NHS Future Forum – October 2011 Workstreams

1. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 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.

2. I write with regard to the current workstreams of the NHS Future Forum:-

   - How can information be made to help improve health, care and wellbeing.
   - How to develop the healthcare workforce to deliver world-class healthcare.
   - How to ensure the public's health remains at the heart of the NHS.
3. We understand the fourth workstream – how to ensure the modernisation programme leads to better integration of services around people’s needs – is due to report at a later date. The College has undertaken a considerable consultation process of its own around this theme, and will report in due course.

4. With regards to the current three workstreams, the College has engaged in a number of ways, including one-to-one meetings and a full consultation process. We note that on this occasion the engagement of our membership has been much less enthusiastic than was the case with the first Future Forum Listening Exercise earlier this year. We draw this to your attention because we think it is important that you know that our members are perhaps suffering from what might be called ‘consultation fatigue’. Some members have reported a perception that the impact of their engagement has been less than they had hoped for, and also some concern at how representative the views gathered by this approach have been. Nonetheless, as a College we have tried hard to encourage members to input their views to the themes addressed by this second stage of the Future Forum, which we do regard as important and in need of systematic, strategic policy development, based on robust evidence. We hope this puts the following response in the appropriate context.

5. We have addressed the specific questions of the Future Forum below:

How can information be made to help improve health, care and wellbeing

We refer you to the College’s response, earlier this year, to the Department of Health consultation ‘Liberating the NHS: An Information Revolution’¹ and to the many publications in this area of the RCGP Health Informatics Group².

How can cultural and behavioural change be fostered to stimulate collection and use of data among all professionals?

It is our view that general practice, and primary care in general, is already well advanced in this respect, with most GPs regarding the accurate recording, collection and use of data, as in the electronic patient record, as a critical part of their role. We would argue that there is a need to bring the quality of information use in secondary care to an equivalent level in order to maximise the advantages for patients.

With regards to cultural and behavioural change, our respondents suggested a number of principles that might be beneficial if borne in mind:

- Robust standards and systems must exist to demonstrate that patient confidentiality is respected at all times. This remains a concern, and clear prioritisation of confidentiality will encourage confidence from both clinicians and patients.

- Information systems should be designed so as to complement rather than increase the burden of existing workflows. One respondent gave as a negative example a PCT where, as a result of SystmOne rollout, health visitors are now required to triple-record data, which inevitably inhibits take-up of new systems.

- Whilst recognising the need for some degree of performance metrics, staff are far more likely to embrace and implement data systems that have a demonstrable clinical use. As in any environment, the recording of data merely to monitor workload and performance may have a harmful effect on the workforce’s sense of professionalism and self-motivation.

- Potentially as effective as financial incentives, clinicians will welcome new systems and feel a sense of ownership if they see feedback and observable outcomes from data that they have contributed to collecting. In primary care, many GPs observe that they would value real-time data on their referrals, prescribing etc, which would enable them to make adjustments in practice as and when needed.

- An emphasis on standards for interoperability of systems to avoid duplication of data recording will have major efficiency benefits.

- Standards for data recording, collection and use must be developed by or with the relevant professional bodies, Royal Colleges etc, rather than being imposed by those, such as government, who may have less clear understanding of the practical implications and be less able to gain the support and ‘buy-in’ of professionals.

- Critically, it must be recognised that information systems will fail without the local education and training to back them up. Resources must be allocated for this training along with implementation, as skimping on this would be a very false economy. Education and training should emphasise the value of data for research and service development, so that clinicians are enabled to regard it as an opportunity rather than a burden.
How can we ensure information is available that enables people to take more control of their own care and enable shared decision-making?

This has been a significant concern of the RCGP Health Informatics Group, notably in their publication ‘Enabling Patients to Access Electronic Health Records’\(^3\). Patient access to their records, safely governed by uniform clinical record and data standards and reinforced by patient education around rights, responsibilities and confidentiality issues, should enable shared decision-making.

More generally, shared decision-making is a recognised element of the GP-patient consultation. The RCGP is at the forefront of training GPs in consultation skills for shared decision-making. The College argues that the key to choice lies in continuing and enhancing this process: greater availability of real time information for GPs and patients, retaining practice–patient continuity, and longer consultation times to help absorb information and make good decisions, together will enable GPs to support informed discussions and reach shared decisions in which clinical expertise is married to individual preference.

Patient-held records and the ability to input from home – blood pressure monitoring for example – will also enable patients to take more control; however, there needs to be a note of realism – such measures will never apply to all patients, all of the time, and should not be seen as an alternative to providing conventional services. Similarly telephone or online consultations may be useful at times, but must not replace the availability of face-to-face consultations for all those who need or prefer them.

Localised information resources – about conditions and services, perhaps commissioned at CCG level - will also be valuable in helping patients take more control. That said, the expertise of GPs and other clinicians remains vital – for example, information about conditions must be contextualised at a finer level of detail than a leaflet or website can typically provide, especially as multi-morbidity is now the norm for many patients.

The RCGP’s recent publication, ‘It’s Your Practice’\(^4\), provides valuable guidance for patients to enable them to make the most of GP services.


How can we ensure that information supports improved care and better integration of services (for example, commissioning, research, clinical audit, public health) whilst protecting patient confidentiality?

Once again, the RCGP Health Informatics Group have considered these kinds of issues, as in their ‘Shared Record Professional Guidance Report’\(^5\) and contribution to the Department of Health’s ‘Good Practice Guidelines for GP Electronic Patient Records’\(^6\).

There is a need for greater interoperability of systems, common read codes and common standards for data input to allow anonymised data to be comparable, safe and accurate, both between practices and across primary and secondary care. Accompanying this, there is a need for investment in technologies, such as safe data havens, to facilitate greater collection and use of anonymous data.

Data collection must always allow for patient consent and opt-outs. The difficulty here is for consent to be informed – patients need to be helped to understand what is actually in their record before they can decide on the need for confidentiality.

Other suggestions received from respondents include:

- Using patient/lay assessors to ensure that information governance requirements are being met locally.
- Use of smartcard technology to ensure that patient-identifiable information is only accessed for direct patient care.

How can we open up access to information and support people to use it?

We would argue that there is already a lot of information available – what is lacking is the means of interpretation and enabling the public to interpret with confidence this information. Established and trusted websites – NHS Choices and GP practice websites, for example – should be used as portals for additional information that meets agreed quality standards. Training stations and staff available for this purpose in practices and hospitals, to guide patients through the process of finding and interpreting information about their health needs, would also be useful – though we recognise the difficult cost implications of such initiatives.


Patients (and staff) must be educated so as to encourage a culture of self-care wherever possible. The use of the latest technologies, for example smartphone apps for diabetes, has a role to play. What must not be the case is that we rely on these technologies to the exclusion of tried and tested approaches and face-to-face consultations, since this risks discriminating against those with additional communication difficulties or with poor access to or uptake of technology, and exacerbating existing health inequalities.

**How to develop the healthcare workforce to deliver world-class healthcare**

We refer you to the College’s response, earlier this year, to the Department of Health consultation ‘Liberating the NHS: Developing the Healthcare Workforce’\(^7\). In this we expressed significant doubts about the current plans for education and training, especially with regards to:-

- the capacity of Local Education and Training Boards (LETBs) adequately to commission education for primary care. It is vital that a high proportion of board members are GPs and other primary care staff, given the large numbers of staff in the community-based workforce and their predominance in clinical load. Dominance by larger providers such as Foundation Trusts should be avoided;

- the capacity of the new system to meet regional and national strategic needs – which will need substantial coordination of workforce planning;

- uncertainty over the stability of the functions of the Deaneries, which were perceived as fulfilling a valuable function in primary care education;

- proposals for a degree of multi-disciplinary training, which some felt threatened to undermine aspects of core GP training;

- the lack of consideration for academic career pathways, particularly in primary care. These have only just become established, and play an important role in the development of the profession and evidence-based best practice. The worry is that, without central direction, LETBs will not be sufficiently motivated to support and fund these pathways, which require a funding pool for backfill. There should be an obligation placed on CCGs to support such backfill and commission accordingly;

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finally, that consortia should be authorised to continue to provide training placements for health professionals, both at undergraduate and postgraduate levels; otherwise there is a risk that formal training in these settings may become a lower priority and the important role of community staff and access to their patients be lost.

How can we ensure that education and training in the new system is flexible and fit-for-purpose for the new way that care is delivered and enables training beyond the job, for example stimulating a culture of continuing professional development or academic and research development?

The RCGP is campaigning for enhanced GP training – an extension of the period of training to ensure that all GPs have the experience and confidence on entering the profession to meet all of the challenges that the role now entails, including experience of working in under-doctored areas and areas of high deprivation and health inequality. GP training currently has the shortest length of postgraduate training of any specialty, at precisely the time when the financial and evidence-based emphasis is to deliver a greater volume of healthcare in the community rather than in hospitals.

It appears to us that the vital impetus to deliver more contact with patients in community settings during training is threatened by the destabilisation of current SIFT/MPET funded opportunities. These or similar funding streams ought to be maintained, and CCGs should have the statutory expectation to support training and CPD placements across their geographic community. It is understood that a wider exposure to different patient communities in training has a positive effect on the clinician’s later ability to tackle the variety of healthcare needs that he or she may face, and in particular has a role in addressing health inequalities.

As ever, continuing professional development (CPD) needs to be developed in such a way that it is perceived by clinicians as necessary (perhaps for appraisal and revalidation) but also useful for their clinical practice, and not just a box-ticking exercise. Under the proposed new systems, many GPs will have greater responsibilities and more calls on their time and resources than ever – the more integrated it is with these responsibilities, the more likely CPD is to be appreciated.

In a similar vein, there is a concern that CPD, if delivered in a ‘multi-disciplinary’ way as envisaged, may not always be efficient or cost-effective. At the very least consideration should be given to the possibility of delivering CPD around workstreams (e.g. a primary care workstream) rather than in professional silos.
How can we ensure the right balance of responsibilities and accountability and line of sight throughout the new system (for example, Health Education England and the provider-led networks, employers / professions / education sector, whole workforce) including for research training?

Once concern is that, with LETBs, education and training will be developed on a largely local basis and produce a workforce that is not equipped to transfer between regions, and therefore not able to meet national workforce needs. Health Education England (HEE) will therefore have an important role in setting robust national standards and sharing intelligence on best practice. Another suggestion is that, whilst LETBs would retain some autonomy as to local workforce development needs, they might be required to operate within a ‘floor’ and ‘ceiling’ set by HEE – so, to take an extreme example, an LETB in one area would not be able to choose to train no midwives in the expectation that other areas would pick up the shortfall. It is imperative that the national balance of healthcare staff is maintained and remains responsive to change.

As mentioned above, we are concerned that LETBs may be dominated by large secondary care providers, to the detriment of primary care education and the efficiency of the NHS as a whole. One suggestion has been that there could be separate primary care training boards to ensure appropriate prioritisation.

Lacking this, it is vital that primary care clinicians are statutorily represented on the executives of all LETBs, that there be a clear role description for these representatives that includes a duty to consult and a person specification that includes the attributes, skills and experience necessary for the role, that the LETBs have clear governance and accountability arrangements that address conflict of interest and require an annual report, that they be required to publish their constitution and terms of reference and that these must specifically refer to the importance of primary care as an essential component of a high quality, cost-effective healthcare system.

How do we best ensure an effective partnership with health, education and research at a local level?

As discussed above, it will be very important to have clarity about finances, and how they move if students and/or activities move. There must be statutory obligations on CCGs and LETBs to fund their respective responsibilities and give an appropriate level of support to coordinated academic career pathways. Representation of academics on CCG boards would also be a very welcome development.

How can we ensure appropriate and effective patient and public engagement in the new system?
As already specified, LETBs must be accountable and transparent. Actual patient and public engagement may be difficult to secure – but there may be a role for local HealthWatch bodies to partner with CCGs in supervising commissioning for training and education.

**How can we improve information on the quality of education and training and what should be the roles and accountabilities of the key players in this?**

HEE must take a lead here, by defining, along with Royal Colleges and others, what quality in medical education and training should look like, with an emphasis on educational outcomes rather than processes, and then quality assuring the providers. This should enable the CCGs to commission services with confidence that education and training needs will be met.

**How to ensure the public's health remains at the heart of the NHS**

We refer you to the College’s response, earlier this year, to the Department of Health consultation ‘Healthy Lives, Healthy People: Our strategy for public health in England’\(^8\).

**What role could NHS and health and care professionals effectively play in systematically delivering improved population health outcomes, including tackling inequalities?**

Our members have identified both risks and opportunities in the currently proposed reforms of health and public health services. The chief risk, clearly, is that by the transfer of public health staff to local authority employment, this expertise will be detached from the current close working relationship with primary care. GPs, and especially those working on Clinical Commissioning Groups (CCGs), must have access to this public health expertise if they are fully to fulfil the new expectations placed on them under the Health and Social Care Bill.

The Public Health White Paper envisaged CCGs and local authorities working together, through local Health and Wellbeing Boards and Joint Strategic Needs Assessments to plan resource allocations and interventions across localities and populations. Given the likely continuing scarcity of resources, this relationship, and the ability to see through conflicting priorities and target resources to those areas of greatest need, will be vital.

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There is a concern that primary care, traditionally concerned with serving the health needs of registered practice populations, will struggle with the adjustment, at CCG level, to commissioning for whole populations. There is more work to be done around the registration of homeless and other vulnerable groups to ensure that services are commissioned and delivered according to need. This will require research, information about best practice to be disseminated, and use of the available levers to ensure that tackling health inequalities is explicitly incentivised – outcome measures may be of use here.

Some GPs may be reluctant to embrace public health interventions (such as obesity or smoking cessation advice) that appear to be dictated without a solid evidence base or understanding of primary care; this even more the case where resources are limited but initiatives can appear limitless. GPs are more likely to implement with full success interventions that are evidence-based, limited in number and that can be conducted in a way that does not take over the whole doctor-patient relationship to the detriment of clinical care. It follows that research to identify and disseminate such interventions will be invaluable in the cash-strapped times ahead.

Our members are also concerned that the ‘choice agenda’, which is very prominent in the Government’s description of its proposed health reforms, may undermine the ability to ‘systematically deliver improved population health outcomes’, and remain unconvinced that those who most readily exercise choice, and thus consume disproportionate resources, will always be those with greatest need. Whilst patient autonomy and choice may be a powerful agent for change, this needs to be accompanied by education as to the practical limits of choice, lest resources that might be strategically targeted at vulnerable groups are instead diverted to those with the loudest voice.

What are the mechanisms that commissioners, providers and the wider system could use to help support professionals in improving outcomes?

We have already identified above some of these mechanisms – access to public health data and expertise, identification of evidence-based best practice, the political will of local authorities and CCGs to target resources appropriately, and public education as to the importance and limits of choice will all have a role.

Our respondents have identified a number of further mechanisms that will be important:

- Better quality, local and real-time information on outcomes, including the outcomes of specific initiatives, that can be used to inform responsive commissioning and clinical decisions, and strategic interventions via Health and Wellbeing Boards.
• The ability of commissioners to set outcome-based contracts, to ensure responsiveness of providers to commissioning priorities.

• Further funding in primary care to allow for longer consultation times and additional primary care staff (thus facilitating the kinds of public health interventions envisaged).

• Incorporation of outcome-based audit of care into appraisal and revalidation processes, so that clinicians are encouraged to assess themselves against priority outcomes.

How can we ensure that the NHS’s role in the public's health aligns with the roles of Public Health England and local authorities?

This is a key worry as identified above. The reforms to public health and to healthcare commissioning, at a time of straitened finances, run the risk of an increase in silo working. On the other hand, if properly implemented, Health and Wellbeing Boards and JSNAs could bring a new era of cooperation between health services and local authorities.

For this to happen, outcome measures will need to be sufficiently harmonised so that different sectors are incentivised to plan together. And the Health and Wellbeing Boards must be scrupulous in ensuring that CCGs are involved at every stage – for example in the scheduling of meetings to ensure that CCGs are represented and clear information flows across sectors, including making sure that public health expertise is not isolated from clinical commissioners.

How can the NHS contribute to people's health and wellbeing in its role as a large employer?

As by far the largest employer in the country, the NHS is clearly in itself a statistically significant contributor to health outcomes. A stressed and overworked workforce reduces the capacity of the NHS to support the health and wellbeing of the population as a whole. The current erosion of national terms and conditions and encouragement of competition between providers may well be a threat in this respect. A strong occupational health service is vitally important here. The RCGP’s well-received Health for Healthcare Professionals⁹ pilot training programme would also be a useful model of what can be done.

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6. We gratefully acknowledge the contributions of members of the College’s Council, Health Informatics and Education groups and regular College members in formulating this response.

Yours sincerely

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Honorary Secretary of Council