‘Refreshing the Mandate to NHS England 2014-15’: consultation on the NHS Mandate

I. The RCGP welcomes the opportunity to respond to the Department of Health’s consultation on refreshing the NHS Mandate.

II. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 49,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

III. We gratefully acknowledge the contributions of our members in formulating this response.
Our response

Summary

1. We welcome this opportunity to comment on the refreshed NHS Mandate. In particular we are supportive in principle of the concept of a ‘named accountable clinician’ for vulnerable older people discussed in the consultation document. The number of patients with a variety of complex conditions is rising and GPs are at the forefront of diagnosing individuals and managing their care. A more integrated health service is essential if we are to address the health needs of an ageing population.

2. However, we have serious concerns about the fact that no mention is made in the consultation document of the need for more resources in general practice in order to address the funding, workload and workforce challenges in primary care. Proper investment in primary care is key to achieving many of the objectives set out in the new Mandate. We are therefore asking NHS England to develop and publish proposals for how it intends to shift greater investment from secondary to primary care to match the movement of care out of hospitals.

3. Many of the measures announced are based around further integration of health and social care, and we welcome wholeheartedly the Government’s commitment to this agenda. We are pleased to see recognition of the role of GPs in delivering integrated care. However, we have a number of concerns around continuing barriers to integrated care, such as the lack of shared record keeping, the payment by results system in hospital care, and the possible abolition of practice boundaries, which have not been addressed in this consultation.

Detailed response

Please note that we have responded only to the questions that are of greatest relevance to patient care in general practice.

Question 4: What views do you have on using the refreshed NHS Mandate to strengthen A&E services?

4. A&E services are a vital part of the health service and we welcome the emphasis on strengthening those services in the refreshed Mandate. However, we view A&E as only one part of a wider emergency and urgent care system, in which GPs play a very
important role. As such we would like the NHS Mandate to reflect this and to make commitments to strengthen the emergency and urgent care system as a whole.

5. We welcome the fact that £100 million of the £500 million announced for improving A&E services will be set aside for primary, community and social care, although we note that there was no specific mention made in the Department of Health’s recent statement concerning funds directed to general practice. However, we feel that a more fundamental review of how we shift more NHS funding into general practice will be key to achieving the Government’s aspirations in this area and other aspects of the Mandate.

6. The lack of proper coordination between services also has a large part to play in the strain placed on A&E, particularly the lack of coordination between health, community and social care in the care of frail elderly patients which leads to unnecessary admissions. We have commented on the issue of integration in Question 12 below.

**Question 5:** What views do you have on the proposal to reflect NHS England’s ambition to diagnose and support two-thirds of the estimated number of people with dementia in England?

7. Whilst in principle we support efforts to increase the number of people who receive an accurate diagnosis of dementia at a time that is right for the patient and their family - a process that will largely take place in General Practice - we feel that setting a specific target in this area is not an effective means of achieving this. Dementia is a complex condition that is often difficult to diagnose accurately, and we are concerned that setting a specific target will increase the risk of misdiagnosis and false positives, especially given that the reasons behind current variation in diagnosis rates are not well understood. Not every person with dementia will find the advantages of an early diagnosis outweigh the possible disadvantages, and if a person’s wellbeing is not enhanced by receiving a diagnosis, then it should not be forced upon them. A better approach would be to ensure NHS England supports GPs to overcome the barriers to delivering earlier diagnosis to more patients who have dementia. In addition, once a diagnosis has been made the resources that are needed to properly treat the condition, such as memory clinics, have insufficient coverage nationwide. In order to deliver an earlier diagnosis for more people who have dementia, significant investment in general practice itself and in services such as memory clinics will be needed.

8. The RCGP has published a position statement on dementia setting out the following key principles:
Approaches to diagnosis and treatment must be shaped first and foremost by the needs and expressed wishes of the individual patient, their families and carers. Interventions to improve the accuracy and timeliness of diagnosis, in particular in the early stages of the disease, and efforts to increase diagnostic rates must be based upon the best possible evidence with regard to the effectiveness and efficiency of different ways of doing this. Routine screening of an unselected population is not supported by the evidence.

Clinicians need to be equipped with the skills and knowledge to identify those people who require further assessment in order to enable an earlier, more timely and accurate diagnosis and make appropriate referral decisions in conjunction with the patient, families and carers.

Recognition and treatment of other causes of cognitive impairment is a key role of general practitioners and other health professionals working in primary care.

Co-ordination of approaches for referral, assessment, and treatment in particular across the boundary between health and social care is essential.

**Question 8:** What views do you have on the ambitions and expectations for the vulnerable older people’s plan?

9. We welcome the Government’s acknowledgement that care for vulnerable elderly people needs to improve, and that GPs will play a vital role in achieving this. We want to support and contribute to the Government’s initiative as it is taken forward.

10. In principle we support the proposal to introduce a named accountable clinician for vulnerable elderly patients, and recognise that GPs would be best placed to act as that named clinician. However, there is a lack of understanding over how the introduction of a named accountable clinician would differ from the current system in operation within GP surgeries. In addition, the way in which the named clinician will be held accountable and for what is not currently clear.

11. Already, when patients register with a practice they are nominally allocated to an individual GP for administrative purposes. Although patients may see a number of different GPs within a particular practice, when booking appointments, most practices will ask patients who their usual or preferred doctor is, and seek to accommodate this if at all possible.

12. However, while GPs may be the best placed clinician to hold responsibility for vulnerable older patients, their ability to discharge this will need to be underpinned by the practical systems and clinical time required to enable the effective co-ordination of care. It is
therefore vital that this policy is underpinned by the provision of additional resources to enable GPs to carry out this role for the growing number of patients who need it.

13. In addition, there is a need to distinguish between proactive care planning and responsibility for responding to unscheduled care needs, including out of hours. While a named clinician may be able to take on responsibility for the former, it is unrealistic to expect a single person to be continuously available to deal with the latter, particularly given the growing number of GPs who work on a part-time basis.

14. One possible model for overcoming this challenge is the development of multi-disciplinary micro teams. These provide continuity of care to identified groups of patients such as those at the end of life, and can involve a range of mechanisms such as buddying, job sharing, and organized handover systems.

15. The lack of joined up IT systems and shared patient records is likely to pose a significant barrier to the effective information sharing that would be necessary to truly realise the benefits of the named clinician proposals. In addition, in order to make the concept of a named clinician effective, there will be a need for providers of secondary care to improve the way in which they communicate with surgeries concerning patients. At present, secondary care providers follow a variety of different practices when selecting which GP to communicate with concerning a patient on a practice’s list. If there is to be a named accountable clinician, it will be important to ensure that in future, they are copied into all correspondence concerning those patients for whom they have responsibility.

**Question 9:** What views do you have on how we should achieve our ambitions on the vulnerable older people’s plan, particularly on how to strengthen primary care?

16. Many of the Secretary of State’s proposals chime with the College’s own vision for the future of general practice, ‘The 2022 GP’. We have consistently championed the role that GP-led care planning can play in delivering better outcomes for vulnerable elderly patients and others. In addition, GPs have been at the forefront of using technology to improve patient care – for example many GPs already use email and telephone extensively to communicate with patients as described in the Government’s proposals.

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1 Royal College of General Practitioners (2012), General Practice and the Integration of Care http://www.rcgp.org.uk/policy/rcgp-policy-areas/-/media/Files/Policy/A-Z-policy/General_Practice_and-the_Integration_of_Care%20_An_RCGP_Report.ashx

17. However, our principal concern is how GPs can be expected to implement the proposals in the context of the huge funding, workload and workforce crises currently facing general practice. There has been consistent underinvestment in general practice in recent years and in next decade rising demand is likely to continue to outstrip supply. An urgent package of investment in primary care is needed to ease immediate pressures on the system and ensure that patient care is safeguarded. As a first step, spending on general practice must increase by at least 10% to take it up to 10% of total NHS spend.

18. We support patients being given greater control over their care, particularly through shared decision making which we believe is most effective when based on a strong patient-doctor relationship. We have concerns, however, about elements of the Government’s proposals around ‘Enhanced Choice and Control’; particularly the reference to building on the findings of the GP choice pilots. The pilots have seen a very poor uptake after the first nine months, and we would therefore urge extreme caution in using evidence from them as the basis of future policy making.

19. The RCGP is strongly opposed to the idea of abolishing practice boundaries on the basis that it will put vulnerable patients at risk. The best way to support patients is for them to be seen by a GP who has a good understanding of the needs of the local community and can work with other services in a joined up fashion, and abolishing practice boundaries would work against this.

20. We strongly support the need for better access for patients, and believe that the best way to ensure this is to invest in increasing the capacity of general practice as the hub for the development of the expanded provision of integrated community care. In the RCGP 2022 vision of general practice we see general practitioners of the future working within federations, networks and multidisciplinary teams, with colleagues in nursing hospital and community services collaborating together in order to deliver more integrated care for the benefit of their patients.

21. However, we have concerns about some of the proposals around access and out of hours care. In terms of rapid walk-in centres, we do not believe that they are necessarily effective in reducing demand elsewhere in the healthcare system, nor that they are necessarily well placed to offer the kind of services most likely to be appropriate to the frail elderly. We are also concerned that there is still a lack of recognition of the extensive role that GPs currently play in delivering care 24/7. GPs currently provide extended hours, often work beyond closing time, provide care in urgent care centres, do out of
hours shifts, and work in hospital emergency departments. It is worth noting that the most recent GP Patient Survey found that just 2% of patients say they are “very dissatisfied” with their surgery’s opening hours, with the vast majority “satisfied” or “very satisfied”.³

**Question 10:** How should the ambitions for vulnerable older people be reflected in the refreshed Mandate?

22. We have responded to this question in our answer to question 12 below.

**Question 12:** What views do you have on updating the objective to reflect NHS England’s role in supporting person centred and coordinated care?

23. We support the Government’s commitment to person centered and coordinated care, particularly the ambition to have fully integrated services by 2018, and welcome the intention to reflect this in the Mandate.

24. However, we have serious concerns about the potential of the £3.5 billion integration fund being used in practice to plug gaps in social care. The joint NHS England and Local Government Association ‘Statement on the Health and Social Care Integration Transformation Fund’ states that “flexibility must be retained to allow for some of the fund to be used to offset the impact of the funding reductions overall”.⁴ In addition, in taking decisions about the use of the integration fund a high priority should be given to proposals to support GPs in the Named Accountable Clinician role by putting in place the resources and systems needed for care planning.

**Question 14:** What views do you have on updating the existing objective to reflect the challenge for NHS England to introduce the ‘friends and family test’ to general practice and community and mental health services by the end of December 2014 and the rest of NHS funded services by the end of March 2015?

25. We support in principle the idea of empowering patients to make informed decisions about their care, and strongly support the collection and evaluation of feedback by GP

³ NHS England and IPSOS MORI (2013), GP Patient Survey - Results
http://practicetool.gp-patient.co.uk/Ccg/Search?id2=N7%200QH&index=0

surgeries as a means of improving their services. However, we have significant reservations about the emphasis placed on the friends and family test as a measure of quality in general practice. A single question survey taken from an unstratified sample is neither useful nor reliable, and will not assist patients in making informed choices based on their priorities for their care.

26. The existing GP Patient Survey presents a much more valuable resource for patients. Not only does it cover a number of different issues, allowing patients to make decisions about their healthcare based on those aspects that are most important to them; the results are also representative down to practice level. We see no need to introduce another test when the GP Patient Survey is in existence. Within this context it is perhaps worth noting that the GP Patient Survey already has a question about whether patients would recommend their GP surgery to someone who has just moved into the local area. 80% said they would definitely (49%) or probably (31%) recommend their local surgery.

**Question 16:** What views do you have on the proposal to update the Mandate for NHS England to work with Monitor towards a fair playing field for providers?

27. We have significant concerns about the effect that enforcing competition between providers would have on primary care and the NHS as a whole. It is our view that increased competition at a practice level is likely to increase fragmentation, damage local services and hamper integration and continuity of care.

28. The primary challenge faced by general practice is capacity and it is vital that Monitor’s work on the creation of a fair playing field does not detract from the ability of NHS England to focus on this overriding strategic priority.

29. The principle should be that, where there are good local services, it is not necessary artificially to seek to impose a diversity of providers. Crucially commissioners, in conjunction with local communities, are best placed to judge the needs of their local communities.

30. In addition, it is a serious concern to us that differing obligations with regard to education and training between different types of providers will not only lead to an ‘unfair playing field’ but will harm the overall health system – by denying trainees exposure to some types of cases. We would argue that a clear standard requirement around education and training should be included in all contracts for those providing NHS services.
31. We have previously given our full position on this issue in our response to Monitor’s consultation on the Fair Playing Field Review.5

**Question 19:** What views do you have on the proposal to be more explicit on the expectation around reporting?

32. We fully understand the need and place for reporting in general practice. However, we have significant concerns about the form this reporting might take.

33. We also have reservations around the criteria against which differences in care between GP surgeries will be judged. GP surgeries throughout the country face vastly differing challenges in terms of the needs of their local communities and the resources that are available to them. Any method of reporting must take into account these differences.

The RCGP welcomes the opportunity to respond to this consultation and looks forward to further dialogue with the Department of Health on this subject.

Please do not hesitate to contact me if you have any questions about our response.

Yours faithfully,

Professor Amanda Howe MA Med MD FRCGP

Honorary Secretary of Council

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5 Royal College of General Practitioners (2012), Response – Monitor consultation on Fair Playing Field Review

http://www.rcgp.org.uk/policy/rcgp-consultations/~/media/Files/Policy/Closed%20consultations/RCGP%20response%20to%20Monitor%20Fair%20Playing%20Field%20Review%20-%20for%20the%20benefit%20of%20patients.ashx