11th October 2010

Department of Health consultation – Liberating the NHS: Transparency in Outcomes

1. I write with regard to the Department of Health consultation – Liberating the NHS: Transparency in Outcomes.

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\(^1\) document 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 appreciates the intention of the paper ‘Transparency in Outcomes – A Framework for the NHS’, to ensure quality of care by assessment of the overall performance of the NHS. Robust indicators can be helpful when evaluating standards of provision.

6. The Government needs to reconsider the potential impacts of setting indicators, in the context of the White Paper proposals as a whole. Although the document makes it clear that the Outcomes Framework is not intended as a tool for the performance management of local healthcare providers, the Government must be aware that, in the context of local commissioning consortia, it is likely to be used in this way. In particular, the NHS Quality Standards are bound to be used for performance management (e.g. in commissioning contracts). Care must therefore be taken to avoid setting indicators which, in the context of the NHS as a whole may make sense, but when applied at the local level may have perverse outcomes (for example, in leading to incentives not to refer patients to secondary care where a diagnosis is uncertain – as in the indicator relating to Emergency hospital admissions for acute conditions usually managed in primary care). The inherent risks of this should be borne in mind in constructing the framework – i.e. indicators should be selected with great caution as to their suitability, or where they might be harmful to patients if used in a performance management framework.
7. The Government should also be careful, in dismissing 'process targets', to recognise the problems in relating clinical actions to long term outcomes. We have argued in the past\(^2\) that process targets may lead to a ‘tick box mentality’ and may result in a distortion in clinical priorities. However, some targets, (for example access to cancer care), are valid short term proxies of longer term outcomes, and have helped to improve the health outcomes and wellbeing of a great many patients. It is not clear that outcome measures, which are often only recognisable at population levels, will have the same impacts on individual care. So, although the College agrees in principle with the Government's approach, we would urge caution before making sweeping changes.

8. Thirdly, as detailed below, we feel that greater attention should be paid in this paper to health inequality issues. Our members are concerned that this is one of the great potential problems with aspects of the White Paper proposals. There are risks in GP consortia commissioning of increasing ‘postcode lottery’ differentials, with loss of services for some disadvantaged minority groups and illnesses. It is all the more important, therefore, that this outcomes framework should highlight the reduction of health inequalities as a priority. We argue, in fact, that health inequalities and inclusion issues may warrant a domain of their own.

9. Above all, the College is committed to evidence-based practice. We have considerable expertise both within our College and in our national GP academic leads which could contribute to detailed developments. We urge that all outcome measures be trialled before nationwide implementation, to ensure that the consequences are those intended i.e. that will be beneficial to patient care.

**Response to Specific Questions**

10. The consultation on ‘Transparency in Outcomes’ contains 35 questions, to which we have provided answers below:

**Principles**

Q1. Do you agree with the key principles which will underpin the development of the NHS Outcomes Framework (page 10)?

We have not received many critical responses to the Framework overall, so broadly speaking we do agree with the key principles.

Q2. Are there any other principles which should be considered?

In the definition on principles, it may be useful to distinguish between those that apply at a population level (such as equity and efficiency), and those that apply at the level of individual patients (such as access, efficacy and safety). The definition of quality (paragraph 2.10) should be expanded to include ‘access’, as however good care may be it is of no use if patients are prevented from accessing it (for example by long waiting times). Including access as a necessary if not sufficient definition of quality may also go some way to addressing health inequality issues.

Q3. How can we ensure that the NHS Outcomes Framework will deliver more equitable outcomes and contribute to a reduction in health inequalities?

If the Framework is built on evidence-based principles and is implemented in a consistent manner it may, in the long term, have some effect in addressing health inequalities. However, being based on a whole range of factors and sectors this will be hard to predict and to demonstrate success. It will need to be rigorously and comprehensively monitored to ensure equitable outcomes, and members are concerned that increased diversity of providers and competition within the sector will make this more complex and costly than the current system.

There is a possibility also that any progress towards reducing health inequalities may be threatened by the emphasis on patient choice – whilst this is obviously desirable in principle, it has long been understood that choice is a factor in the operation of the ‘inverse care law’ – those with the greatest health needs are often those with the least ability to exercise choice.

Q4. How can we ensure that where outcomes require integrated care across the NHS, public health and/or social care services, this happens?

There is already a strong evidence base for indicators for many specific clinical conditions, held within NICE and/or the Royal Colleges, plus in the research base

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from academic partners. Where sets of indicators need to be created for standards of clinical pathways operating across sectors, these should be rapidly collated as a basis for commissioning and provision. These indicators should be piloted before being rolled out, which would be much more cost-effective than implementing a wide roll-out and then finding them problematic.

It is also important to recognise that outcome indicators which operate across clinical services will need to be applicable regardless of the differing geographical and population bases of the commissioning consortia, healthcare providers and local authorities who are unlikely to have coterminous boundaries under most circumstances. Clear guidelines will need to be set on how these different bodies are to approach setting local priorities for achieving these outcomes.

**Five domains**

Q5. Do you agree with the five domains that are proposed in Figure 1 (page 14) as making up the NHS Outcomes Framework?

Yes, we do agree with the domains specified – but see Q6.

Q6. Do they appropriately cover the range of healthcare outcomes that the NHS is responsible for delivering to patients?

We would argue that consideration should be given to a sixth domain relating to reducing health inequalities and improving inclusion. The current domains fit well with the experiences and outcomes of individual patients, but may not advance population-level issues of equity and efficiency. A domain around health inequalities would encourage and incentivise providers to address environments in which poor outcomes occur. An outcome indicator relating to inclusion would also help ensure services focus on hard-to-reach groups and non-registered people.

**Structure**

Q7. Does the proposed structure of the NHS Outcomes Framework under each domain seem sensible?

Sensible seems a weak criterion for evaluation: the value of the structure depends on whether ‘measuring the measurable’ occurs at the expense of aspects of holistic care, including the practitioner/patient relationship, which are much harder to measure. PROMs may be expected to proxy for this, but we encourage caution – see below. The NHS may require time and support to develop quality standards that meet the needs of this structure – at present, many NICE standards are largely process rather than outcome measures.

**Domain 1 – Preventing people from dying prematurely**

Q8. Is ‘mortality amenable to healthcare’ an appropriate overarching outcome indicator to use for this domain? Are there any others that should be considered?

Yes, we agree that it is appropriate, but with a number of important provisos: that care should be taken with international comparisons, as these are known to be difficult (because of e.g. changes over time in coding practices in multiple countries); that consideration should be given to health outcome differences in black and minority ethnic populations; and that consideration should be given to more modest performance levels for patients in situations of multiple deprivation.

Q9. Do you think the method proposed at paras 3.7-3.9 (page 20) is an appropriate way to select improvement areas in this domain?

Yes it is, so far as it goes. We would question however the complete exclusion of mental health issues from the list of causes of mortality amenable to healthcare in Annex A. Given that suicide is one of the leading causes of death amongst young men and women, and that suicide is in many cases associated with psychotic illness\(^6\), this seems a significant omission from this section.

Q10. Does the NHS Outcomes Framework take sufficient account of avoidable mortality in older people as proposed in para 3.11 (page 21)?

Yes, it does. However the approach outlined is more suitable to assessing care of older people in the hospital setting. We would like to see thought given to ways of

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assessing the access of older people to multidisciplinary community healthcare, since the emphasis should be on extending the years of quality living.

Q11. If not, what would be a suitable outcome indicator to address this issue?

See above.

Q12. Are either of the suggestions at para 3.13 (pages 21) appropriate areas of focus for mortality in children? Should anything else be considered?

The areas suggested are appropriate. We would also like to see more nuanced indicators that could take account of non-accidental injury in children, and also, perhaps an indicator to cover childhood cancers.

**Domain 2 - Enhancing the quality of life for people with long-term conditions**

Q13. Are either of the suggestions at para 3.19 (page 24) appropriate overarching outcome indicators for this domain? Are there any other outcome indicators that should be considered?

While efforts to assess quality of life are laudable, the measures identified are potentially so subjective as to be of very limited practical use. Such questions need refining to be robust and valid, and problems have occurred with such questions previously – for example, in the results of the recent GP Patient Survey⁷, a very high 49% of respondents self-identified themselves as having a long-standing health problem, disability or infirmity, a considerably greater number than clinical evidence would predict. The second proposed question (‘feeling supported to manage your condition’) is one of a number of possible questions that could be used in this area. However this question forms part of the care planning questions in the GP Patient Survey: one of our academic colleagues notes that ‘these questions did not fare well in cognitive testing by IPSOS-MORI and do not show good practice-level reliability’.

Q14. Would indicators such as those suggested at para 3.20 (page 24) be good measures of NHS progress in this domain? Is it feasible to develop and implement them? Are there any other indicators that should be considered for the future?

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⁷ GP Patient Survey 2009-10 http://www.gp-patient.co.uk/results/
We are concerned about the reliance on PROMs. As stated in our response to the February 2009 consultation on developing Quality and Outcomes Framework\(^8\), we do not feel PROMs and their interpretation have been sufficiently scientifically validated, and particularly not for the purpose of tracking longitudinal progress in the UK. There are a number of identified problems with PROMs – concerns that their impact on clinician behaviour is limited\(^9\); important differences in assessments of care in different ethnic minority groups\(^10\); possible negative effects of PROMs on the doctor-patient relationship/communications; and patient concerns about who will review or use the information. Even in the absence of harm, the use of PROMs (performing the surveys, computing and reviewing) is a costly process, and should be considered very cautiously in the current financial climate\(^11\). We would urge that further expert advice be sought before proceeding with the measures currently identified. The RCGP and the academic Heads of Department have expertise which may assist in this regard.

Q15. As well as developing Quality Standards for specific long-term conditions, are there any cross-cutting topics relevant to long-term conditions that should be considered?

Indicators for end-of-life care would seem to be a relevant omission here.

**Domain 3 – Helping people to recover from episodes of ill health or following injury**

Q16. Are the suggestions at para 3.28 (page 27) appropriate overarching outcome indicators for this domain? Are there any other indicators that should be considered?


\(^{9}\) Valderas J et al. The impact of measuring patient-reported outcomes in clinical practice: a systematic review of the literature (Quality of Life Research 2008 Volume 17, Number 2, 179-193)

\(^{10}\) Mead N and Roland M. Understanding why some ethnic minority patients evaluate medical care more negatively than white patients: a cross sectional analysis of a routine patient survey in English general practices (BMJ 2009 339(163), b3450-).

We feel that great care should be taken with these indicators to avoid perverse incentives developing (see paragraph 6 in this response). These indicators, when applied at the local level, may ultimately give GPs an incentive not to refer patients to hospital, when obviously what is required is for them to be free to apply their clinical judgement. The indicator on ‘emergency hospital admissions’ also requires a subjective judgement of which conditions are appropriate for secondary care. With the ‘emergency bed days’ indicator there is also the perverse incentive for a hospital to keep a patient in a bed for longer than necessary rather than risk them being readmitted.

It has also been noted that these indicators are very much focused on secondary care – whereas recovery from illness is, on the whole, a primary care activity.

Q17. What overarching outcome indicators could be developed for this domain in the longer term?

This needs answering from the existing evidence base, and we would urge more careful consideration before pressing ahead with indicators which may have the perverse outcomes suggested above.

Q18. Is the proposal at paras 3.30-3.33 (page 28-29) a suitable approach for selecting some improvement areas for this domain? Would another method be appropriate?

Please see our earlier comments (Q14) with regards to PROMs. We are not convinced that these are sufficiently proven that they should be given such significance.

The other measures (causes leading to most emergency bed days) are, of course, very secondary care based. As noted in our answer to Q16, recovery from illness is more often managed through primary care, and we would wish to see appropriate indicators developed.

It is also suggested that these specific indicators for unplanned care might be symptom rather than diagnosis-based. That is, when a patient is admitted it is based on a set of symptoms (i.e. Chest pain), and the indicators may be more useful if framed in this way.

Q19. What might suitable outcome indicators be in these areas?

Length of stay might be a useful indicator here.
**Domain 4 - Ensuring people have a positive experience of care**

**Q20. Do you agree with the proposed interim option for an overarching outcome indicator set out at para 3.43 (page 32)?**

We broadly agree with the proposals in this paragraph, but with some concerns about the detail. Patients cannot be good judges of the overall quality of their care – quality of interpersonal communication does not always reflect whether a clinician has done the right things. Similarly, assessment of the quality of coordination of care is a complex issue without agreed criteria. Lastly, the inclusion of choice in this section posed problems for some of our respondents, who questioned how much one could generalise about what patients want – for example, choice of treatment rather than choice of provider.

**Q21. Do you agree with the proposed long term approach for the development of an overarching outcome indicator set out at para 3.44 (page 32-33)?**

Yes, this approach seems appropriate.

**Q22. Do you agree with the proposed improvement areas and the reasons for choosing those areas set out at para 3.45 (pages 33-34)?**

Yes, we do agree with these proposed improvement areas, although we would question the division into different strands of care – it might be useful to have some more holistic improvement areas, emphasising continuity of care.

Respondents mentioned nutrition in hospital as a potential indicator in the section.

**Q23. Would there be benefit in developing dedicated patient experience Quality Standards for certain services or client groups? If yes, which areas should be considered?**

Yes, there probably would be benefits. Our respondents suggested potential Quality Standards for different BME communities and for people with mental illness – however, they recognised the difficulty and potential complexity of doing this:– where to set the sub-divisions and how to assign patients appropriately to Quality Standards.

**Q24. Do you agree with the proposed future approach for this domain, set out at paras 3.52-3.54 (pages 36-37)?**
Yes, we feel this is a very thoughtful and sensible section, particularly the emphasis on cross-cutting conditions and complex and multiple service use. We would like to see the addition of hard-to-reach-groups – asylum-seekers, homeless, travelers etc – as a priority in this section. These groups often have significant health needs but have poor access to often substandard care.12

**Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm**

**Q25. Do you agree with the proposed overarching outcome indicator set out at para 3.58 (page 38)?**

No, we do not agree with the measures that make up this indicator. Incident reporting in particular is a poor measure of safety – near misses will be poorly recorded, and this approach is at odds with the methodology which focuses on small measures of change. There is perceived to be a culture of blame within the NHS, and more work will be needed here to overcome this and encourage greater openness and reporting.

**Q26. Do you agree with the proposed improvement areas proposed at para 3.63 (page 39-40) and the reasons for choosing those areas?**

Yes, we broadly agree – the focus on vulnerable groups is particularly welcome. However, we would advise caution on the use of emergency re-admission as a measure of safe discharge/transition – it is not proven that emergency re-admission is often caused by deficiencies in previous care. And a case may be made for including over-investigation/inappropriate investigation amongst the indicators in paragraph 3.63 under safe treatment.

Also, this is again very much focused on secondary care. We would recommend reference to the RCGP’s Practice Accreditation Scheme13 as a tool for thinking through how to address patient safety in the primary care setting.

**General Consultation Questions**

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12 Flanagan S, Hancock B. Reaching the hard to reach – lessons learned from the voluntary and community sector- A qualitative study (BMC Health Services Research 2010 Apr 8;10:92)

Q27. 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 outcomes for all patients and, where appropriate, NHS staff?

Feedback needs to get back to those responsible for services in a way that supports improvement.

Outcome measures need to be clearly attributable to the people they are measuring – otherwise they risk demotivating staff and/or lead to gaming with statistics.

All outcome measures must be evidence based, or at the very least based on informed consensus, and piloted wherever possible.

Q28. Is there any way in which the proposed approach to the NHS Outcomes Framework might impact upon sustainable development?

Yes – inevitably the outcomes framework will result in investment and concentration on the identified measures, and relative neglect of non-measurable aspects of care.

There are also inevitable costs in developing, implementing and analysing the results of the framework.

Q29. Is the approach to assessing and analysing the likely impacts of potential outcomes and indicators set out in the Impact Assessment appropriate?

We have no comments on this.

Q30. How can the NHS Outcomes Framework best support the NHS to deliver best value for money?

Respondents suggested a number of approaches to this:

1. The framework should only collect appropriate data that can usefully be acted upon.

2. Measures should be carefully piloted before implementation.

3. The Department of Health should create clear channels of communication with the professions involved so they see the framework as an aid to improving patient care rather than a stick to beat them with.
4. The framework should find ways to avoid incentivising over- or inappropriate treatment. Unnecessary treatments carried out from fear of missing something cost money and cause harm.

Q31. Is there any other issue you feel has been missed on which you would like to express a view?

We have no comments on this.

ANNEX A: Identifying Potential Outcome Indicators

Potential indicators

Q32. What are the strengths and weaknesses of any of the potential outcome indicators listed in Annex A with which you are familiar?

As already stated, we would argue for careful piloting of all outcome indicators – we do not feel this is the time to be assessing them individually.

Beyond the indicators themselves, we would foresee problems in the coding and collection of data preventing accurate comparisons over time.

Q33. Are other practical and valid outcome indicators available which would better support the five domains?

There possibly are – this is a huge question, and will require extensive research and piloting, as already mentioned.

Q34. How might we estimate and attribute the relative contributions of the NHS, Public Health and Social Care to these potential outcome indicators?

We feel this is very difficult, but hugely important to do. The College recognises the key importance of collaboration between services in achieving desirable outcomes, and we await the proposals of the forthcoming Public Health White Paper.

Principles for selecting indicators

Q35. Are the principles set out on pages 48 and 49 on which to select outcome indicators appropriate? Should any other principles be considered?
Yes, they are appropriate. Additional principles might be that indicators should be unambiguous in wording, evidence or consensus-based and piloted for issues of feasibility, validity, reliability, unintended consequences and cost effectiveness.

Indicators should also be able to be disaggregated by consideration of environment, level of deprivation and health inequality and other local data.

11. We gratefully acknowledge the many contributions of College members, and in particular members of the College Council and the Patient Partnership Group, 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 Response¹⁴

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;
v. a crucial role for the RCGP in setting standards, leading by example, sharing good practice, disseminating information, setting standards for clinical pathways and

¹⁴ 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.
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.