The All Party Parliamentary Group on HIV and AIDS
Health White paper response

Liberating the NHS

The new White Paper recognises that good health is much more than curing illness, and that the government's role in supporting health goes beyond what is provided by the NHS. Prioritising public health and aligning all areas that contribute to it, for example NHS, social care and children's services, through local authorities is very welcome.

We also welcome the proposed ring fence for public health and the principle of a public health premium. We look forward to receiving further details in the Public Health White Paper.

Ensuring the public health and patient treatment functions of the NHS work together.
Like many other conditions, HIV crosses into both public health and individual treatment. There are some cases where it is difficult to separate the two. For example when someone is diagnosed with HIV, supporting them to disclose to their partner and to protect their partner from infection is a public health as well as a personal health issue. It is vital that the two arms of health delivery are in close communication with each other and there is clarity about who funds what.

The GP consortia/special health commissioning boards and the local authorities will need to work together to create Joint Strategic Needs Assessments and to share out responsibilities. The GP consortia/ NHS commissioning boards should therefore sit on the local health and community well being boards.

Care pathways that cross public health/NHS treatment boundaries must also be clear. For example, public health programming should include opt-out HIV screening in certain settings to reduce the level of undiagnosed HIV in the UK. However, as soon as someone is identified as HIV positive from a screening test, they will need to access personal care. *The pathways from public health to personal care should therefore be clear, with no risk of patients being lost to follow up.*

Including a domain in the NHS Outcomes framework which captures the specific NHS responsibility and contribution to screening, testing and diagnosis, to the prevention of illness and infection and to broader public health will help incentivise and drive good cooperation between the two arms of health provision.

Public health promotion
Where treatment and care for a condition is commissioned directly by the NHS Commissioning Board it may make sense for prevention of that condition to be organised at a regional level as well.

HIV prevention tailored to the local community is very important. However sometimes it will be appropriate for local authority Well Being Boards to work together, since populations are mobile and HIV does not respect boundaries. This may help achieve economies of scale and coordination efficiencies and impact. This will be particularly important in urban areas with a large number of local authorities.

We look forward to reading the Public Health White Paper and seeing how its proposals link in with the proposals in the Liberating the NHS paper.

The All Party Parliamentary Group on HIV and AIDS response to:
Commissioning for Patients

How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?
It will make sense to have some high value, low volume services commissioned directly by the NHS Commissioning Board, and we believe that HIV treatment and care will probably fall under this category.

GP consortia, particularly in areas of low prevalence, may struggle to find the expertise necessary to commission HIV treatment and care locally and this may not, in any case, be a cost-effective approach. The NHS commissioning board, working on a regional basis would be well-placed to deliver the expertise and the economies of scale needed for HIV commissioning.

This is a model that is already working. HIV outpatient care was removed from the Specialised Services National Definitions Set in 2009 but some areas have none-the-less opted for specialist joint commissioning and this has been very successful.

Pan London HIV Commissioning has created an easily accessible service for patients that delivers high quality care. Regular meetings are held between commissioners and providers, good audit structures are in place, and those who work in the specialised commissioning body have a high level of understanding of the complexities of HIV. The London Procurement Programme has also delivered excellent value for money on prescribing costs.[1]

Open access/ patient choice principles
Many patients with HIV choose to access testing, treatment and care outside of the area in which they live, often for confidentiality reasons. Localised commissioning should not limit such freedoms. *It is important that whatever models is chosen for HIV diagnosis, treatment and care, the open-access, self-referral principles currently present in GUM are maintained.*

Commissioning HIV treatment in secure settings
We welcome the proposal that the Specialist Commissioning Board be responsible for commissioning in prisons. *We recommend that this includes immigration detention and removal centres.*

What support will GP consortia need to help them manage risk?
Commissioning HIV treatment and care services on a regional basis will limit GP Consortia's exposure to the financial (insurance) risk associated with low volume high cost interventions.

How can GP consortia best be supported in developing their own capacity and capability in commissioning?
The APPG understands the potential benefits of GP led commissioning which are stately clearly in the White Paper. GPs are in general well placed to have an overview of a populations care needs as they are the first port of call for most patients.

However, this is not currently the case for people living with HIV, the majority of whom go to a specialist HIV clinician for most aspects of their care – even if they are seeking advice on a health issue that is only indirectly linked to their HIV status.

[1] The September 2010 stakeholder workshop convened by BMS with HIV clinicians and commissioners and other HIV experts was of this view.

HIV clinicians have historically been better equipped than GPs to understand interaction of other medicines with anti-retrovirals and to deal with the possible side effects of HIV medicines. HIV clinicians are used to dealing with people living with HIV and therefore patient experiences of stigma in specialised settings are very rare.

Unfortunately reports of HIV stigma in primary care settings are not rare. Therefore the bond of trust and understanding of needs that exists between most patients and their GPs is not necessarily present for people living with HIV, many of whom have not even told their GPs that they are living with the virus. As provision of HIV services migrates from specialist to primary care, the trust is likely to develop gradually.

If GPs are to take on a greater role in the commissioning and provision of care for people living with HIV in future, *there will need to be investment in training for GPs,* many of whom may have an outdated understanding of life with the virus. Training on stigma issues will be particularly important.

In the medium term there is a strong case for commissioning of HIV treatment and care to be undertaken directly by the NHS Commissioning Board both for economic and quality of care reasons.

What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?
Third sector organisations may need help to compete with wealthier private sector providers. Local organisations that provide a service tailored to a community's specific needs can sometimes provide the best services to the end user but sometimes lack the technical bid writing capacity to compete with slick national operations. At a time when charities' funding is being cut, it may be particularly difficult for them to find funds up-front to make their case.

It is important that companies are not allowed to put out loss-leading bids for work, in order to monopolise the market later.

What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?
We welcome the explicit duty of the NHS Commissioning Board and GPs Consortia to address inequality of outcomes. HIV predominantly affects vulnerable groups in the UK who aside from their HIV status already have worse health outcomes – these include men who have sex with men, and black Africans.

It is important that the views of patients with stigmatised health conditions or from disadvantaged groups are heard and to avoid the 'he who shouts loudest, wins' approach. *Groups of people living with HIV need to be resourced and supported to take part in the accountability process and patient confidentiality needs to be assured.*

The All Party Parliamentary Group on HIV and AIDS response to:

Transparency in Outcomes: a framework for the NHS

(Q 5) Do you agree with the five outcome domains that are proposed in Figure 1 as making up the NHS Outcomes Framework?

(Q 6) Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?

The consultation document rightly states that there will 'be outcomes that can only be delivered for patients and carers if the NHS works in partnership with the new public health service that will be created and with social care services' [2.20]. It states that separate outcomes frameworks will be developed for public health and social care to encourage such 'an integrated cross-service approach'. But to achieve such integration we need all services, including the NHS, specifically to have outcomes requirements relating to such cross-service activity.

The APPG supports NAT's (the National AIDS Trust) proposal that the NHS Outcomes Framework include an additional domain which captures the specific NHS responsibility and contribution to screening, testing and diagnosis, to the prevention of illness and infection and to broader public health.

This domain could be called 'Ensuring public health and prevention benefit from the provision of NHS services'. It would be the key 'point of contact' with relevant and integrated outcomes for public health and social care, and thus help ensure full integration of the NHS, the Public Health Service, and Local Authority health improvement and social care services.

Design Principles for Outcome indicators (P 48)
Isolating outcomes that are achieved by healthcare from outcomes achieved by public health and social care is going to be extremely difficult and might force the exclusion of certain important indicators. For example, the NHS indicators suggested on p53 on acute hospital admissions will often be affected by timely diagnosis which will be the product of good public health practices.

The APPG understands that each part of healthcare (public health, NHS and social care) must be evaluated for its own contribution to health but this should not be at the expensive of evaluating performance in areas which cannot easily be segregated.

Domain 2 Long term conditions

(Q 15)As well as developing Quality Standards for specific long-term conditions, are there any cross-cutting topics relevant to long-term conditions that should be considered?
Three underlying principles are proposed for managing long-term conditions: treating the individual, functional and episodic outcomes, and meeting the needs of all age groups. These are all good principles. It may be worth considering an additional principle of 'timely diagnosis'. This is important in most long-term conditions and certainly in HIV.

Improvement areas: The annex to the Outcomes consultation includes a number of indicators for improvement areas (page 53). This is a very incomplete list missing out many major conditions, of which HIV is one. *Good HIV outcomes data for example on emergency hospital admissions, and suppressed viral load one year on from treatment commencement is already available and should be included in this table.*