Department of Health consultation – Liberating the NHS: Commissioning for Patients

1. I write with regard to the Department of Health consultation – Liberating the NHS: Commissioning for Patients.

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. The College has responded separately to the consultation on the Government’s White Paper – ‘Equity and Excellence: Liberating the NHS’ and to the three further consultation papers relating to this that have been published so far. This response should be read in the context of our overall views on the proposed reforms to the NHS.
4. After consultation with our members and discussion by the College’s Council, we published a Framework document\(^1\) outlining our position towards the proposed NHS reforms. This draws attention to the many opportunities GPs have identified within the White Paper proposals, but also to many challenges and concerns that our members have expressed. This document, and all our responses to the White Paper, have been drawn up 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,

\(^1\) See Appendix: The RCGP and the White Paper – A Framework for our Response
• 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.**

General Response

5. The College notes the Department’s definition of the characteristics of good commissioning (paragraph 1.6) as: to ensure high-quality outcomes; maximise patient choice; and secure efficient use of NHS resources. We are keen to engage with these priorities and agree with the Department that GPs, as clinicians who work alongside patients and public in the community, are in an ideal position to influence the direction of service development in the NHS.

6. We see that *Commissioning for Patients* makes a very strong case for the Department’s chosen model of GP consortia commissioning services, supported by an NHS Commissioning Board. This model involves a very radical alteration in the structures of the NHS, with many attendant costs and outcomes which are necessarily uncertain. We would urge that other models for commissioning services be considered. For example, some of our members have questioned whether commissioning of services by PCTs could not be allowed to continue, but with far greater and statutorily guaranteed involvement by GPs and other clinicians at board level, as well as greater patient/public involvement. This might lead to many of the benefits envisaged in *Liberating the NHS*, but without some of the risks.

7. Many of our members, particularly some of those in the early years of their careers, are enthusiastic to take up roles in GP commissioning. They recognise the inadequacies in the current system and are confident, as are we, that they will be able to make better choices and achieve the goals identified in paragraph 5 above. That enthusiasm, however, is not universal, and is influenced by pre-existing
experience with practice-based commissioning and the successfulness or otherwise of relationships with local PCTs. We would urge caution and flexibility in imposing the timeline for change to the proposed new model – to ensure that GPs in all areas are able to take on their new responsibilities, and to ensure that examples of current good practice by PCTs are retained.

8. If, as seems likely, the proposals in Liberating the NHS: Commissioning for Patients are to be implemented, we would urge that the Department provide much more detailed guidance on the intended structures and governance models of GP consortia. Some of our members are reluctant or cautious with regards to the proposals, and in part this is down to a perceived lack of detail. GPs are being asked to stake their careers, their practices and the wellbeing of their patients on a new structure that has not been extensively trialled – they would find greater detail and specificity in the proposals reassuring.

9. The funding of GP consortia will be a critical factor in determining their success. The lack of detail as to the funding formulas to be applied, the level of the management allowance, the relationship between consortia and practice income, and the potential impact of current PCT budget deficits on the finances of nascent consortia are all matters of concern for our members. It is difficult for us to endorse these proposals as enthusiastically as we might whilst these issues and their consequences remain unclear.

10. Excellence in commissioning and quality assurance requires accurate data that is well analysed and rapidly available. The wholesale move of public health departments into local authorities removes this essential resource from GP commissioners, and should be reconsidered.

11. It is essential that GPs’ role as commissioners must not be allowed to detract from the crucial doctor-patient relationship and GPs’ longstanding role as advocates for their patients. We expect GPs to conduct themselves with the utmost probity, but there will still be the need, (see below), for strict governance rules to ensure that all commissioning decisions are open and fully scrutinised.

12. As stated above, the College is committed to the education of GPs and the development of the role of General Practice. We are already actively producing
material\textsuperscript{2} that will support GPs in better commissioning. If GP commissioning goes ahead, we expect to be at the forefront of providing and accrediting education and training opportunities for our members, with the goal that all GPs, whether at the start or near the end of their careers, and whether taking major or minor roles in commissioning services, are supremely well equipped to meet the challenges of this new environment.

**Response to Specific Questions**

**Q1. In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?**

As an initial stage, we would expect the NCB to have a role in producing best guidance for the proposed new consortia on governance structures, and helping them make use of the best existing local management and administrative professionals with successful track records and a stake in the community.

With regards to regional specialised services, the NCB will need to work with the proposed consortia to set meaningful outcomes and objectives, establish means of communication for these objectives to be reported and assessed, and meet with them regularly to ensure regional services are effective and well co-ordinated.

A fair starting point might be for the Board to request a report from consortia on the strengths and weaknesses of local services, which it could then use to guide its commissioning of regional provision.

The Board should also be proactive in ensuring patient and public involvement in local commissioning – that is, supervise consortia to ensure that this is not overlooked.

The Board will need to take special care when commissioning local pharmacy services to take account of the role of dispensing GP practices. These practices, particularly in rural areas, are often dependent on combining their GP and pharmacy roles, and play a crucial role in the rural community.

\textsuperscript{2} For example, the new RCGP online course *Commissioning in General Practice: Improving Patient Journeys* has been launched on the RCGP Online Learning Environment (www.elearning.rcgp.org.uk).
We would argue strongly that GP commissioners should be integrally involved in the commissioning of maternity care. The consequences of lack of GP involvement in maternity care are discussed in depth in the recent Kings Fund report\(^3\). General Practice has a vital role in antenatal and postnatal care, as part of the lifelong continuity of care that is central to the NHS. Many of our members do not see why maternity services should be primarily the domain of the NHS Commissioning Board rather than the proposed consortia.

Some of our members have also argued that consortia would have a useful role in commissioning district nursing services.

**Q2. How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?**

We would argue that these services will be best commissioned by large consortia or groups of consortia working together, to ensure that a service is viable clinically and avoid overburdening individual practices or smaller consortia, whilst maintaining local access to these services for patients. The NCB may have a role in helping these groups of consortia form in a rational way that ensures comprehensive and stable provision of these low volume services. The commissioning of these kinds of services may also need to be considered within training programmes for GP commissioners.

**Q3. Are there any services currently commissioned as regional specialized services that could potentially be commissioned in the future by GP consortia?**

This is likely to be the case – however, given the steep learning curve already expected of the proposed consortia, it may be wiser initially to leave these services to be commissioned at the national/regional level. There are likely to be difficulties over lack of competition/choice in these kinds of services, and dangers for inexperienced commissioners. As experience grows more services can be delegated to be commissioned at consortia level, or perhaps at ‘lead consortia’ level. Our respondents have suggested services such as renal services and some psychiatric services as likely candidates.

---

\(^3\) Smith A, Shakespeare J, Dixon A. The role of GPs in maternity care – what does the future hold? The King’s Fund, 2010

Q4. How can other primary care contractors most effectively be involved in commissioning services to which they refer patients, e.g. the role of primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?

These contractors will need to form direct relationships with consortia in order to help steer commissioning decisions. Dentists and optometrists will be providers as well as effective commissioners, and we can imagine a synergy of interests in developing services in the community wherever possible. There are already cases of local opticians collaborating with Practice Based Commissioning groups, and we expect this approach to develop. Some respondents have suggested that representatives of dental and ophthalmic providers may even sit on the consortia commissioning boards, or alternatively that they be allocated budgets in the same way as GP consortia – though there is concern that this risks further fragmentation and may prevent local consortia reaching consensus on services to be commissioned.

Q5. How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?

Consortia will need to develop systems for local peer review against relevant criteria – presumably related to aspects of the Outcomes Framework and defined in partnership with patients and public. Each consortium will need the capacity to collate, analyse, and compare data practice-by-practice, and establish incentives to prevent practices falling behind.

We feel this will be one of the most challenging and potentially divisive aspects of the new commissioning model, and will need to be rigorously implemented and fully funded to avoid accusations of unfairness. Existing appraisal and anticipated revalidation processes will also play a significant role in ensuring and improving services at practice level.

Consortia will also need to be engaged in providing effective education to their members, so that best practice can be identified and shared.

We also feel that consortia will have a role in facilitating better communication between primary and secondary care, and developing more stable care pathways, so that standards of referral may be improved.
Q6. What arrangements will support the most effective relationship between the NHS Commissioning Board and GP consortia in relation to monitoring and managing primary care performance?

We would envisage the Commissioning Board having a collaborative and supportive relationship in this respect, based on the sharing of information on best practice and the development of meaningful goals related to the Outcomes Framework, rather than a policing role.

In monitoring primary care performance, it will be crucial for the Board and consortia to bear in mind particular circumstances which may impact on specific practices – for example the vulnerability of small practices to apparent statistical anomalies. Other factors such as sociodemographic diversity or rurality also alter practice activity, and all those assessing practice performance need a sophisticated appreciation of these issues (hence the need for some public health competencies).

Q7. What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?

One of the most exciting aspects of service developments where GPs have led is in ‘GP specialist’ provision in community settings. Many GPs have a clinical special interest in which they offer clinical sessions, and these can reduce hospital referral as well as being cost-effective. We need to retain and develop these options, and the confirmation that these would be acceptable providers by Andrew Lansley at the RCGP conference was encouraging.

Conflicts of interest are, however, obviously a difficult area. Some of our respondents have suggested that consortia will need to appoint an external organisation to supervise or approve their primary care commissioning. Alternatively, a committee elected by GPs in the consortium may be able to hold the authority, considering GP providers on the same basis as others for any specified contract.
Consortia should be obliged to report contract profiles, and publish financial and patient satisfaction and outcome information\(^4\), so that patients and the NCB can hold them to account.

A further issue relating to transparency, however, is that GP providers will likely be competing with private providers who have the advantage of being able to claim commercial confidentiality and who, for example may be able to tender for contracts on a ‘loss leader’ model. It will be difficult to maintain a level playing field under these circumstances.

Many of our members have grave misgivings about the apparent emphasis on ‘choice’ in service provision in primary care. As discussed in our response to the main paper of *Liberating the NHS*, we feel that the policy of free choice of GP practice in particular is potentially damaging and not warranted by patient demand. We would argue that patient choice in primary care may be better accommodated by the development of GP Federations and other local measures. Managing resources and effective commissioning is unlikely to give free choice, and patients need to understand in the context of resource management. Again, clear and transparent procurement processes which show that clinical decisions are not influenced by personal gain will be essential.

**Q8. How can the NHS Commissioning Board develop effective relationships with GP consortia, so that the national framework of quality standards, model contracts, tariffs, and commissioning networks best supports local commissioning?**

We would see this as a significant challenge within the whole scheme – the difficulty for a national NHS Commissioning Board in coordinating activity with a large number of local commissioning consortia. One of the objects of *Liberating the NHS* is to strip away the middle tiers of NHS bureaucracy, in particular the SHAs, but the RCGP is not sure it will work without something at the middle level – whether ‘super-consortia’ to co-ordinate information sharing or regional NCB teams. Without something at this level, it will be very difficult for the NCB to get a clear idea of what is going on locally and provide support where needed, let alone to commission primary medical care and other family health services. Healthcare

\(^4\) Though see our response to the ‘Transparency in Outcomes’ paper for the need for all outcomes to be suitably robust
in secure environments is another challenge and emergency planning will also require some kind of regional direction.

Of course there are numerous regional bodies, such as RCGP faculties and BMA Regional Councils, with which the NCB will wish to fruitfully engage and which may help it to retain a balance between local commissioning and national supervision.

Q9. Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?
We would hope for a particular engagement from the NCB in supporting lead GP commissioners in the initial stages of the transfer of commissioning responsibilities. Input at this stage could be very helpful in avoiding damaging early errors.

The Commissioning Board should work with the RCGP and other bodies to develop and share guidance on best practice.

Q10. What features should be considered essential for the governance of GP Consortia?
This is a matter of immense significance to ensure public confidence in the new model of commissioning. There is existing guidance available\(^5\), but in particular we would advocate:

1. That at least some of those involved in consortia boards should retain face-to-face contact with patients. It would be unacceptable if lead commissioners were to all become full-time ‘managers’ and potentially lose the connection with patients that the new system is intended to promote.

2. That there should be a stated commitment to the values of the NHS, to adherence to quality standards and to the avoidance of widening health inequalities.

3. That there should be public declaration of any conflicts of interest for commissioners and providers, and that no individual should be permitted to directly profit from a commissioning decision.

\(^5\) British Medical Association. The dual role of practice based commissioner and GP provider: avoiding conflicts of interest and ensuring probity. BMA 2008
4. That there should be a Financial Officer with oversight of the consortium budget.

5. That there should be a clear commitment to financial probity, annual reporting and clear policy for how any profit/underspend and other income of the consortium will be allocated.

6. That there should be clear allocation of roles to ensure that the consortia can assume the various tasks previously conducted by PCTs, aside from commissioning.

7. That there should be a mechanism for oversight by Local Authorities, public and patients – presumably through the proposed health and wellbeing boards.

8. That there should be mechanisms to ensure the fair representation of all practices within a consortium, including especially rural practices and those with already disadvantaged populations.

9. That national clinical standards relevant for common conditions should be supported across all settings.

Whilst not advocating a prescriptive model, it should be recognised that many GPs, if they are to be actively engaged with commissioning, will want far more detailed guidance on appropriate models of governance. The College looks forward to co-operating with the Department of Health and other bodies to support GPs in this way.

Q11. How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?

There should be flexibility in this, with the guiding factor being whether it benefits patient care. If practices use the same providers, or have populations with related needs, this may well be more significant than geographical connection.

This approach also leaves the way open for practices to leave or join other consortia with which they have more in common, which may well make sense in optimising benefits from the new structures. There would need to be scrutiny of the process either through the NCB or local authorities.

A key proviso would be that this should not damage continuity of care or lead to increased health inequalities (i.e. if it meant that practices with deprived
populations were left out of strong consortia and not appropriately resourced as a consequence)

Q12. Should there be a minimum and/or maximum population size for GP consortia?

There are obvious difficulties with smaller population consortia, if they are not to be outweighed by larger local providers. Alternatively, small consortia may need to join with others with shared interests and shared providers to ensure their bargaining power is effective and manage financial risk.

Another consideration is that the smaller the consortium, the greater will be the duplication of management and administrative roles, which will make it more difficult to achieve the anticipated bureaucracy savings.

Rural consortia pose a particular challenge here, and will need to be protected under the commissioning arrangements – it may not always be appropriate to form larger-population consortia if the geographical spread is too large, but consortia with smaller population will still need protection from exploitation by providers.

On the other hand, there are clear disadvantages with larger consortia as well – one can imagine a scenario where successful consortia grow to a scale where they lose some of the local perspective on commissioning that the model is intended to facilitate.

There has been discussion of 500,000 as a likely minimum size of consortium for financial viability\(^6\), but the RCGP thinks it may be better for consortia to be allowed to find their right size independently, as there is currently insufficient evidence with which to be prescriptive. As with Q11 above, there will need to be mechanisms for scrutiny by the NCB or local authorities to ensure that over-small or over-large consortia do not have a negative impact on their populations or distort local healthcare services in other ways, and there should be support through the initial transition period and if future re-structuring of consortia is required.

---

Q13. How can GP consortia best be supported in developing their own capacity and capability in commissioning?
New GP consortia will clearly need excellent administrative staff, most likely recruited from the staff of current PCTs. They will also need leaders who are committed to GP commissioning and have sufficient education and ability in this area. They will need the financial support to allow experienced GPs to be taken away from front-line clinical work. And they will need sophisticated, multi-level training, information and guidance from central bodies such as the NHS Commissioning Board and the RCGP.

Q14. What support will GP consortia need to access and evaluate external providers of commissioning support?
This is obviously a critical question, as there are likely to be many external organisations bidding to provide this support. It will be down to organisations such as the RCGP to provide advice on the best approach to accessing these services, based on existing experience of what (and who) has worked well in the past. Some suggest there may be a need for quality standards for support organisations, and possibly a process of accreditation. We will provide more information regarding our approach in due course.

Q15. Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?
The criteria seem appropriate.

Consortia will need to employ support from finance managers and accountants, for which they will need adequate financial resources – this should not be underestimated. And as discussed already they will need considerable education resources, as financial risk management at the scale of consortia is beyond the current skills set of most GPs. Beyond this, the NHS Commissioning Board should be prepared to step in quickly with support if it looks like a consortium may be failing financially, and there should be transparent processes for these situations so that any risk to continuity of care is avoided. With regards to underspends, it will be critical not to disincentivise efficiency.

Q16. What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?
As discussed in our response to *Regulating Healthcare Providers*, though we are not opposed in principle to choice and competition amongst healthcare providers, we are concerned that factors that really make for the success of local healthcare, such as providing continuity of care, effective pathways and strong relationships between primary and secondary care will not be measured if there is a literal application of competition rules. There does need to be oversight to promote choice, but it should also take account of these factors and be prepared to demonstrate flexibility.

Consortia should be required to demonstrate full financial openness, and declare all conflicts of interest publicly and with scrutiny from patient groups, Monitor and/or the NCB.

**Q17. What are the key elements that you would expect to see reflected in a commissioning outcomes framework?**

It is crucial that these reflect current best evidence and practice, as for national guidelines and indicators. Please see our response to *Transparency in Outcomes* for more detail of our views on the NHS Outcomes Framework. Outcomes should explicitly address how the frameworks will minimise health inequalities and address inclusion. We note that many of the outcomes are dependent on complex interaction with public health and social care – we await publication of proposals in these areas. With these provisos, we would expect a commissioning outcomes framework to reflect many of the same outcomes and indicators.

**Q18. Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?**

Though there is the need to incentivise performance and collaborative work on the part of practices in their role as members of consortia, to link this to practice income seems to us a very dangerous proposal, with potential for a great deal of unfairness or disruption and, if GPs are perceived to be prescribing or referring with a view to their practice income, risks to the vital doctor-patient relationship. We would urge that alternative forms of incentive be found.

**Q19. What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?**
As stated in our response to *Liberating the NHS*, many of our members do have concerns that the proposals around commissioning consortia have the potential to increase health inequalities within and between commissioning areas. As mentioned above, health inequalities should be explicitly featured in the outcomes framework, with outcomes mapped across social groups. Strong input from patient groups and local authorities into the local JSNA, if conducted appropriately, should also give consortia goals to aim for. Additionally, there needs to be sharing and encouragement of best practice in this area, guided by national organisations such as the RCGP or the NHS Commissioning Board itself.

**Q20. How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?**

The proposals for local HealthWatch to engage with local authorities and GP consortia, provided they are established sensibly and with a view to being fully representative, are a useful start as a way to get patients involved in commissioning decisions. We would also support the inclusion of lay members on consortia boards, and association with patient groups at practice and consortium level, though the viability of these will depend on the management allowance apportioned to consortia. If consortia and the NCB publish full financial and other information, such as their vision, aims and principles, and the public are educated in the opportunities and limits of commissioning, there will be a real opportunity for local public scrutiny and engagement with decisions made.

**Q21. How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?**

Clearly the constitution of local HealthWatch, as well as of other patient groups that may be formed or already exist, is critical here. As we have argued in our response to the consultation on *Local Democratic Legitimacy in Health*, if these groups are merely constituted so as to reflect ‘the same old voices’ we will miss the opportunity to reflect all groups within local communities and risk perpetuating health inequalities and existing failures of inclusion.

More broadly, a combination of education and consultation will be required of consortia, to ensure that they are reflecting the widest possible range of views
within their local community. Consortia can learn from processes of engagement carried out by some PCTs⁷, and reach out at the planning stage to local community groups, voluntary sector organisations, even local schools and colleges, but they will need the management funding to do this.

Q22. How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices’ Patient Participation Groups?

As discussed above, GP commissioning makes engagement with these groups absolutely critical. The NHS Commissioning Board may have a role in this area in ensuring that consortia take their patient engagement responsibilities on board, and are funded to do so. Patient/public engagement will require time and resources, both of which are likely to be under pressure in the vital period of transferring commissioning responsibilities, and this must not be allowed to be overlooked.

Q23. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?

We have already discussed in our response to Equity and Excellence: Liberating the NHS the ways in which we are concerned that the new model of commissioning, together with the purchaser-provider split and ‘any willing provider’ policy have the potential to heighten health inequalities without stringent scrutiny. Policies that encourage open and transparent processes, education and fully funded engagement with patients and the public as discussed above, will be crucial in ensuring opportunities and outcomes that are as fair as possible. Accurate data on outcomes is essential, and there must be capacity in this made available for all consortia.

Q24. How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?

There is a challenge in the proposals, in that GP consortia may well not be coterminous with local authorities – each consortium may need to work with the health and wellbeing boards, Directors of Public Health and HealthWatch

⁷ For example, The Big Health Debate conducted by Liverpool PCT in 2006-07 - http://www.centralliverpoolpct.nhs.uk/Library/Your_PCT/Hearing_your_voice/Big%20Health%20Debate.pdf
organisations of more than one local authority, and vice versa. This presents a bureaucratic challenge, though not an insurmountable one if adequately funded.

There are many services for which PCTs currently collaborate with local authorities, and it will be an urgent priority for GP consortia to identify their commitment to these services and, where necessary, identify lead consortia to take on specific projects.

Clarity about the budgetary commitments of consortia, local authorities and other stakeholders will be essential to ensure there is no collapse in funding for these kinds of jointly-funded projects. The health and wellbeing boards should be a viable mechanism for managing this, and will need to be established early on to work with consortia during the transition period. The NHS Commissioning Board will have a role in ensuring that these relationships are facilitated.

Q25. Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts, Children’s Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to the new arrangements?

Joint working will require clearly defined roles and responsibilities, in order to develop relationships between GPs and their partners that are firmly based on trust.

Pooled budgets may well be necessary to support certain projects – but GPs will need to be confident that those budgets will not be diverted from the projects for which they were intended in order to make up shortfalls elsewhere.

Crucial to the maintenance and success of these relationships will be the assembly, analysis and sharing of examples of best practice, a role in which the RCGP fully expects to participate.

Q26. How can multi-professional involvement in commissioning most effectively be promoted and sustained?

The College believes that close working between GPs and other professionals in healthcare and beyond will be crucial to the success of the White Paper commissioning proposals. GPs are eager and enthusiastic to work with others in building improved care pathways and designing innovative new approaches to patient care.
We are concerned that there are risks in the White Paper, in the role of competitive tendering and the principle of ‘any willing provider’, that GP practices will be set up in competition with other healthcare professionals, and that this will prevent the kind of long-term, strategic collaboration that will be the ideal outcome of GP commissioning.

13. We gratefully acknowledge the contributions of many College members in formulating this response.

Yours sincerely

[Signature]

Professor Amanda Howe
Honorary Secretary of Council
Appendix: The RCGP and the White Paper – a Framework for our Response

1. Background
The Government published its White Paper on its plans for the NHS, ‘Equity and excellence: Liberating the NHS’ in July. Following on from the publication of this document, four further consultation documents were released. These are:

- Commissioning for patients
- Transparency in outcomes – a framework for the NHS
- Increasing democratic legitimacy in health
- Regulating healthcare providers.

There is an obvious challenge for the RCGP as a UK wide body, as the current White Paper specifically applies to the NHS in England. However, Council on September 10th 2010 agreed that the RCGP should debate the implications, and should respond to the consultation with a constructive critique from all countries and Faculties to reflect members’ concerns to the government, in a way which will maximally influence their eventual policy implementation. Further testing of membership views up till the close of the consultation, will form the basis of our written and verbal efforts over the next period to influence the definitive outputs of this policy challenge.

This Framework is based on an overview of members’ responses, set in the context of the College’s vision, purpose, values and priorities. We have used these to evaluate whether the reforms proposed are likely to enhance or jeopardise our core values, which are that:

- 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.

2. Consultation responses
The largest numbers of comments grouped around the following issues.

2.1 Opportunities for:

i. greater influence by GPs on patient care and health services, through direct leadership and greater input to the Department of Health;
ii. overall benefits to patients if instigated effectively;
iii. better use of local knowledge for appropriate resource allocation and strategic planning;
iv. streamlining resource use, less wastage and duplication;

---

8 This Framework is based on a paper debated by Council on September 10th. The wording is largely unchanged except for some editing and some additional points of emphasis required by Council, all added by the Honorary Secretary.
v. a crucial role for the RCGP in setting standards, leading by example, sharing good practice, disseminating information, setting standards for clinical pathways and services (in collaboration with other Royal Colleges) and providing training to skill members up for leadership and commissioning.

Other opportunities flagged by senior officers include the opportunity to work more closely with local government, joining up with social care and public health; delivering even better education and training for nurses and for GPs – including extending the period of GP training to deliver GPs with appropriate knowledge and skills; and potential for better workforce planning. Council emphasised real opportunities to work more closely with patients, and to develop stronger links with colleagues in specialist practice.

2.2 Concerns

There were many queries about the lack of detail of how the reforms might impact on services and the workload for practices, and a significant numbers of comments on the risks of these reforms to the NHS in England, as follows:

vi. Rather than efficiency savings, both financial and human resources would be diverted away from clinical care and quality improvement into issues around commissioning and resource management. The extent and speed of the reforms risk destabilising both the interpersonal relationships and economic basis of local health economies at primary and secondary care level.

vii. Local diversification will be likely to increase rather than reduce health inequalities.

viii. GPs will be seen as the purse-holders: this could reduce public trust and decrease their ability to advocate for patients, and they will be blamed for failures and cuts in services.

ix. Many GPs currently lack time, skills and capacity for commissioning – this will need addressing urgently.

x. The reforms open a door to increased involvement of the for-profit private sector in the NHS, and tax payers’ money will be diverted into private companies and their shareholders. This could be seen as the break up of the NHS with some private companies ready to take over the provision of services.

xi. The reforms take the health service in England further away from the health services in the other UK countries, although the training for GPs remains the same.

3. RCGP Council Debate

In the light of these findings, and of the content of the proposed reforms, Council had an extensive debate which is reflected in the following statement:

"The Royal College of General Practitioners exists ‘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’. We are committed to equitable access to, and delivery of, high quality and effective primary healthcare for all; and to protecting the principle of holistic generalist care which is integrated around the needs of and partnership with patients. We are an independent professional body with enormous expertise in patient – centred generalist clinical care. 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."
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”.

In principle, 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; that includes overcoming health inequalities. 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 accept the need to plan and deliver our services according to evidence based outcomes and public health needs.

GPs already have strong partnerships with other clinical specialities, and the possibilities for more collaborative commissioning and integration of clinical care are welcome. We value the expertise of effective management and want to retain this for the NHS. We also welcome the emphasis on a stronger patient voice, and any ways in which we can improve health outcomes, especially for those disadvantaged by personal and socioeconomic circumstances.

However, 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. Some members are also concerned that GPs will be held responsible for shortcomings in services, and that this will disrupt public trust in the crucial doctor-patient relationship which underpins effective uptake of services and clinical interventions. Fundamental to those members’ 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.

Other members, particularly at the start of their careers, welcomed the opportunities for increased potential to influence services to patients and the wider community.

4. Next Steps

We have consulted with our members on the White Paper and supporting documents and will continue to do so. We shall respond in detail to these by the deadlines, and will include there the many other points already made by members and Faculties, and debated at Council. In particular, we shall highlight the need for the government to provide clearer details on how these reforms will reduce rather than exacerbate health inequalities, as the existing evidence base on commissioning suggest there is little impact on inequalities, and
increased local variability can lead to disadvantaged populations being further marginalised. We shall also emphasise our concerns about the diversion of GPs away from clinical work into managerial and leadership roles, and the long-term implications for workforce capacity of these new roles. We expect that we shall be involved in further discussions with government, and that our views and concerns will be taken into account.

Whatever the outcome of the consultation, we shall uphold our values, work closely with patients, 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.