers in Scotland is set out below:

	Base No of Beds	Max no of Beds	Max occupancy
Winter 1999-00	127	160 (est)	N/K
Winter 2000-01	140	165	134 (96%)
Plans for 2001-02	145	175	N/A

1.3.4 Actual numbers of ITU beds depend on availability of skilled staff. All Boards have plans in place for securing ITU nurse staffing. The Scottish ICU beds bureau provides on-line access to information about availability of ICU resources. All Scottish ICUs are connected. This enables patients to be transferred rapidly from hospitals which have reached their ICU capacity limit to the nearest unit with space available.

Hospital beds/Capacity

1.3.5 NHS Boards are completing plans, including capacity plans, for this winter. The key determinants of available capacity are the number of delayed discharges and the number of acute emergency admissions. Trolley waits of over 8 hours are very unusual in Scotland. Many hospitals are now developing acute admissions units to help speed the admission process. "On the day" cancellations are also relatively rare but will of course be monitored carefully throughout winter.

Delayed Discharges

1.3.6 The high number of delayed discharges is a major operational risk to NHSScotland. Overall numbers have remained steady since September 2000. Consequently Scotland will enter winter 2001-02 with approximately the same number of delayed discharges as last winter. NHS Boards are fully aware of the risk. Four of them have a ratio of delayed discharge beds above 10%. The Department is working with these Boards and others to target ways of unblocking beds. Joint working with local authorities and with nursing home operators is taking place. A number of Boards are planning to use additional resources to secure extra nursing home places. Some Boards are planning to provide nursing home-type care themselves.

1.3.7 More work is needed on longer-term solutions. These are being explored vigorously, and include greater joint working and revised financial arrangements. The Chief Executive, NHSScotland has pulled together a cross-sectoral group of top officials from social work, housing and the NHS to develop radical proposals for reducing delayed discharges.

Resources

1.3.8 An additional £11m has recently been provided specifically to help deal with winter pressures, in addition to the £60m in additional recurring funding issued in 2000-01 for winter and related issues. The plans and progress summarised above reflects the position before the £11m addition. NHS Boards will update their plans by 31 October.

Media

1.3.9 Getting messages across successfully will again be vitally important this winter. A media strategy is being prepared which will build on last year's approach. Key points are: a dedicated Scottish Executive Health Department (SEHD) winter media team with an enhanced rebuttals capacity; dedicated winter contacts in each NHS Board area; shared winter information for SEHD and NHS Boards; a proactive approach to briefing the press; drawing in third party endorsement and support; and distribution of a winter press pack setting out positive examples of winter preparedness in Scotland. These measures will help to get the message across that NHSScotland's winter preparations are professional and thorough.

Conclusion

1.3.10 NHSScotland is continuing to build on the basis established last year, supported by additional investment. Resources and effort are being concentrated on addressing major risks. The areas identified have been highlighted with NHS Boards and are very clearly understood by them. The Boards are now taking the necessary measures to ensure, as far as possible, that risks are covered adequately in their planning. Overall, arrangements are more robust than last year, but there is no room for complacency. Current wider uncertainties mean that the Service must be ready to respond to a wide range of pressures and incidents. Heightened vigilance and monitoring will continue throughout winter.

Scottish Executive – Health Department
18 October 2001

1.4 WINTER PLANNING IN NORTHERN IRELAND

Background

1.4.1 A Departmental report *'Facing the Future: Building on the lessons of Winter 1999/2000*, published in May 2000, reviewed the events of winter 1999 and set out a programme of action designed to ensure that the services could deal more effectively with pressures in the future. It also acknowledged that many services were increasingly coming under pressure all year round, and indicated that, in particular, intensive care and high dependency services needed to be strengthened.

1.4.2 Arising from that report, a programme of action was undertaken to improve the capacity and effectiveness of services. This included ensuring better co-ordination of service planning for winter, the provision of additional services, particularly medical beds, community care packages, extra GP and pharmacy services, as well as the implementation of best practice more uniformly across the service and better communication with the public. In planning for winter, the service is also considering the contingency arrangements that may be needed should demand outstrip supply.

1.4.3 To reduce pressure on hospital services, the influenza immunisation programme is being extended. Following on from the success of last year's programme, when 68% of over 65s were immunised, the target for vaccination this year has been set at 70%. The campaign has been publicised on local TV and radio. Promotional material, including posters and leaflets, have been widely distributed. In line with last year's practice, Health and social services employers have been requested to offer influenza immunisation to employees. We will be working hard to improve on last year's staff uptake of 11%.

1.4.4 Intensive care and high dependency provision has been extended by approximately 20% in the past year – 11 additional intensive care beds and 10 high dependency beds. Further increases in high dependency beds are being brought on stream this year and additional beds are planned until 2004.

1.4.5 Following on from *'Facing the Future: Building on the lessons of Winter 1999/2000*, a review of community care is also now under way. It is reviewing the implementation of community care policy, including services for elderly people. One of the issues that the review is looking at is ways of preventing inappropriate hospital admissions and reducing delays in discharge from hospital. An interim report from the review is due to be submitted to the Minister by the end of October and will be shared with Departments in England, Scotland and Wales.

Summary of Progress

1.4.6 Following the severe pressures on services during the winter of 1999, new winter planning arrangements were introduced to enable health and social services to deal more effectively with the annual peaks in demand for services during winter. At the same time, the Chief Medical Officer was commissioned to undertake an urgent review of critical care services. The Chief Social Services Inspector was asked to review community care services.

1.4.7 As a result of that work, Health and Social Services Boards now submit comprehensive winter plans to the Department each Autumn. These are prepared in collaboration with Trusts and the Primary Care sector and include the provision of extra bed capacity: last year, for example, up to 300 additional hospital beds were available. The service has been asked to plan for similar levels of extra provision this year.

1.4.8 Additional community care packages are also a feature of winter planning, including intermediate care schemes to reduce the need for inappropriate hospital admissions and help to ensure that people who do not need to be in hospital can be discharged. Enhanced primary care services, particularly GP and community pharmacy services, will again be available this winter.

1.4.9 In line with recommendations made by the Chief Medical Officer last year, intensive care and high dependency services have been expanded significantly (by approximately 20%) over the past year, and further high dependency beds are due to come on stream this year and over the following two years.

1.4.10 A fuller review of community care is also under way. It is reviewing the implementation of community care policy, including services for elderly people. One of the issues that the review is looking at is ways of preventing inappropriate hospital admissions and reducing delays in discharge from hospital. An interim report is due shortly.

1.4.11 To reduce the incidence of flu and flu-related illnesses, which often require hospital admission, an influenza immunisation programme is being run, as in previous years. Building on the success of last year's programme, in the course of which 68% of people over 65 were immunised, a target of 70% influenza immunisation rates has been set for this year. Health and social services employers have been requested to offer influenza immunisation to employees. We will be working hard to improve on last year's staff uptake of 11%.

Major issues

1.4.12 **Overall Capacity**: since 1995, the number of admissions to hospital has increased by 14%, while our bed numbers have reduced by 10%. Lengths of stay have shortened and bed occupancy levels have increased on average from 75% to 81%. However, in our major hospitals, occupancy rates in specialties such as general medicine and cardiology are frequently above 90%, especially at peak periods.

1.4.13 **Trolley Waits/Emergency Admissions:** with hospitals running at near full capacity in key specialties, trolley waits have now become a year-round phenomenon. Over the past year, the growth in emergency admissions (up 8% in the Eastern and Northern Board areas) has resulted in high numbers of trolley waits at hospitals throughout these areas.

1.4.14 **Delayed Discharges**: with increasing demand for health and social services, an increasing number of hospital beds are being occupied by patients awaiting discharge into the community. In some Trusts, up to 20% of beds are unavailable at peak periods because of delayed discharges. In many cases, health and social services in the community do not have the resources to provide packages of care such as nursing home places or domiciliary support to facilitate a patient's early discharge. Additional funding has been made available for community care services this year.

Conclusion/Points for Discussion

1.4.15 The integrated system of health and social services offers scope for comprehensive and co-ordinated planning across all sectors. All Boards have established multi-disciplinary teams to develop and co-ordinate their winter planning arrangements, covering both hospital and community sectors. Rapid response schemes, with multi-disciplinary team membership, have been introduced, which are able to target and treat people early in the community and prevent admission to hospital. Flu immunisation has been a success and is recommended for staff.

1.4.16 Health and social services are now experiencing almost all-year pressures, with high numbers of emergency admissions and trolley waits in many of our main hospitals. Even with well co-ordinated winter campaigns in place, it will not be easy to contain peak pressures this winter.

1.4.17 There is no simple solution to these problems, many of which are related to funding and capacity issues. Ministers will, however, wish to consider the effectiveness of winter planning in the past and, in particular, the extent to which initiatives aimed at boosting the role of primary care and developing the role of community schemes have been successful. They will also want to consider what further work could usefully be done in this area.

DHSSPS

October 2001

JOINT MINISTERIAL COMMITTEE ON HEALTH

NHS MODERNISATION PROGRESS

A Note by the Secretaries

Please find attached four papers by officials in the Department of Health, National Assembly for Wales, Scottish Executive Health Department and Department of Health, Social Services & Public Safety respectively. Each paper sets out the country's position on modernising health services and the major issues.

This is for discussion at the Committee's meeting on Monday 22 October.

Summary

The first stages of reforming the NHS in England, Wales and Scotland were published in the *NHS Plan (2000), Improving Health in Wales (2001*) and *Our National Health Plan (2000)* respectively. A three strand approach is being taken to reformation of health and social services in Northern Ireland- strategic management and direction, closer working with the Health and Social Services (HPSS) and promoting the HPSS as priority in the Executive Programme's for Government and its budget allocations.

There is a common focus on delivery across the NHS in Great Britain, in terms of ensuring robust arrangements to support implementation at the same time providing services and delivering clinical priorities. Structural change is in progress in all three GB countries with the aim of bringing the NHS closer to people and improving patients' experience. There is a need to sustain the momentum of these reforms.

Primary care reform, quality and governance are common on the reform agenda across the UK. A framework for modernising HPSS is expected to be shaped by a number of new developments including arrangements for primary care, decisions on the governance and the future pattern of acute hospitals and revised management arrangements. Priorities for Action introduced new planning and accountability arrangements and set out 95 targets for delivery but success is expected to hinge upon securing increased allocations for HPSS from the Executive's budget.

The Committee is invited to note the developments set out in the papers and may wish to exchange views on the following:

a) Managing the major risks and challenges facing each country
b) Managing the transition whilst continuing to maintain enthusiasm and momentum on implementation in the services;
c) Managing public perception of asymmetric delivery across the UK.

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2. NHS MODERNISATION PROGRESS

2.1 THE NHS PLAN

Background

2.1.1 The first stage of reform of the NHS was the publication of the NHS Plan (2000); this is a plan for reform with far reaching changes across the NHS. Outlined within the plan is a new delivery system for the NHS, offering standards and clinical frameworks set nationally.

2.1.2 The next stage is intended to see the centre of gravity move from Whitehall to front-line NHS. The new flatter NHS structure will help liberate local services so that they can get on with the business of reform, freeing over £100 million from bureaucracy for investment in front-line services.

2.1.3 The delivery strategy consists of an approach of:

- overarching policies, plans and strategies (including the NHS Plan) implementation arrangements
- support and development
- feedback and challenge.

2.1.4 This approach is applied across the six delivery priorities. The delivery plan is complex and has interconnected deliverables. To deliver this sustained programme of reform and modernisation, action is required from people and organisations across the whole system of health and social care.

2.1.5 A team of NHS leaders, patient groups, and frontline modernisers were appointed in September 2000 as members of the NHS Modernisation Board, to help drive forward the programme of work and hold the NHS to account. In addition, front-line NHS staff and patient group members have been brought together in eleven taskforces, they have been charged with driving forward the Implementation of the Plan. They are already playing a key role in highlighting and spreading good practice across the whole of the service.

Summary of Progress

Tackle cancer, cardiovascular disease and mental health and narrow the health gap by improving services

2.1.6 Steady progress is being made against a number of key targets underpinning this priority:

- Implementation of the Cancer Plan and Coronary Heart Disease National Service Framework (NSF)
- Investment of £450m (hypothecated) in cancer and CHD services in 2001/02
- Upgrading and expansion of equipment for diagnosis and treatment of cancer is well underway
- The targets for capacity expansion are being exceeded: the target of 6000 extra revascularisations from April 2000 to March 2003 will

be achieved during 2001; 140 rapid access chest pain clinics are already in place (target: 100 clinics by March 2002)

- Two regions are already meeting the standard to provide outpatient appointments within two weeks for suspected cancers and all other regions are making good progress
- 126 Local Implementation Teams are working effectively as local planning collaboratives for mental health services

Cut waiting times and improve emergency care

2.1.7 Recent figures show that the number of outpatients waiting over 26 weeks and the number of inpatients waiting over 12 and over 15 months are lower than a year ago.

- £30m has been allocated to Regions to tackle over 15 month waiters for in-patients
- All hospital trusts are now booking some patients in at least two specialities or high volume procedures. By end March 2002, 5 million patients will have benefitted from the National Booked Admissions Programme
- Over 24 hour trolley waits have been eliminated in all Trusts, and over 12 hour waits have been eliminated in the majority of Trusts
- Performance Improvement Plans have been introduced for areas at greatest risk ; a capacity mapping system has been introduced, and the Modernisation Agency is working with challenged Trusts

Improve the Patient Experience

2.1.8 Progress to date includes:

- £120m capital funding allocated to abolish Nightingale wards for older people. Refurbishment of 233 wards will commence this year, with completion in 2004.
- Ward housekeeping services are in place in at least some wards in 29% of acute hospitals and 23% of mental health hospitals.
- Action is in hand to reconfigure structures and establish modern matron posts
- The national NHS menu was launched in May, and Trusts have been issued guidance on implementation

Improve older people's care

2.1.9 A number of targets are forecast to be met, and some may even be exceeded:

- The NHS and Social Services are on track to meet targets for reducing emergency admissions and re-admissions for people over 75
- Recent data confirms that the rate of bedblocking by over 75s is 10% lower than the same time last year
- The target for increased numbers of intermediate care beds looks as though it will be exceeded by a significant margin

- G&A bed numbers have increased by over 700 beds from the 1999-00 baseline, to a total of 135,794, the first increase for over 20 years.

Modernise primary care

2.1.10 Good progress is being made on access to primary care professionals:

- 39 walk-in centres now open, with 43 NHS walk-in centres operating by end 2001
- Up to 600 more GPs by September 2001
- Access Fund set up for primary care (Funding of £84.5m this year, rising to £114.5m next year)
- Increased number of locally agreed Personal Medical Service contracts for primary care; coverage up from 5% to 20% of GPs in a single year
- All Health Authorities have in place Dentistry Action Plans to ensure everyone in the local area can access NHS Dentistry

Strengthen frontline capacity

2.1.11 The NHS plans to secure significant increases in medical and non-medical workforce numbers over 2001/02:

- 150 extra General Practice training places have been agreed
- March 2001 plans forecast increases of around 12,000 nurses in 18 months from September 2000 to March 2002
- By end July 2001, 1,298 nurses, midwives and health visitors had returned to the NHS since April 2001.
- 300 Spanish nurses recruited this year to date
- Negotiating documents have been circulated and discussed for a new contract for staff other than consultants, and a major job evaluation exercise has been conducted to underpin new salary structures. Proposals for the new consultant contract have been discussed with the BMA

Major Issues

Shifting the balance of power (StBOP)

2.1.12 Reform in the NHS has to come from within the NHS, and the balanceof power must be shifted towards frontline staff who understand patient's needs and concerns. The shift in the balance will be towards local communities so that they reconnect with their services and have a real influence over their development. The changes to the way the NHS works will require cultural change supported by structural change to align responsibilities and capacity at the most local levels:

- **Primary Care Trusts (PCTs)** will become the lead NHS organisation in assessing need, planning and securing all health services, and improving health. They will forge new partnerships with local communities and lead the NHS contribution to joint work with local government and other partners.

- **NHS Trusts** will continue to provide services, working within delivery agreements with PCTs. Trusts will be expected to devolve greater responsibility to clinical teams and to foster and encourage the growth of clinical networks across NHS organisations. High performing Trusts will earn greater freedoms and autonomy in recognition of their achievements.

- Approximately 30 **Strategic Health Authorities (SHA's)** will replace the existing 95 Health Authorities. They will step back from service planning and commissioning to lead the strategic development of the local health service and performance manage PCTs and NHS Trusts on the basis of local accountability agreements.

- The **Department of Health** will change the way it relates to the NHS, focusing on supporting the delivery of the NHS Plan. The Department of Health Regional Offices will be abolished and four new Regional Directors of Health and Social Care will oversee the development of the NHS and provide the link between NHS organisations and the central department. The Modernisation Agency, Leadership Centre and the University of NHS will support the development of frontline staff and services.

Performance Ratings

2.1.13 In September 2001 all non-specialist acute NHS Trusts were issued with performance ratings (stars) reflecting their performance during 2000/1. The star status assigned to organisations is based upon delivery of national targets and overall performance as measured against a balanced scorecard reflecting staff, patient and clinical focus. Performance ratings will determine the level of earned autonomy within which they will be able to operate, including the level of discretion allowed in the use of the Performance Fund. While the performance rating system provides a national driver for performance improvement at organisational level, the performance fund provides a lever for Chief Executives to use locally to incentivise improvement at clinical level. All organisations will receive a share of the Fund regardless of their performance rating.

2.1.14 A second set of performance ratings will be issued during 2002/3 covering *all* NHS organisations' performance in 2001/2.

Earned Autonomy

2.1.15 Depending on an organisations performance rating they will expect to receive different levels of earned autonomy. The best performing trusts can expect less frequent monitoring from the centre, fewer inspections by the Commission for Health Improvement, retention of more of the proceeds of local land sales for re-investment in local services, extra resources for taking over and turning round persistently failing Trusts, be able to establish private companies, and have the opportunity to shape national policy.

Local Modernisation Reviews

2.1.16 The purpose of the LMRs are to engage staff, patients and NHS partners in local government and the private and voluntary sector in reviewing what needs to be done to deliver the Plan locally. The findings from the reviews will be used to develop, with all local partners, robust three-year action plans that take a whole systems approach to bringing about health and service improvement, and both identify and address risks to delivery.

Modernisation Agency

2.1.17 The Modernisation Agency was launched in April 2001, helping NHS organisations reform their services to offer patients better, faster care. The Agency is already supporting 30,000 clinicians and managers to make change happen: to raise standards of service and improve access to services.

Improved co-operation between health and social care

2.1.18 The flexibilities provided for under the Health Act 1999 have achieved the necessary framework for improved co-operation between health and social care. The Act provides for the establishment of new 'Care Trusts', single organisations responsible for joint commissioning of health and social care services. Fifteen Care Trust demonstrator sites are preparing to go live from April 2002 to April 2003, receiving financial support for the preparatory period from the money recently announced to reduce bed blocking. Co-operation on the use of this money will be supported by the capacity planning being carried out by the local health and social care economy.

Points for Discussion

2.1.19 How do we manage the transition as new organisations (PCT's, SHA's etc) begin working to a more local agenda, when we have firm ongoing commitments to deliver on national targets put in place by the NHS Plan?

2.1.20 How can we continue to retain the enthusiasm and momentum for implementing the NHS Plan through the LMR process and StBOP, particularly over the winter period?

2.1.21 Are there any practices that can be shared in terms of addressing the workforce shortages?

2.2 IMPROVING HEALTH IN WALES

Background

2.2.1 Following the publication of "Improving Health in Wales" in February 2001, an Implementation Framework was approved and published by the Minister for Health and Social Services. This framework involved the establishment of a National Steering Group, an Implementation Group and nine working groups – "Task and Finish Groups" - to help implement the Plan. All groups were fully operational by April, involving hundreds of people either through membership of the groups or through new reference groups and other existing networks.

Summary of Progress

2.2.2 The progress of the work of the Task and Finish Groups is as follows.

Structures

2.2.3 This group's main priority was to produce a consultative document on structural change in the NHS. This was published on the 19th July 2001 with a three-month consultative period ending on the 19th October. This document made recommendations on the role, constitution and relationships of Local Health Boards as well as the role and structure of the NHS Directorate. It also examined the positioning of public health within the proposed structures. The Group is continuing its work on :

- professional advisory arrangements which will be subject to consultation later in the year;
- a full analysis of Health Authority functions and these have now been analysed for re-allocation to the National Assembly Local Health Boards and NHS Trusts. This will form part of the new core accountabilities for these organisations;
- the commissioning and planning processes which have been re-designed and guidance on the new requirements will be issued in October 2001;
- a detailed assessment on organisation development needs to enable a full implementation of the structural changes;
- the principles of the personnel processes for managing the changes within the NHS and full procedures will be out for consultation with staff in the Autumn 2001;
- accountability frameworks which are being developed and will be finalised early in December 2001.

Service Development

2.2.4 This group has taken on the major strategic work relating to the development of primary care and acute services. This includes making the acute services strategy for Wales operational (Access and Excellence) and the development of the NHS in taking a more central role in health advocacy and health improvement. The Group has created four main areas of work, three of which reflect these main strategic areas, and another addressing intermediate care and mental health. This group is also tasked with developing a Primary Care Action Plan by March 2002 to implement the findings of the Welsh

Primary Care Strategy consultation exercise. The consultation is running in parallel with the Structural consultation.

2.2.5 This will include comprehensive strategies for contractor professions, which are now being commissioned. Guidance has been drafted on the intermediate care and will soon be issued to the NHS and its partners to help in the planning of this new range of services. Attention will now turn to the complex issues of advising on clinical networks and health economies in line with the proposals within Access and Excellence. It is envisaged that the Group's work will pave the way to the establishment of a Planning Forum that will provide on-going advice on service development in support of the proposed Health and Well-being Partnership Council.

Finance and Assets

2.2.6 This group concentrates on three main areas - the management of the NHS Estate in Wales; the capital programme and implementation of the resource allocation review in Wales (The Townsend Review); and the various financial management aspects of the new NHS structure and the information needs of a renewed NHS Wales. In view of the importance of the information and information technology needs of the Plan an Information Task and Finish Group was established in August. It is making good progress in the development of a National IM&T Development Plan.

Workforce

2.2.7 The Workforce Group has in the first instance examined the many areas targeted by the HR Strategy and integral to all aspects of improving personnel practices and workforce planning. It is now analysing workforce futures to ensure that workforce planning, training and education is in line with future needs.

Performance Management

2.2.8 This group is researching a dynamic and new approach to performance management in Wales and has examined a wide range of systems. The performance management concept is being considered from a number of perspectives including: leadership and change; the mechanics of the system; primary care; health and local government; waiting times; public, patient and staff engagement; learning from others; ambulance services; clinical governance and information management and technology.

Health Challenges

2.2.9 This group is examining clinical networks, national service frameworks, clinical governance, research and development and children's services. Its work will be complete by the end of the year, but a system will be needed in its place to oversee the implementation of National Service Frameworks in the future. Significant progress has been made in putting in place cancer networks, and networks for coronary heart disease. It is also looking at a generic approach to the implementation of national service frameworks.

Patient Focus/Public Involvement

2.2.10 This Group is looking at the wide area involved in developing patient and public engagement. It has been given the responsibility for advising on the implementation of the patient information and support proposals and is

also involved in looking at the future role and functions of Community Health Councils and the implications of the Kennedy Report.

Public Health Review

2.2.11 The Public Health Review has completed the first stage of its work, in which it has considered the role and positioning of public health in terms of the structural proposals for NHS Wales. Two further stages of work are proposed. Stage 2 will consider building capability across the public health family in Wales, and Stage 3 to produce "Better Health Better Wales Mark II".

Joint Working

2.2.12 The Joint Working Group was stood down after completion of its work on strategic partnerships, which will now form part of the legislation underpinning the implementation of the Plan. The organisational development process will progress the work of this group to produce guidance on the planning mechanisms and public service accountabilities.

2.2.13 It is envisaged that all Task and Finish Groups should all be stood down between now and next summer. Any on-going work required beyond this will be taken forward by standing advisory mechanisms as necessary.

Next Steps

2.2.14 Attention is now turning to managing the transitional process and organisational development needs. A transitional Organisational Development Sub-Group is working under the auspices of the Structures Task and Finish Group to put together a preliminary structural change programme and the various organisational development issues. This is early preparatory work that will be completed when the Health and Social Services Committee of the National Assembly endorse the way forward on the 7th November.

2.2.15 The role and remit of a National Health and Well-Being Partnership Council is being developed. It is envisaged that at an appropriate time in the New Year that this would succeed the Steering Group currently overseeing the implementation process.

2.2.16 An Implementation Programme is also under development. The programme will articulate the undertakings in the Plan into specific action to guide the remaining work of the Task and Finish Groups, to inform future planning work and to assist in the performance management of the Plan. The Programme is being made flexible enough to accommodate new influences on the sector and to accommodate the need to implement change while running the service effectively and efficiently.

Conclusion

2.2.17 Significant progress has been made since the publication of the Plan. The next phase, in managing the structural changes and in organisation development, are of crucial importance. This of course includes the legislative requirements to implement the structure through both primary and secondary legislation. Integral to this work is the need to ensure that health services for patients served across the England and Wales border is not adversely affected through the changes affecting both countries.

2.3 NHS MODERNISATION PROGRESS IN SCOTLAND

Introduction and Background

2.3.1 The Scottish Health Plan, *Our National Health, a plan for action, a plan for change*, which was developed through an inclusive process, was launched in December 2000. By summer 2001, a quarter of the 261 commitments in *Our National Health* had been implemented.

2.3.2 The main themes of *Our National Health* and some major areas of progress are:

Improving health by building a national effort to improve health and reduce inequalities

- appointed National Diet Co-ordinator
- planned Healthy Scotland Convention for November

Rebuilding our National Health Service with national standards, increased accountability, streamlined bureaucracy, and integrated planning and decision making

- reaffirming the NHS in Scotland as one *national* service – NHSScotland
- strengthening governance, accountability and stakeholder involvement by streamlining the 43 separate board structures and establishing 15 new unified NHS Boards
- introduced a Performance Assessment Framework to improve accountability of NHS Boards to local communities and to the Scottish Executive
- published first report by the Clinical Standards Board for Scotland comparing local performance against national standards for treatment of CHD
- developed NHS24 to be launched early in 2002

Improving the patients journey with reduced waiting, better fairer access, and increased flexibility

- published national frameworks and plans for maternity services, children's services and the health of homeless people
- improved access to Primary care services with the Personal Medical services schemes,

Involving people with patients given a stronger voice and people and communities involved in the design and delivery of services

A lifetime of care with a new priority for the health and well being of children and older people

- established the Scottish Commission for the Regulation of Care and the Scottish Social Services Council
- introducing free nursing care for the elderly from April 2002

Working in partnership, with staff, local authorities, public and voluntary agencies, patients and the public

- promoted primary care development through Local Healthcare Co-operatives

Major Challenges

2.3.3 The major challenges that we will have to deal with if we are to successfully deliver our commitment to the development of patient centred, responsive, high quality, modern healthcare services are:

- workforce issues: labour supply and NHS pay
- generalising best practice in service redesign, including reducing waiting
- removing barriers to change: financial systems and contractual arrangements
- the need to address the organisational, professional and financial barriers between health and social care

Issues for discussion

2.3.4 The increasing proportion of older people and reducing working population will provide many challenges for healthcare services in the future. Alongside that, advances in science and medicine, coupled with rising public expectations, create significant pressures for the NHS. Against this background, the Chancellor has commissioned a study of future health trends. Continued close co-operation across the UK in this area will be important.

Scottish Executive Health Department
18 October 2001

2.4 MODERNISING THE HEALTH AND PERSONAL SOCIAL SERVICES (HPSS)

Background

2.4.1 Since the establishment of the Executive in December 1999, it has become evident that the HPSS has not been given in the past the priority it deserves:

- There had been chronic under-investment both in terms of delivering services and in renewing and modernising buildings and equipment;
- As a result of successive years of a policy of cash savings some £190m, in today's money, had been taken out of the service;
- The service had not kept pace with developments in Great Britain and still reflected many of the characteristics of the 'internal' market, including the continuation of GP Fundholding;
- Crucially there had been no long term investment in the workforce to ensure the availability of trained staff to meet the increasing demands across the whole spectrum of services;
- There was still too much emphasis on dealing with illness rather than prevention.

Summary

2.4.2 To date progress in modernising the HPSS has been markedly slower than that evident in England, Scotland and Wales.

2.4.3 This is largely due to:

- The scale of the problems inherited by the Executive in relation to the HPSS;
- The continuing acute pressures on front-line services across the entire spectrum; and
- The absence, to date, of the scale of 'growth' funds available in the other countries.

2.4.4 Despite this, considerable progress has been made in identifying the strategic direction for key services and in putting in place strengthened arrangements for management and accountability in the service.

Approach

2.4.5 Action to tackle these problems has been based on three main strands;

- A range of measures to provide strategic management and direction;

- Closer working with the HPSS to resolve the immediate problems which are evidencing;

- Arguing the case for the HPSS to be accorded the appropriate priority in the Executive's Programme for Government and its Budget allocations.

Process

2.4.6 Strategic direction has been set out in a range of key areas;

- Winter planning, including the provision of intensive care and high-dependency beds;

- Residential child care;

- Education and training of nurses;

- Modernisation of the Ambulance Fleet.

2.4.7 A range of further initiatives, subject to consultation, is under way;

- Future arrangements for primary care;

- A public health strategy "Investing for Health";

- Arrangement for setting standards for quality and governance;

- The future pattern of acute hospitals;

- A development plan for Cardiology and Cardiac Surgery;

- Reviews of community care and renal services.

Priorities for Action

2.4.8 Because of the annuality of the Budget process it is not feasible at this stage to devise a medium-term Plan for modernisation linked to resources. Following the publication of the Programme for Government in February 2001, the Minister issued a set of specific objectives and targets for the HPSS called 'Priorities for Action'. This introduced new planning and accountability arrangements in the HPSS and set out 95 targets which the service is expected to deliver in 2001-02.

Resources

2.4.9 Funding for the HPSS has not kept pace with that for the NHS and Personal Social Services in England. During the 1990s, the HPSS budget grew by 35% in real terms: in England, growth amounted to 57%. Matters

have worsened as a result of Spending Review allocations. For example, if the HPSS had got an uplift in 2001-02 equivalent to England's, it would have brought an extra £83m into our budget. The draft Budget for 2002-03 recently published by the Executive provides an additional £31m on top of the baseline allocation. The Departmental bid was for £122.6m which even then was just to meet inescapable commitments and top-priority developments. That figure, even if it had been achieved would not have enabled the HPSS to match the level of investment in modernisation evidenced in England. In the event the outcome falls short of meeting inescapable commitments and as a result much needed developments will not be possible, and it will be necessary to defer the introduction of free nursing care.

Way Ahead

2.4.10 A number of important policy developments, work on which is currently underway, will shape a framework for modernising the HPSS. The key developments include:

- New arrangements for primary care, including the abolition of GP Fundholding and the creation of new local Health and Social Care Groups;

- A new cross-cutting public health strategy, called "Investing for Health";

- Decisions during 2002 on the future pattern of acute hospitals, on the foot of a major report on acute hospital services and management structures;

- Revised management arrangements, following the Executive's Review of public administration.

- The outcome of the current review of community care.

2.4.11 Progress on delivering on this new framework for modernising the HPSS will depend critically on the provision of significant additional funds to bring the growth of the HPSS back into line with that being achieved in England.

DHSSPS
October 2001

JOINT MINISTERIAL COMMITTEE ON HEALTH

COMMUNICATION AND CO-ORDINATION

A Note by the Secretaries

Possible paper to follow from the Minister for Health and Community Care in the Scottish Executive.

JOINT MINISTERIAL COMMITTEE ON HEALTH

NHS PAY MODERNISATION FOR ALL STAFF GROUPS

A Note by the Secretaries

A paper will follow from Department of Health officials, setting out progress on NHS Pay Modernisation talks (*Agenda for Change)*, and negotiations on the Consultant and General Practitioner contracts.

This is for discussion at the Committee's meeting on Monday 22 October.

JOINT MINISTERIAL COMMITTEE ON HEALTH

FREE NURSING/PERSONAL CARE

A Note by the Secretaries

Please find attached four papers by officials in the Department of Health, National Assembly for Wales, Scottish Executive Health Department and Department of Health, Social Services & Public Safety respectively. Each paper sets out the country's position on free nursing and personal care.

This is for discussion at the Committee's meeting on Monday 22 October.

Summary

Arrangements implementing free nursing care in all settings are in force in England and will come on stream in Wales following statutory directions later this month. Implementation in Scotland is expected to commence in April 2002 subject to the passage of an enabling Bill currently before the Scottish Parliament. Primary legislation is in progress in Northern Ireland to allow the introduction of free nursing care in nursing homes, however further resources are needed before provisions can be commenced. Wales and Scotland are expecting to reimburse nursing care costs at a flat rate weekly figure. There are 3 bands of registered nursing care need in England.

All GB countries are taking a wide range of measures to improve services for older people but unlike Scotland, there is no commitment to introduce free personal care in England. Both Northern Ireland and Wales are committed to examining the costs and implication of free personal care.

Responsibility for financing the range of free care differs between Scotland and England, being based on ordinary residence in Scotland and registration with a GP in England. Anomalies arising from cross-border relocation will need to be addressed and arrangements made between the responsible authorities- numbers of people moving are not expected to be significant.

Officials are maintaining contact on these developments.

The Committee is invited to exchange views on the differences in direction of travel across the UK.

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5. FREE NURSING/PERSONAL CARE

5.1 FREE NURSING CARE IN ENGLAND

Summary of Progress

5.1.1 As from this month NHS nursing care has been made free in all settings in England. People identified as needing nursing-home care will no longer have to meet any of the costs for the registered nurses involved in their care, or for the specialist equipment used by these nurses. Instead, the NHS will meet these costs. People who can afford to do so will still have to make a contribution towards their personal care and accommodation costs while in a nursing home.

5.1.2 The introduction of free nursing care in every setting is designed to provide the right incentives to the NHS and social services to work together to provide the modern quality care that people need. It will encourage the NHS to provide rehabilitation services that people are able to benefit from. It will reduce the perverse incentive to discharge people too early to social services funded care.

5.1.3 The changes for free nursing care are being introduced in stages. From October 2001 people who are funding their nursing home placement themselves ('self-funders') will no longer need to pay for the registered nurse care they receive. The NHS will be responsible for paying for this care with effect from this date.

5.1.4 The situation for people who are currently receiving some financial support from social services will remain unchanged until April 2003. People who are already resident in a care home, or who enter a nursing home after October 2001 and are being supported by social services will have their means assessed by councils to determine the contribution they should make to their care (as is currently the case). When the cost of registered nursing care for all people in nursing homes becomes an NHS responsibility, all those currently resident will be assigned to an appropriate band of nursing need, based on individual care plans and assessment records.

5.1.5 In the period between October and April 2003, anyone assessed as needing nursing home care that needs financial support from their local council, will continue to have all the costs of their care (including care from qualified nurses) paid for by their local council.

5.1.6 In England, nursing care will be provided through a Primary Care Trust. They will pay up to £110 per week (on average £85 per week) for nursing care. The bands of registered nursing care need each correspond to a level of funding (the indicative bands have been set initially at £35, £70 and £110 per week respectively). HAs will receive an additional allocation of funds to cover these costs of nursing care.

5.1.7 Responsibility for financing nursing care in England will be based on registration with a GP, rather than the ordinary residence rules applied by councils. For a variety of reasons, a large proportion of nursing home

placements are made at some distance away from the individual's place of residence prior to them entering a nursing home and this will continue to be the case after the introduction of free nursing care. In these circumstances, the PCT where the individual lives prior to entering a nursing home should notify the PCT responsible for the nursing homes so that the receiving PCT can plan nursing care services in its area effectively.

Major Issues

5.1.8 In Scotland, the existing rules relating to ordinary residence will apply in regard to free personal care. Someone will have to be ordinarily resident in Scotland in order to get free personal care. A person moving to a home in Scotland will remain the responsibility of the LA in England making the arrangements and, as such, will not receive free personal care. The LA making the arrangements will continue to be responsible for the person's care management and funding and for the contract with the home.

5.1.9 Henry McLeish and Alistair Darling are in contact with each other about the possibility that the Scottish approach to implementing free personal care will mean the withdrawal of entitlement to Attendance Allowance and Disability Living Allowance. Their discussions are continuing.

5.2 FREE NURSING/PERSONAL CARE IN WALES

Background

5.2.1 Following the Royal Commission on Long Term Care and the introduction of the Health and Social Care Act 2001, similar arrangements are being made in both England and Wales to implement a regime of NHS funded registered nursing care for self funders in nursing homes. This will remove the anomaly in the funding arrangements for long term care, where only self funders pay for their registered nurse care – it is free in all other settings, Start up of the new arrangements in Wales will be triggered by a Statutory Direction for the NHS later in October to take on this new responsibility. At the same time guidance will be issued to health authorities and local authorities, a Users Guide published and a more general announcement made to the Care Sector.

5.2.2 There is no commitment to introduce free personal care in Wales but an amendment to an Assembly plenary motion commits us to examine the implications as part of the developing Strategy for Older People in Wales, due to be published in draft in April 2002. Low key work is looking at the financial and other issues but significant changes would require primary legislation.

Summary of Progress

5.2.3 Announcement by the Minister of Health and Social Services about start of arrangements in Wales due following completion of consultation on 19 October. We are obliged to consult for longer than the 5 weeks (including August) allowed in England

Major Issues

5.2.4 Consultation in Wales has heavily favoured standardised funding model rather than the banded arrangements in place in England.

5.2.5 Differences likely in benefits of policy to self-funders between England and Wales ie in England 10% will receive £35 per week, 45% - £70 and 45% - £110. In Wales, all will receive at least £90 per week (final figure to be agreed).

5.2.6 Cross Border arrangements will need to be agreed by relevant authorities in England and Wales at am operational level

5.3 FREE NURSING/PERSONAL CARE IN SCOTLAND

Background

5.3.1 The Care Development Group was set up by the Scottish Executive in February 2001. The Group was asked to bring forward proposals to develop long term care and to implement free personal care. The main conclusions of the Group were:

- significant progress with the policy was possible, within the budgetary provision that had been made
- for those in care which are currently self-funding, a flat rate payment should be made of £90 a week for personal care, and for those needing nursing care an additional £65 a week. These sums reflect the current average costs for those in similar circumstances whose costs are currently paid from the public purse. They also assume continued DWP payment of £55 per week for Attendance Allowance – see above
- personal care currently provided in peoples' homes should be free of charge, from April 2002
- there should be a renewed impetus behind the development of better services at home, to allow more old people to stay in their homes for longer.

Summary of Progress

5.3.2 The Scottish Executive issued its initial response to the Royal Commission Report on Long Term Care in October 2000. This included a commitment to introduce free nursing care. Following a subsequent Policy Review, the Scottish Executive agreed in January 2001 to bring forward proposals for the implementation of free personal care for older people. Detailed proposals by a Care Development Group were published in September 2001. An enabling Bill is now before the Scottish Parliament with a view to implementation of the new arrangements in April 2002.

Major Issues

Cross-border cases

5.3.3. We have no reason to expect significant migrations of older people to Scotland to be assessed and placed in care here, in order to benefit from free personal care. But we are asking local authorities to monitor the situation carefully. Cross-border placements (i.e. where an old person is assessed as needing care by a local authority on one side of the border, but for personal or family reasons wants to be placed on the other side of the border) will continue under existing arrangements. Again, the operation of this may need to be kept under review.

Long Term Cost of the Policy

5.3.4 The Care Development Group concluded that, on a plausible set of assumptions, the cost would increase significantly in real terms over a 20 year period – but that the additional cost of the policy was not highly material in relation to the projected real-terms increase in the costs of existing health and

social policies, over the same period. An argument difficult to counter, politically – but the real terms increase and the cost of the policy over time is obviously a potential problem.

Interaction with benefits policy.

5.3.5 A difficulty has arisen here because DWP do not agree with the Care Development Group's recommendation that savings on the loss of eligibility for Attendance Allowance (which ceases when another public body pays for care costs) should be recycled to fund the Scottish Executive's new policy. This presents a resource problem for the Scottish Executive – but more broadly, may indicate the need for a more holistic approach, across Government, to the interrelationship of social security benefits and other social policies. The immediate consequence for the Scottish Executive if the disagreement with DWP cannot be resolved, is likely to be delay in the expansion of personal care services at home.

Practicalities of implementation

5.3.6 The new policy will be implemented through local authorities and the burden being placed on them, against a tight timetable, should not be underestimated.

Pressure to extend the policy to England and Wales

5.3.7 We acknowledged that some such pressures are appearing, e.g. from Age Concern. But it is important in this, as in other areas of devolved responsibility, that we acknowledge that policy divergences of this kind are a logical consequence of the devolution legislation, and that in devolved matters no administration should feel pressurised to adopt the same priorities as the others.

Conclusion

5.3.8 Work will now proceed with local authorities on the practicalities of implementation. It is intended that the proposed payments to those in care homes should start in April 2002 (subject to further consideration of amounts in the light of the DWP difficulty) and that charges for personal care provided at home should be removed, also from April 2002.

Scottish Executive Health Department
18 October 2001

5.4 FREE NURSING/PERSONAL CARE IN NORTHERN IRELAND

FREE NURSING CARE

Background

5.4.1 Following the Assembly resolution in February 2001 that the recommendations of the Royal Commission on the Long Term Care for the Elderly be implemented in full, the Executive agreed, in principle, to the introduction of free nursing care in nursing homes from April 2002. However, the scenario envisaged in the Executive's draft budget proposals, announced on 25 September 2001, does not provide sufficient resources for the introduction of free nursing care.

Summary of Progress

5.4.2 Primary legislation to allow for the introduction of free nursing care in nursing homes is being introduced into the Assembly in the near future but unfortunately the relevant provisions will not be commenced until the necessary resources are made available by the Executive.

5.4.3 The Chief Nursing Officer has set up a working group to consider and make recommendations on the assessment tool for free nursing care. This work, which is drawing on that undertaken in Scotland, England and Wales, is continuing and an assessment tool is to be piloted this month.

Major Issues

5.4.4 The scenario envisaged in the Executive's draft budget proposals, announced on 25 September, does not allow for the introduction of Free Nursing Care from April 2002 The estimated costs were in the region of £9m per year.

Conclusion/Points for Discussion

5.4.5 The intention to introduce free nursing care for nursing home residents from April 2002 will be deferred under the scenario envisaged in the draft budget.

5.4.6 It will be important to consider this decision in the context of what has been and is going to be decided for England, Wales and Scotland regarding the provision of Free Nursing Care.

FREE PERSONAL CARE

Background

5.4.7 Following the Assembly resolution in February 2001 that the recommendations of the Royal Commission on the Long Term Care for the Elderly be implemented in full, the Executive agreed to commission an interdepartmental expert group to examine the implications and costs of introducing free personal care here, drawing on the findings of the Scottish Care Development Group.

Summary of Progress

5.4.8 An interdepartmental expert group has been commissioned by the Executive to examine the costs and implications of introducing free personal care here.

5.4.9 The first meeting of the group took place on 8 October, at which the terms of reference and programme of work were agreed.

Major Issues

5.4.10 A major element of the work will be the assessment of costs and the consideration of equality and New TSN implications of introducing free personal care - initial estimate of costs was in the region of at least £25million per annum.

Conclusion/Points for Discussion

5.4.11 The Executive will consider the way ahead in relation to personal care once it has received and examined the report from the interdepartmental group.

5.4.12 It would be useful to consider the implications of the different approaches being pursued.

DHSSPS
October 2001

JOINT MINISTERIAL COMMITTEE ON HEALTH

LESSONS FROM BRISTOL AND ALDER HEY

A Note by the Secretaries

Please find attached a paper by officials in the Department of Health setting out the issues and learning from the Bristol Heart Inquiry and Alder Hey Hospital experiences.

This paper is for information.

Summary

The Public Inquiry into Children's Heart Surgery was commissioned by the then Secretary of State, Frank Dobson in 1998. The report was published this summer with 198 recommendations. Its broad philosophy is in line with the direction set by the NHS Plan and indeed, Professor Kennedy who chaired the Inquiry reported that the NHS had moved on from the time of the terrible events.

A number of the recommendations were accepted immediately in England. A Government response was promised for autumn and it is expected for November subject to the pressures of Parliamentary business.

Evidence arose from the Bristol Inquiry that the largest collection of retained hearts in the country was at Alder Hey Hospital in Liverpool. The recommendations of the interim report of the Inquiry were taken into account in the Chief Medical Officer's report on *The Removal, Retention and Use of Human Organs and Tissue from Post-Mortem Examination*, published in January 2001. Ministers accepted the 17 recommendations of the CMO's report. Action is being taken forward which focuses on informing and empowering patients. A Retained Organs Commission has been set up to oversee the return of retained organs where families wish. There is a fundamental review of the law on taking and using human tissue backed by commitment to clarify existing legislation further. Complementary changes may be expected to the Coroner's system in the light of a Home Office review.

Northern Ireland and Scotland are undertaking independent reviews of the relevant legislation and may wish to make changes. Officials are in contact across the four Health departments and consideration is being given to the cross-border timescales for bringing new legislation forward.

The Committee may wish to note.

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6. LESSONS FROM BRISTOL AND ALDER HEY

6.1 Bristol

Summary

6.1.1 Professor Ian Kennedy submitted 2 reports:

- Interim Report ' Removal and retention of human material' (published in May 2000).
- The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. (Published July 2001).

6.1.2 The recommendations of the Interim Report were taken into account in the CMO's report 'The Removal, Retention and Use of Human Organs and Tissue from Post-Mortem Examination' published in January 2001. A number of recommendations from the main report were accepted in England immediately:

- A national director of children's healthcare services (Professor AL Aynsley Green);
- Publication of information for patients and parents about the question they should ask before consenting to treatment;
- A specialist patients' advocacy and liaison service (PALS) in every Trust by April 2002;
- The establishment of a new independent office for information on Healthcare Performance within the Commission for Health Improvement (CHI);
- The establishment of an overarching regulatory body for the healthcare professions (already proposed in the NHS Plan);
- The development of a new code of professional conduct for NHS managers.

Major issues under consideration

6.1.3 The broad philosophy of Professor Kennedy's Report is very much in line with the direction set out by the NHS Plan and the recently published consultation document "Involving Patients and the Public in Healthcare". We envisage that the Government's Response will provide an opportunity to set out the nature of the Department's role in England vis à vis the NHS:

- To establish the resource framework
- To establish priorities
- To commission appropriate standards of care either through the National Institute of Clinical Excellence (NICE) or the National Service Framework (NSF) process;
- To ensure that appropriate independent regulation of staff is in place;
- To ensure there is a strong inspection function.

While this is moving in the direction of Kennedy it rejects Kennedy's central premise of the independence of the standard setting process.

6.1.4 We therefore envisage that the DH Response will centre around:

A regulatory framework for quality;

- Strengthened and expanded role of CHI in providing independent inspection;
- NICE guidance to be mandatory;
- Non-statutory Council for the Quality of Healthcare;
- Establishment of the Office for Information on Healthcare Performance.

Changes to Professional Regulation

- The establishment of the Council for the Regulation of Healthcare Professionals;

Clinical Negligence Review – White Paper to be published next year.

Health Information

- Improving the information which is available to patients and the public

Children's Services

- Fast tracking the NSF module on acute care;
- Other detailed recommendations to be considered in the development of the NSF;

Patient and Public Involvement

- The development of PALS, the Consent Initiative and VOICE

Leadership initiatives and cultural change

- Development of the Leadership Centre and role of the Modernisation Agency.

6.1.5 The Government's response has been promised in the autumn. Subject to the pressures of Parliamentary business, we envisage that it will be presented to Parliament mid-November.

Conclusion

6.1.6 DH officials are keeping in touch as work on the Government Response progresses. We recognise the particular interest in respect of:

The Health Bill

- Strengthening the role of CHI - (NAW is not planning to introduce a 'star rating' system)
- The establishment of the Council for the Regulation of Healthcare Professionals
- Patient empowerment (NAW intends to retain and strengthen CHCs)

- The role of NICE in standard setting

(Committed to NICE guidance being mandatory in England, (manifesto commitment)- there is no similar commitment in Wales)

6.1.7. Officials will also keep in touch about the timing of the presentation of the Response to Parliament to enable appropriate arrangements to be made in the Devolved Administrations as relevant.

6.2 ALDER HEY

Background

6.2.1 The Royal Liverpool Children's Hospital (Alder Hey) Inquiry arose after evidence given to the Bristol Inquiry indicated that the largest collection of retained hearts in the country was at Alder Hey. This was a fact finding inquiry including an investigation into the extent to which the Trust had complied with the requirements of the Human Tissue Act 1961. The report, by Michael Redfern QC, was published on 30 January 2001.

6.2.2 The findings and advice from the Chief Medical Officer's national investigation into organ retention were also published in January 2001[1] and these took account of both the Alder Hey and Bristol Inquiries insofar as they related to organ retention.

Summary of Progress

6.2.3 The CMO made 17 recommendations accepted by the Minister, in respect of issues around the retention and use of human organs, specifically targeted to recognise and address the key problems which had come to light through the Alder Hey and Bristol Inquiries and his own investigation into organ retention. Action is now in train to implement all of these recommendations in England. These actions focus on:

- providing better information for families when an autopsy takes place (to include a new code of practice on communications at this difficult time);
- obtaining valid consent from families for any removal, retention or use of organs or tissue (to include new consent forms and information leaflets to ensure that people can make informed decisions about autopsies and organ retention);
- setting up a Retained Organs Commission (to consider the national archives of organs and to oversee the return of retained organs where families wish this);
- a fundamental review of the law on the taking and use of human tissue (this subsumes a commitment to clarify and extend the Human Tissue Act to ensure valid parental consent for the taking of children's organs and provide a penalty for breaches);
- education for the public and training for professionals (to improve openness and understanding of all the issues surrounding the taking and use of human organs);
- improving bereavement services (including the appointment of bereavement advisers in NHS Trusts);

[1] *"The Removal, Retention and Use of Human Organs and Tissue from Post Mortem Examination" "Report of a Census of Organs and Tissues Retained by Pathology Services in England"*

- links through the Home Office (to establish linked and complementary changes to the Coroner's system, the subject of a parallel review in the Home Office).

Major issues emerging

6.2.4 It was clear from the findings of both Inquiries and from CMO's investigation that there were large archives of human organs and tissue at a number of centres across the country. Valid consent had been obtained for some of the samples in these stores in accordance with the terms of the Human Tissue Act, but by no means for all. Even where consent had been obtained it was often poorly understood. The Act itself was also open to misinterpretation. In addition, the Alder Hey and Bristol Inquiries demonstrated a lack of understanding between health professionals and the public and a gulf between the expectations of each in terms of why and how human organs and tissue could be removed and used.

6.2.5 In essence, the law needed to be clarified, professional attitudes needed to catch up with modern public expectations (for information, to be part of the decision-making process etc.), valid consent was needed for autopsy and for the taking and use of organs, and a major public and professional education exercise would be necessary to counteract poor understanding on both sides.

6.2.6 An attempt earlier in this year to draft a short Bill to amend the Human Tissue Act to improve practice concerning the taking and use of children's organs (for which Parliamentary time was not available) demonstrated that drafting legislation in this field would be complex.

Devolution aspects

6.2.7 Cross border issues - England, Northern Ireland and Scotland are undertaking independent reviews of the relevant legislation and may wish to make changes. Consideration to be given to cross-border timescales for bringing new legislation forward. Contact is established at official level. No particular issues are anticipated in Wales, where there are no powers to legislate.

6.2.8 In Northern Ireland, England and Wales the law is the same and any changes made are likely to align. In Scotland, the final report of the review group is due to be with the Minister for Health & Community Care at the end of October. As part of the process of consulting on those recommendations, the Scottish Executive Health Department will want to ensure that there is consistency of legislation across the UK as a whole.

RESTRICTED

JOINT MINISTERIAL COMMITTEE ON HEALTH

ECJ RULINGS AND CROSS-BORDER HEALTH CARE

A Note by the Secretaries

Please find attached a paper by officials in the Department of Health setting out the issues arising from the recent ECJ rulings and subsequent domestic developments.

This paper is for information.

Summary

The announcement by the Secretary of State for Health in August, to remove the obstacles in the NHS Act 1977 which prevent health care commissioners in England and Wales from purchasing health care directly from providers in other EU countries for UK residents, was prompted in part by legal advice from leading Counsel that developments in European Community law had made the traditional interpretation of the NHS Act that commissioners were limited to UK providers, unsustainable. Whilst the NHS was still arguably not a service for remuneration in terms of the Treaty, this position would become difficult to sustain where treatment is being commissioned from the private sector in the UK. Arrangements are in hand in Scotland to ensure that legislation is in line with the ECJ rulings. There are already powers under Northern Ireland legislation to refer patients abroad. A UK-wide approach needs to be taken on the wider implications of the rulings for purchasing care home services abroad.

The changes offer an additional option for commissioners of healthcare to find additional capacity whilst local services are being expanded, and may therefore be a boost to efforts to reduce waiting times. Nevertheless, there are a number of legal, clinical and quality difficulties to resolve if this is to be a viable alternative for patients. Pilots are in progress in South-east England and the results should inform the production of Department of Health guidance. The Devolved Administrations will want to consider the extent to which they wish to use the new opportunity to commission care abroad.

The Secretary of State also announced that the operation of the existing system for referring patients to other EU countries under Community law, the so-called E112 system would be reviewed to ensure that it operates transparently and effectively.

Officials across the four Health departments are in contact on these developments.

The Committee may wish to note.

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7. ECJ RULINGS AND CROSS-BORDER HEALTH CARE

Background

7.1 The traditional interpretation of the National Health Service Act 1977 is that it prevents health authorities and trusts commissioning treatment from service providers in other member states. This interpretation can no longer be sustained following recent ECJ rulings. In the joined cases C-157/99 Geraets-Smits and Peerbooms and Case C-368/98 Vanbraekel[2] the ECJ ruled that some hospital services may be services for the purposes of the Treaty (and therefore fall within EC single market rules) if they are provided for remuneration. It should be pointed out that these cases concerned insurance-based systems which differ in important respects from the UK system. On this ground, therefore, and on another more technical (but important) ground it is still arguable that services provided by health authorities from public funds are not services within the meaning of the Treaty. However, this may be more difficult to argue where the health authority or trust commissions treatment from the private sector.

7.2 Increased use of the private sector is of course central to NHS reform. It is because the judgements make clear that there are hospital services in Europe that provide services that are within Treaty rules on free movement of services that the traditional interpretation of the 1977 Act set out above is no longer tenable. The possibility therefore arises of health authorities and trusts commissioning treatment for their patients in other Member States.

7.3 The position with regard to individuals seeking treatment in another Member State under the E112 system set out in EC Regulation 1408/71 remains in principle largely the same as before. The Court found that that a system of prior authorisation was justified as long as it was based on objective, non-discriminatory criteria which are known in advance and on a procedural system which is easily accessible and ensures that a request for authorisation will be dealt with objectively and impartially within a reasonable time. In addition refusal must be capable of being challenged in judicial or quasi-judicial proceedings. However, the Court made clear that authorisation may not be refused where treatment cannot be obtained in the home state "without undue delay". Further, where a national condition for authorisation requires that the treatment be regarded as "normal in the professional circles concerned", regard must be had to what is normal, tried and tested in international medical science and not limited to what is regarded as normal in the state concerned.

Summary of Progress

7.4 In the light of these rulings Secretary of State announced on 28 August that he would clarify the law to make clear that the NHS could commission treatment from other Member States of the EU, as part of their wider efforts to reduce waiting times. Since the NHS Act 1977 covers England and Wales DH officials are consulting NAW colleagues on the necessary amendments. Northern Ireland legislation already contains power to refer patients abroad. Scottish colleagues are considering with solicitors to what extent their legislation requires amendment.

[2] Judgment given in both cases on 12th July 2001

7.5 Once any necessary amendments to legislation are made it is matter for the Department of Health and the Devolved Administrations to what extent they wish to use this new opportunity to commission care abroad. To address the practical issues involved in sending NHS patients abroad for treatment the Department of Health is currently working with three Health Authorities within south-east England to pilot sending NHS patients to mainland Europe. It is intended that patients will receive treatment abroad before the end of the year. The Department will produce guidance for the NHS based on the pilot. Devolved Administration colleagues are being kept informed of progress. The much greater geographical distance of Scotland from mainland and the low level of private sector health care purchasing are amongst the reasons why Scotland may have less interest in sending patients abroad. Further action in Scotland is therefore likely to be based on an evaluation of the possible benefits and implications for patients in Scotland and as yet, there are no plans for a pilot.

7.6 Secretary of State has also announced a review of the E112 system under which individuals currently wishing to go abroad for treatment apply for the costs of treatment to be met from NHS funds. 1100 authorisations were made under the E112 scheme in the year 2000. Colleagues in the devolved administrations are involved in that process. Meanwhile the E112 scheme will operate in parallel to the pilot scheme since this is a legal requirement under EC law. The new arrangements for direct purchasing will be an additional flexibility for health authorities rather than a replacement scheme.

7.7 As far as social care is concerned, at present the National Assistance Act 1948 prevents local councils from making placements in care homes outside England and Wales. Although mechanisms exist to allow people to be placed in homes in Scotland and Northern Ireland, they are not straightforward. There are no arrangements to make placements in the Channel Islands or the Isle of Man.

7.8 The Health and Social Care Act 2001 enables regulations to be made to allow councils in England and Wales to make and pay for residential care placements in Scotland, Northern Ireland, the Channel Islands and the Isle of Man. This will allow people needing residential care to have care closer to their families and friends. The provisions allowing cross-border placements to be made within the UK are due to come into effect next year.

7.9 In addition, the decision to allow the NHS to purchase healthcare abroad has implications for social care placements. Demand for a social care placement in another country might arise for example if a person living in England, who had originally come from Southern Ireland, wanted to be placed in a care home in Ireland to be near their relatives. John Hutton, when MS(C), corresponded with his opposite number in Dublin on this issue. A consistent approach needs to be taken UK-wide to any implications arising from the ECJ rulings for purchasing care home services abroad. A Community Care and Health Bill is currently being prepared for consideration by the Scottish Parliament and has to be in line with the implications of the ECJ judgements to avoid being ultra vires. Department of Health officials are currently looking at the wider implications of the rulings and are in touch with counterparts in the Devolved Administrations.

Major Issues

7.10 Sending NHS patients abroad raises a number of legal, clinical and quality issues. It is essential for the credibility of the policy that patients receive high quality care, that they find the experience acceptable and that commissioners receive good value for money. It is also vital that the policy is presented as an opportunity for hard-pressed commissioners to access further capacity rather than being seen as an admission of NHS failure.

7.11 The mere fact of perhaps several thousand patients receiving care abroad in this way each year may provide a catalyst for change in hospital systems here and abroad. German hospitals currently contracted to provide secondary care to UK Army personnel stationed there have made changes to accommodate UK citizens' expectations of hospital care, changes which have also been welcomed by local patients. Similarly, positive patient experiences of hospital care abroad may have a significant impact on patients' expectations of the NHS.

7.12 The UK has long argued in Europe that although the Community has competence in public health (and is very active in supporting Community activity in that area) the EU does not have any locus in the organisation or financing of health care. Indeed, the UK has always argued strongly that hospital services and their organisation are matters for Member States, not the Community. Article 152(5) of the Treaty specifically says that Community action "shall fully respect" Member State responsibilities. However a wide range of other Community activity – for example in the regulation of medicines, medical device, medical qualifications and employment law – all have an impact on health care systems.

7.13 As mentioned above, the longstanding interpretation of the NHS Act 1977 has been that Secretary of State and his agents have no general power to purchase treatment for NHS patients abroad.. The ECJ's recent rulings have already caused a significant change in this interpretation and have led to the recent change in policy in this country The next expected ECJ judgement (Muller – Van Reit) is specifically about waiting times We are therefore considering the longer-term implications of the ECJ judgements – and other EU developments – on the competence issue. Again, officials in the devolved administrations are fully involved.

Conclusion

7.14 The ECJ rulings have led to a significant change to existing health policy. DH officials are currently working with NHS colleagues to facilitate patients travelling abroad for treatment as soon as possible. Officials will share reports on progress with colleagues in the Devolved Administrations. Ministers in Devolved Administrations may wish to indicate whether their local health economies are likely to want to take advantage of this new opportunity.

7.15 There is the possibility that the Court may produce further judgments with far-reaching implications. The UK and other Member States may need to consider what action the Council should take in response. Ministers in Devolved Administrations may wish to comment.

JOINT MINISTERIAL COMMITTEE ON HEALTH

CONSUMER PROTECTION ACT - HIGH COURT RULING AND HEPATITIS C COMPENSATION

A Note by the Secretaries

Please find attached a paper by officials in the Department of Health setting out the issues arising from the recent High Court ruling on compensating for hepatitis C arising from blood transfusions.

This paper is for information.

Summary

In March this year, the High Court awarded damages to 114 people who had been infected with hepatitis C virus during the period between the coming into force of the Consumer Protection Act (CPA) and the introduction of hepatitis C screening for blood donors in the UK. Negligence was not the issue but the ruling increases moral pressure on Government(s), especially for other Groups seeking compensation.

Following the CPA High Court ruling, the Scottish Executive announced in August a decision to settle outstanding legal actions brought under the Act by Scottish blood recipients infected with hepatitis C. However, the Parliament's Health & Community Care Committee published a report in October calling for financial and other support to all patients infected with hepatitis C through blood and blood products irrespective of whether negligence has been proven. This moves away both from established policy and the strict liability basis of the High Court ruling. UK estimates put numbers infected in the 1980's, prior to the availability of screening at around 4000 people with haemophilia, 679 identified non-haemophiliacs (114 of them in the CPA case) and a further 4000-5000 people who cannot be traced. A financial settlement based on these figures would be very costly - around £200m based on payments to haemophiliacs 10 years ago, excluding the cost of more targeted financial support such as help with mortgages.

A number of arrangements may need to be looked at again in the light of this ruling. For instance, ex-gratia payments made 10 years ago to haemophiliacs and non-haemophiliacs infected with HIV from blood and blood products which do not extend to haemophiliacs infected by the same route with hepatitis C. Current policy across the UK is that the NHS does not pay compensation where it is not at fault.

The Committee may wish to note.

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8. CONSUMER PROTECTION ACT - HIGH COURT RULING AND HEPATITIS C COMPENSATION

Background

8.1 On 26 March 2001, the High Court awarded damages on a no fault basis under the Consumer Protection Act 1987 (CPA) to a group of people infected with hepatitis C through transfused blood. The 114 people who received damages were infected between March 1988 (when the CPA came into force) and September 1991 (when hepatitis C screening for blood donors was introduced in the UK). This was a very strict product liability interpretation of the provisions of the CPA for "defective" products post March 1988 (when the Act came into force). Negligence was not an issue. Claimants must take action under the CPA within 10 years of the injury. Anyone who got hepatitis C through blood who has not yet initiated proceedings is therefore likely to be timed out.

8.2 Initial damages in 6 test cases ranged from around £10,000 to around £45,000 depending on severity of illness, loss of earnings etc. The average payments are between £20,000 and £35,000, although one claimant has been awarded £200,000 because of loss of high earnings. Total cost around £4m. Claimants may be entitled to further damages in future if their condition worsens (eg progression from chronic symptoms to end stage liver disease).

8.3 Prior to the High Court ruling, ex-gratia payments were awarded in 1990/91 to 1,280 haemophiliacs in the UK infected with HIV through contaminated blood products pre 1985. The Macfarlane Trust, established in 1998, made regular payments to haemophiliacs with HIV/AIDS "in need of assistance, or their needy spouses and other dependants after the death of the person". Special payments were later extended to non-haemophiliacs infected with HIV through blood through the Eileen Trust (a sister Trust to Macfarlane).

8.4 However, compensation was not paid to haemophiliacs infected with hepatitis C through contaminated blood products (also pre 1985)- Frank Dobson announcement in July 1998. This was in line with the general principle that individuals are not compensated in cases of non-negligent harm. The previous Government had reached the same conclusion and to date this position has been held across the NHS in the UK

Issue

8.5 On 29 August 2001, the Scottish Executive announced a decision to settle outstanding legal actions under the CPA by Scottish blood recipients infected with hepatitis C.

8.6 On 2 October 2001 the Scottish Parliament Health Committee published a report calling for financial and other support (eg help with mortgages, counselling etc) for all NHS patients who contracted hepatitis C through blood and blood products regardless of whether negligence has been proven.

Major Issues

8.7 The Scottish Executive decision is equivalent to the new status quo in England following the High Court ruling. However, the Scottish Parliament Committee report

puts pressure to move away from the policy that the NHS does not pay compensation where it is not at fault (ie that there should be no payments to haemophiliacs and others with hepatitis C or those who have not initiated legal action under the CPA). That line would be difficult to sustain in the rest of the UK if the Scottish Executive commits to the Scottish Parliament report.

8.8 The CPA ruling in England has awarded damages on a strict liability basis to people infected with hepatitis C through blood after 1 March 1988. The ruling does not benefit those who were infected pre 1988. Nor does it give any legal rights to compensation for haemophiliacs or those infected after March 1988 who did not take legal action. However, it arguably increases the moral pressure on Government. A financial settlement on up to 4,000 haemophiliacs plus anything up to 5,000 others infected with hepatitis C through blood would be very costly and would set precedents for other groups seeking compensation. For example, to give 4,000 haemophiliacs £25,000 each - the sum awarded initially to haemophiliacs with HIV 10 years ago - would cost £100 million and up to double that if non-haemophiliacs were included. It is not possible to estimate the cost of the more targeted financial support (eg help with mortgages) recommended by the Scottish Parliament.

Further Background

Hepatitis C

8.9 Hepatitis C is spread primarily by contact with the blood of an infected person. Currently the main route of transmission in the UK is the sharing of contaminated equipment by injecting drug misusers. Most patients with hepatitis C live out their normal lifespan. Hepatitis C is cleared in about 20% of cases, but persists in about 80% to become chronic infection. Most of those with chronic infection will have only mild liver damage, many with no obvious symptoms. Others will suffer from skin and digestive problems and severe fatigue. About 20% of patients with chronic infection develop cirrhosis after 20-30 years. Studies indicate that about 1-5% of patients with chronic infection may develop liver cancer.

Treatments for Hepatitis C

8.10 Interferon alpha treatment has limited success rate (around 20% of those treated) and is unsuitable for all patients. Combination drug therapy appears to be successful in clearing infection in around 40% of cases. Liver transplantation can be an effective treatment for patients with cirrhosis associated with chronic hepatitis C infection.

Hepatitis C Strategy

8.11 In March 2001 the Department of Health set up a Steering Group to oversee development of a strategic approach to hepatitis C, covering prevention, control and treatment. A document for consultation with the NHS, professional bodies and the voluntary and community sectors will be produced in late 2001 for Ministers to consider.

Affected Groups

8.12 Around 0.5% of the UK population may be chronic carriers of hepatitis C infection. Many people were unknowingly infected during the 1980's by hepatitis C

through blood and blood products before the virus itself was identified and isolated, and before the procedures existed to eliminate it. These included:

- up to 4,000 haemophiliacs infected through contaminated clotting factors, mostly pre 1985 before viral inactivation techniques were developed. Of these, around 200 may have died to date as a result of their infection;

- 679 non-haemophiliacs infected in England through transfused blood prior to 1991 identified through a look back exercise. Plus an estimated 4,000 to 5,000 others who cannot be traced. Additional cases have been identified in Scotland, Wales and Northern Ireland.

8.13 Of the 679 identified blood recipients infected with hepatitis C in England, around 470 were infected after the CPA came into force and 114 of these took part in the group action and received damages in the High Court.

Payments to Haemophiliacs with HIV

- £24m initial settlement in 1990 (£20,000 per person)

- £44m in a further settlement in 1991 (amounts varied)

- £25m through the Macfarlane Trust to date (via monthly payments, single grants and special winter payments). Payments by the Trust to surviving registrants, their widows and dependant children currently total around £2.8m pa.

Justification for HIV Scheme

8.14 Exceptional circumstances - life expectancy at the time for haemophiliacs with HIV was dramatically reduced and there was no treatment. In addition there was a huge stigma attached to those infected no matter how the infection was acquired.

Haemophilia Society Campaign

8.15 A financial settlement for haemophiliacs with hepatitis C is one of the aims of the Haemophilia Society's *Carpet of Lilies* Campaign. The other aims are a public inquiry into the infection of haemophiliacs with HIV and the provision of synthetic clotting factors for all haemophilia patients in England. Ministers have rejected the first two aims. The call for synthetic clotting factors is being considered as part of SR2002.

No Fault Compensation

8.16 Compensation in general is only paid where legal liability can be established and where it can be shown that: (i) there has been negligence (through act or omission); (ii) there has been harm; and (iii) and that the harm was caused by the negligence.

8.17 HMG has undertaken to explore no fault compensation as a means of saving time and costs in achieving settlements. But there is no promise that it will be introduced.

Other Groups Seeking Compensation

- RAGE (Radiotherapy Action Group) – patients who have suffered permanent damage as a result of breast cancer but failed to win damages in the courts. Ministers have maintained the line that no scheme will be introduced for this group but that Trusts must pay compensation where harm has been caused by clinical treatment and negligence can be established;

- Bristol Royal Infirmary Inquiry Cases – No compensation has been offered by the Department. Parents will be taking action through the courts;

- Retained Organs – Parents are taking action through the courts.

- Myodil Action Group – seeking compensation for alleged injury following use of Myodil, a diagnostic agent. It has been established that there is no basis for a negligence claim against the Department or MCA and, on that basis, the Department has refused compensation.