Department of Health consultation on Equity and Excellence: Liberating the NHS

1. I write with regard to the Department of Health consultation on Equity and Excellence: Liberating the NHS.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 42,000 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.

3. We shall make every effort to influence the outcomes of these reforms in a way that reflects the core principles of excellent general practice, which has already been shown in international research to be highly effective and efficient.

4. The College welcomes the opportunity to respond to this consultation, and has considered the proposals therein with reference to the College’s core statement of Object, Vision, Purpose and Values:
OBJECT
The Royal College of General Practitioners is a registered charity with the Object:

To encourage, foster and maintain the highest possible standards in general medical practice and for that purpose to take or join with others in taking any steps consistent with the charitable nature of that object which may assist towards the same.

OUR VISION

A world where excellent person centred care in general practice is at the heart of healthcare.

Our role is to be the voice for General Practice in order to: promote the unique patient - doctor relationship; shape the public’s health agenda; set standards; promote quality and advance the role of General Practice globally.

OUR PURPOSE

To improve the quality of healthcare by ensuring the highest standards for General Practice, the promotion of the best health outcomes for patients and the public and by promoting GPs as the heart and the hub of health services.

We will do this by:

- ensuring the development of high quality general practitioners in partnership with patients and carers,
- advancing and promoting the academic discipline and science of General Practice,
- promoting the unique doctor-patient relationship,
- shaping the public health agenda and addressing health inequalities,
- being the voice of General Practice.

OUR VALUES

The RCGP is the heart and voice of General Practice and as such:

- We protect the principle of holistic generalist care which is integrated around the needs of and partnership with patients
- We are committed to equitable access to, and delivery of, high quality and effective primary healthcare for all.
- We are committed to the theoretical and practical development of General Practice.

Responding to this consultation

5. To produce this response, the College consulted very widely with its membership, both directly and through its devolved councils, faculties and committees. Our conclusions are based on many hundreds of responses from members and Fellows from across the UK. The College also has members in the Republic of Ireland and across the world who contributed their thoughts and suggestions. In September we
published a ‘Framework for our response’ and invited further comments upon this. This response therefore represents views expressed in comments from the majority of our faculties both in England and the rest of the UK. A debate was also held at the College’s Council meeting in September.

6. We will submit separate responses to the four detailed consultations so far published in relation to the White Paper, as well as to any subsequent consultations that may be forthcoming. This response, therefore, as with the White Paper itself, takes a strategic overview, and it will be necessary for the reader to consider our further responses for a more detailed approach to specific issues.

7. Whatever the outcome of the consultation, we shall uphold our values, work closely with patients and local communities, other health professionals, and other Colleges to retain and develop excellent primary care for all. We shall offer leadership and guidance to members as they seek to deal with the consequences of the NHS reforms. We shall also provide guidance, education and training opportunities, and ensure the sharing of good practice to assist our members to develop the necessary skills to lead effective clinical primary care within the context of GP consortia and commissioning groups if these pass into law.

**General Response: Liberating the NHS**

8. We note the opening paragraphs of ‘Liberating the NHS’:-

- “The Government upholds the values and principles of the NHS: of a comprehensive service, available to all, free at the point of use and based on clinical need, not the ability to pay.
- We will increase health spending in real terms in each year of this Parliament.
- Our goal is an NHS which achieves results that are amongst the best in the world”.

9. The RCGP welcomes all opportunities which bring the expertise of GPs into effective roles for developing and improving services that meet the needs of our patients. We also welcome initiatives which allow a more effective patient and public voice within the NHS and those which enable people to play a greater part in society; and any ways in which we can improve health outcomes, especially for those disadvantaged by personal and socioeconomic circumstances.
10. We believe that GPs can assist in the effective and efficient use of NHS resources, and wish to play an active role in reducing waste and duplicated effort. We appreciate the need to plan and deliver our services according to evidence based outcomes and public health needs. We recognise and value the expertise of effective management and want to retain these skills to serve the NHS.

11. GPs already have strong partnerships with other medical specialities and with other healthcare professionals; therefore, the possibilities for more collaborative commissioning and integration of clinical care are welcome.

12. Members, particularly those at the start of their careers, welcomed the opportunities for increased potential to influence services to patients and the wider community, and expect the reforms to allow more freedom for local provision of GP led services.

13. The College supports the Department of Health’s goal of cutting bureaucracy and improving efficiency, and recognises the uniquely difficult financial circumstances that the country currently finds itself in. Our respondents universally recognise that there can be no blank cheque for the NHS, and that the combination of the budget deficit with increasing life expectancy and unavoidably rising healthcare costs means that difficult choices are inevitable.

14. Some of our members are not convinced that the scale of the changes proposed is justifiable, especially in the context of cost reductions. They are concerned that the proposed scale, pace and cost of change will prove disruptive; and that the proposed reforms may not achieve the stated aims because they will divert effort, costs and human resources into complex commissioning and local decision making. Fundamental to these concerns was that the ability of the NHS to provide a high quality service should not be jeopardised by irreversible changes to the infrastructure of the NHS, including imperatives to offer choice and an increased dependency on private providers.

15. Many are worried that moving budgetary control to GPs in the context of economic strictures means that GPs will be held personally responsible for consequent shortcomings in services. Another concern is that public perception that services are set against practice income will disrupt trust in the crucial doctor-patient relationship, which underpins effective uptake of services and clinical interventions. The Government will need to counteract this perception and demonstrate clear structural divisions between consortia budgets and practice level income.
Putting patients and the public first

16. Patient-centred healthcare is at the core of General Practice, and we would always argue that health outcomes are maximised by consultation and cooperation between patients and their doctors. This is why we have consistently argued for longer consultation times between GPs and their patients, and continuity of care through maintaining the practice list.

17. We agree therefore with the principle of ‘shared decision-making’, and the statement: *no decision about me without me*, which was first used by one of our Honorary Fellows, Don Berwick.

18. The emphasis on patient choice may actually detract from the achievement of improved health outcomes in the longer term:-

   i. We have already previously criticised the plans for free choice of GP practice proposed by the previous government. We believe this will be damaging in terms of continuity of care, health inequalities and, potentially, patient safety. It will very likely threaten the viability of some local, especially rural practices that provide a vital service to those residents who are less mobile and potentially more vulnerable. We have previously suggested alternative solutions to the genuine issue of those patients who wish to choose their GP practice – in common with the General Practitioners Committee of the British Medical Association we advocate the use of Primary Care Federations to extend choice, along with technological solutions to allow remote consultations and the availability and promotion of drop-in centres, particularly for those patients working in urban areas but living elsewhere.

   ii. We are also concerned that the emphasis on ‘any willing provider’ for healthcare, here and particularly in the document on *Regulating Healthcare Providers*, will impede the development of effective co-ordinated services. We

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2 RCGP 2010, Response to Department of Health consultation ‘Your Choice of GP Practice’

would argue that, if consortia are obliged by Monitor in its role as a competition regulator to consider all tenders for services, it will be more difficult to form the partnerships between primary and secondary care providers that are the absolute cornerstone of effective healthcare. Integrated care provides a much more patient-focused approach to care - barriers must not be erected that prevent a more integrated approach to care. We discuss these concerns further in our response to Regulating Healthcare Providers.

iii. Additionally, and this is again particularly relevant to rural areas, members worry that the requirement to offer choice will result in expensive duplication of services – for example low-uptake services in areas of low population density. This will be less of an issue in urban areas, where choice is likely to develop fairly naturally.

19. We welcome the creation and engagement in decision-making of local HealthWatch organisations. However, it is important that local HealthWatch organisations do not merely represent the same special interest groups that currently sometimes populate LINKs organisations – there must be strenuous efforts to ensure that these bodies genuinely represent their communities, including those groups who are currently often overlooked and who may suffer from health inequalities.

Improving healthcare outcomes

20. The College agrees with the White Paper proposal to set objectives for the NHS according to measures of outcomes rather than process targets. Aspects of the previous regime of process targets were resented by clinicians, who felt that they consumed considerable amounts of valuable time and resources and sometimes led to perverse incentives for behaviours and interactions that did not benefit patients.4

21. However, as we discuss in our response to Transparency in Outcomes, we would urge the Department of Health to use caution before implementing wholesale reforms of NHS performance management. Some aspects of the previous target regime have had beneficial effects on patient wellbeing and experience. We feel it is vital that changes be properly trialled before implementation – the danger of not doing so is that current gains will be lost, and a great deal of time and resources may be

expended, only to result in perverse incentives different but just as damaging as previously existed.

22. We would also strongly recommend consideration of including a sixth domain in the Outcomes Framework, in the area of health inequality and inclusion. This would help to ensure that NHS providers and commissioners are incentivised to look out for the healthcare needs of those who might otherwise be disadvantaged or neglected under the proposals of Liberating the NHS.

23. Given that many of the proposed outcome measures described in Transparency in Outcomes depend on collaboration between healthcare providers and public health and social care services, we look forward to reading the forthcoming White Papers in these areas, and hope that they will reveal a coherent and workable system.

**Autonomy, accountability and democratic legitimacy**

24. Our members are enthusiastic about the opportunity for GPs to play a leading role in shaping services for their patients. Though there are a number of reservations about the specific form of the White Paper’s proposals on GP commissioning, the College is confident that GPs, already having the greatest knowledge and understanding of the healthcare needs of their patients, are supremely well placed to shape the future development of NHS services.

25. Many of our members, particularly those fresh from training or in the first few years of practice, are keen to participate in the commissioning of services. They see inefficiencies that currently exist and already have ideas about how to address them. Others, already working exceptionally hard for their patients, are less keen to engage in commissioning, and seek reassurance that the core of our very successful system of general practice, the face-to-face consultation with patients, will not be damaged by the withdrawal of talented GPs into management and commissioning.

26. The College will outline its position with regards to commissioning in more detail in its response to Commissioning for Patients. Our chief concerns, though, are as follows:-

i. As stated above, we are confident that GPs are able to perform the functions described in the White Paper.

ii. To do so, however, they will require further education and training, in skills specific to commissioning and business management. We are concerned at the almost complete lack of reference to education and training requirements
in the White Paper documents so far, considering the new skill expectations outlined, and the pressing need to maintain training capacity across both community and hospital settings regardless of organisational changes. We look forward to the forthcoming consultation on education and training.

iii. The time and expertise of GPs that will be taken up by new developments in the first period of wholesale change is clearly going to lose clinical sessions from the frontline services as GPs attend meetings and prepare material related to commissioning. We hope the education and training paper will clearly address the potential drain on time, personnel and finance.

iv. There will also be the need for time away from the practice for qualified GPs, for additional continuing professional development (CPD) related to various aspects of the White Paper proposals – this will have substantial cost and personnel implications, which will be problematic if borne by the new consortia.

v. The new expectations on General Practitioners also need to be reflected in formal GP specialty training, which is currently the briefest of any medical discipline. Extending training to five years\(^5\) will ensure their clinical decision-making, understanding of secondary care, ability to commission and manage resources and facilitate patient choice will be greatly enhanced.

vi. Some of our members are worried that the new system will involve multiple tiers of GPs – from full-time commissioners to those who are just involved in commissioning at the level of prescribing – with different training and CPD requirements. Salaried GPs and locums voiced particular concerns that their contributions would not be recognised within the new structures. This will require some finesse in constructing appropriate curricula – but it is certain that all GPs and practice staff will need extra training at some level if the system is to work effectively and ensure that the most able commissioners have the most influence.

vii. There is a concern, also, that the different requirements being placed on GPs in England as a result of commissioning will result in a divergence in training requirements and levels of skills and experience between England and the

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\(^5\) RCGP 2010 – Business Case for the Extension of GP Training
other countries of the United Kingdom. This poses a particular challenge for a UK-wide organisation such as our College.

viii. Many of our members are concerned at the potential loss of management and commissioning experience from existing PCTs and other NHS bodies involved in this radical and rapid shift to GP commissioning. It should be acknowledged that, although there have been inefficiencies, much good work, beneficial to patients, has been done through the PCTs, and this should be retained to serve the NHS.

ix. Some members question the need for such a wholesale change in NHS structures, and propose instead considering less radical alternatives to achieve improvements in commissioning, for example by placing a much greater number of GPs on the boards of current PCTs. This, they argue, would avoid the potential loss of 'institutional memory' but still allow GP knowledge and experience to be brought to the fore.

x. Greater flexibility in the timescale of implementing these changes would help avoid some of the potential local problems that might be brought about through lack of experience and 'bedding-in' of the new commissioning arrangements. GPs will be up to the task, some are ready right now, but others need time to learn new skills, build new kinds of relationship and engage in the right partnerships.

xi. Our members have also expressed the concern that PCT expertise is already being lost. The White Paper stresses the importance of continuity and PCT engagement in the interim (paragraph 4.7), but members observe that many of the best managers and administrative staff are already seeking and obtaining alternative employment, with the likelihood that those left behind may become demotivated.

xii. We would welcome more detail of how GP commissioning consortia will be expected to work.

xiii. A number of around 500 General Practice consortia is mooted, but there is little guidance on the expected size, structure and governance model of consortia. We welcome the trust that this implies in GPs' judgement, but have concerns about the implications if particular consortia are founded badly and fail to meet initial expectations. There may be a period of founding and re-
founding, as consortia find their feet and seek the optimum size for commissioning – the challenge being to maintain the benefits of localism in commissioning whilst avoiding the pitfalls of vulnerability to fluctuations in expenditure (related, for example, to expensive cancer drugs). This may lead, especially given the compressed timescale of the proposed changes, to disruption for patients.

xiv. There is particular concern about the lack of clarity with regards to the level of management allowance that will be allocated to GP consortia for carrying out their new responsibilities. We understand that, given the current economic situation and the pledge to find £20 billion in efficiency savings, the Department of Health will need to look at this allowance very carefully. If asked to perform many of the administrative functions of the PCTs without appropriate resourcing, GP consortia risk being financially imperilled from the start. We see that the Secretary of State has acknowledged these concerns\(^6\), but would note that the lack of specificity on this issue will deter many GPs from being able fully to embrace the reforms.

xv. Other areas where the White Paper does not currently offer sufficient clarity include:-

- the position of GPs working in secure environments, their services currently being commissioned by PCTs;

- the commissioning of healthcare providers in cross-border areas between England and Wales, and between England and Scotland, which will in future be subject to widely divergent commissioning regimes;

- the implications for performance management and the revalidation of GPs, previously organised at PCT level – it is not clear where Responsible Officers, with a vital role in revalidation, will be sited;

\(^6\) Andrew Lansley MP, September 2010, Letter to all GPs
- the large number of PCT responsibilities, far beyond commissioning alone, as identified by the Department of Health But as of yet not allocated.

- and the practical expectations on consortia with regards to how to behave fairly when GP practices are both commissioners and potential providers of services.

xvi. There are grave concerns, expressed by many of our membership, about the level of engagement of the for-profit sector in the re-structured NHS. We recognise that for-profit companies may have much to bring to the NHS in terms of efficiency and management experience. The likely involvement of such businesses, both in providing support services to commissioning consortia and, as a result of the ‘any willing provider’ stipulation, supplanting some primary and secondary care providers, may undermine the essential ethos of the NHS – to provide equitable, high quality healthcare for all, free at the point of use. The injunction that there will be no bail-out for failed commissioners would seem also to offer the possibility of private companies supplanting GP consortia. The College is open-minded with regards to engagement with the for-profit sector but would also wish to restate the value of partnership between GPs and existing secondary care organisations. Collaboration, we believe, far more so than competition, is the model which will result in the best possible outcome for NHS patients.

xvii. Many GPs are concerned that a system of GP commissioning will lead to the erosion of the crucial relationship between GPs and their patients. Heretofore GPs have seen their role as being an advocate for their patients, prescribing the best course of treatment for the individual’s healthcare needs. We are sure that GPs will continue to be so, but worry that this may be open to public doubt when GPs, in their role as commissioners, are also responsible for the allocation of resources. Many of our members would accept that there needs to be a debate about the rationing of limited resources in the NHS, but would find it unacceptable if this were to take place at the level of the individual GP and their patient. A threat to the trust between doctor and patient, which we

may anticipate will be magnified through its portrayal in local and national press, will have widespread repercussions in the effective uptake of services and clinical interventions, and ultimately on perceptions of the NHS as a whole.

xviii. A concomitant concern, and one which underlies many of those above, is the worry that the new commissioning system will tend to exacerbate existing issues of health inequality and failure of inclusion. The operation of the ‘inverse care law’ is familiar to medical practitioners. The College and its members enthusiastically welcome the opportunity to influence and improve the development of local services in the interests of patients and the local community. We are concerned that the likely divergence in local services will lead to a ‘postcode-lottery’ effect, and that without careful attention and supervisory structures improvements in healthcare services and outcomes will be unequal.

27. We agree with the need for the establishment of the NHS Commissioning Board, and while the precise division of responsibilities between this and the commissioning consortia is not always clear and will presumably evolve, the broad proposals here seem sensible.

28. We support closer working between the NHS and local authorities, and see potential in the local health and wellbeing boards to improve local engagement and assist coordination between healthcare, public health and social care providers. We are concerned, however, that at a time of serious financial strain it may be more difficult for local authorities to allocate the appropriate resources to this role: this may result in outcomes that are less impressive, and above all less equal, than might otherwise be hoped for.

29. We are concerned at the proposals for de-regulation of foundation trusts (paragraphs 4.21-4.22). The benefits of these proposals are not made clear and we feel that de-regulation in these cases may pose risks to important public services and investments. We discuss this further in our response to Regulating Healthcare Providers.

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8 Julian Tudor Hart, (The Lancet, 1971) The Inverse Care Law
30. As also discussed in that response, we have concerns about the proposed role of Monitor: how precisely it will interact with the CQC; its ability and preparedness to take on what we see as a vastly expanded role; and the potential conflict between its roles as guarantor of continuity of service on the one hand, and promoter of competition on the other. Above all, we are critical of the emphasis on the role of competition law here and in *Regulating Healthcare Providers* as potentially at odds with one of the major benefits of General Practice commissioning – the enhanced ability of GPs to plan and commission healthcare services in collaboration with providers.

31. As already alluded to, *Liberating the NHS* does not provide nearly enough detail on its proposals for medical education. We hope that our concerns will be addressed in the forthcoming education and training proposals, but in the meantime we would strongly urge the Department of Health, in its present understandable search for efficiency-savings, not to overlook the importance of medical education for the future development of the NHS. We will be happy to discuss with the Department how education and training may best be supported in a post White Paper world. Structural reforms will not bring about improvements in health outcomes if we overlook the training of the GPs and other clinicians of the future.

**Cutting bureaucracy and improving efficiency**

32. Many of our members feel that there are significant opportunities to make efficiency savings – they see areas where current organisations may be wasteful, and can identify ways in which GP commissioners will be able to cut costs without impacting on patient health outcomes. Giving GPs more control over care pathways should ensure there are less unnecessary referrals and that patients have a smoother, more rational experience.

33. Members are sceptical that the reforms outlined in *Liberating the NHS* will save money, in either the short or the long term. There are enormous costs associated with reorganisation; in this case the redundancy costs of whole tiers of NHS management, as well as the likely expansion of General Practice staff and facilities. If, as the White Paper suggests, there will be 500 GP consortia, as against 150 current PCTs, many of our respondents fear that the duplication of management and administrative costs will actually make the new system more expensive.

34. A great number of our members are concerned that, even if these reforms were successful in improving efficiency, they would be a temporary measure and further
reforms would be enacted within a few years. There is a widespread feeling of institutional exhaustion – a cumulative loss of goodwill and enthusiasm engendered by repeated reforms over recent years and a sense of futility in over-engagement in any particular re-structuring. If the White Paper proposals are to work for the benefit of patient care they will be dependent on the development of extensive new networks of relationships; our members urge that these be allowed to settle in and be seen as permanent. We encourage the careful piloting of proposals and that all changes are based on a sound evidence base, to avoid unnecessary expense and ensure that any new arrangements are fit for purpose.

In Conclusion

35. General Practice is the central plank in our world-class healthcare system. The College thoroughly agrees that it makes a great deal of sense to give GPs, with their unique patient-centred perspective, a central role in commissioning and directing healthcare services. Whether this is done through the proposed consortia model, or by involving GPs more centrally in existing models, we are confident that General Practice can rise to the challenge and institute changes in service provision that will improve healthcare outcomes.

36. The Department of Health must address concerns that these proposals, by increasing local diversity of provision and the likely intrusion of for-profit organisations into the NHS, will increase health inequalities, an area in which England already performs poorly. One step towards doing this may be to include health inequalities and inclusion amongst the domains of the proposed Outcomes Framework, but we would like to see a greater emphasis on addressing health inequalities throughout the proposals.

37. The Department must also address concerns over education and training, especially if it expects General Practitioners to lead and commission healthcare services, whilst at the same time continuing to provide the excellent service that they already do. The extension of GP training to five years would demonstrate the Government’s commitment to getting the best out of the profession.

38. There are concerns that the GP workforce will be stretched to breaking-point without adequate support, which would be disastrous for patient care. The Department must recognise the extent of the new demands being placed on GPs, and ensure that they are properly resourced.
39. The Department should also recognise that the greatest achievements will be made through collaboration and innovation between primary and secondary care organisations, and not allow enthusiasm for efficiency savings and enforced competition to stifle these opportunities, which will be the real measure of success of the White Paper proposals.

40. The College looks forward to continuing to engage with the Department of Health in this process, and trusts that its views will be accepted as always having the best interests of patients at heart. We will support our members to develop and succeed in the new healthcare landscape, and work with other health professionals, the third sector, expert providers, local authorities and other Colleges to ensure the continuation of a world-class health service.

41. We would like to express our gratitude for the contributions of many hundreds of College members who have contributed to this response, whether as individuals or as members of our faculties and committees. This document is necessarily a synthesis of the most commonly expressed views, but we are confident that our members, as GPs passionately engaged in the development of patient care, will continue to make their voices heard, both directly and through the College – this is, therefore, a start, not an end, to the debate.

Yours sincerely

Professor Amanda Howe
Honorary Secretary of Council