Royal College of General Practitioners

Health and Social Care Bill: Re-committal to Bill Committee
Call for written evidence – RCGP response

Introduction

1. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the UK 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.

2. RCGP welcomes the opportunity to submit written evidence to the Public Bill Committee on the Health and Social Care (Recommitted) Bill. The College understands that the NHS needs to change. We acknowledge and welcome the focus in the proposed reforms on patient outcomes, choice and value for money. We welcome placing General Practitioners (GPs) at the heart of planning services for their patients, and increasing professional and patient involvement in health service design and funding decisions, and accept competition in provision of services where it adds value to existing services without risking essential services or damaging equity of access or outcome. We welcome an increased focus on prevention, reducing health inequalities, and improving joint working between health and social care.

3. The Government's response to the Future Forum and the proposed amendments are an encouraging step in the right direction, and this suggests that the Government has taken on board at least some of our concerns. We acknowledge that in a number of the areas where we raised concerns amendments have been tabled which seem to move in the direction we have called for including greater integration, patient voice and avoidance of conflicts of interest.

4. We do, however, continue to have a number of areas of concern where we look to the Committee to ensure the legislation provides the clarity and rigour that is needed.

5. When we presented evidence to the Committee mention was made of a survey of RCGP members. Initial results can be viewed here.

Duty of Secretary of State

6. As a consequence of establishing independent commissioning groups and an independent NHS Commissioning Board, and - by extension - the Secretary of State's power to direct these bodies as he could the SHAs and the PCTs, the Bill removed the Secretary of State's current direct duty to "provide or secure the provision of services".

7. Although we welcome amendments 54 to 56 that ensure that the Secretary of State's duty to promote a comprehensive health service will be retained along with ultimate accountability for providing or securing the provision of services, we are concerned that this does not a direct accountability.

8. Rather than securing services directly (as before the reforms), the Secretary of State will be exercising his duty to provide in future through his non-directive relationship with the NHS bodies to be established through the Bill, for example the NHS Commissioning Board by way of the "mandate".

9. Ministers will be responsible, not for direct operational management, but for overseeing and holding to account the national bodies – in particular, the NHS Commissioning Board and the regulators – backed by powers of intervention in the event of significant failure. The RCGP continues to believe that responsibility must ultimately lie with the Secretary if State for securing the provision of NHS services.

Multi-professional involvement in commissioning

10. The RCGP has long called for other health professionals to be involved in commissioning and believe that closer working with these colleagues will be a much better way of achieving care that crosses organisational boundaries.

11. NHS chief executive Sir David Nicholson has also recently said that structures based on PCT clusters would remain in place as “local arms of the NHS Commissioning Board” – even where Clinical Commissioning Groups (CCGs), or GP consortia, were ready to take the majority of the budget.

12. There is a danger that this could lead to CCG becoming mere 'agents' of the Board rather than having freedom to innovate and meet needs of local populations.

13. We have also have major concerns that there is a vastly increasing bureaucracy that, rather than freeing consortia to commission what is appropriate locally and lead service redesign, will instead constrain it further.

14. With the new announcements the structure of the NHS is looking even more confusing and bureaucratic with: the National Commissioning board; SHA clusters; regional NCB bodies; clinical senates; PCTs; local NCB bodies; Health and Wellbeing boards; Clinical Commissioning Bodies. We estimate that the number of statutory organisations will almost treble.

15. We look to the Committee to strictly limit through amendments Clinical senates and other bodies to advisory roles and ensure that the emphasis on GP commissioning leadership is not lost. It is crucial that GPs be given the freedom and autonomy to lead the decision-making and design of future integrated health systems drawing on the support of other health, social care and third sector services. We support clinician-led commissioning but continue to believe that GPs are best placed to lead this process.

16. We are concerned that there appear to be no safeguards against the wholesale privatisation of commissioning support, in other words the outsourcing of commissioning work to organisations with a conflict of interest in relation to providers of services and whose activities and processes are not as transparent as those in the public sector. Furthermore, retaining the link with the public health function, based in local authorities, is essential and is undermined by such outsourcing from the Clinical Commissioning Groups to such entities.

Equal treatment of public and private sectors

17. We are encouraged by amendments that would prevent Monitor, current or future Ministers and the NHS Commissioning Board from pursuing any deliberate policy to increase private provision of NHS services

18. However, if the Government wish to encourage innovation, the development of social enterprises or new models of delivering good patient care in the NHS then Ministers may have to be partial - the NHS and those who rely on its services need the Government to be a champion. For example the Government’s commitment to “promoting” the ‘right to provide’ – the ability for staff to form social enterprises or mutuals to drive innovation and

improve the quality of services – in section 5.39 of its response to the Future Forum would be in direct contravention of this rule.

19. In the absence of any duty on the NHS Commissioning Board, CCGs, Monitor and the CQC to have regard to the risk to existing essential services, such as A&E, ITU, training and research, when authorising or encouraging new market entrants, then the proposal of neutrality between the NHS and private providers leaves NHS service vulnerable to being undermined or destabilised. The RCGP does not oppose clinically-led planned hospital service closures in relevant circumstances but we fear for the welfare of the sickest or most vulnerable patients if existing essential services are undermined or destabilised.

20. Furthermore the proposal in amendment (148) to in respect of Monitor's duties there is a duty on Monitor to prevent anti-competitive behaviour where it is not in the interests of patients. But neutrality demands that there needs to be a duty to prevent anti-collaborative behaviour which could similarly be against the interests of patients, and this is a separate issue from the question of the duty to promote integration?

21. Without this, Monitor would remain focused on preventing anti-competitive behaviour where this harms patients but not be concerned with anti-collaborative behavior.

Integrated care

22. The RCGP welcomes the amendments that make it explicit in the Bill and in regulations under the Bill that clinical commissioning groups will be responsible for arranging emergency and urgent care services within their boundaries, and for commissioning services for any unregistered patients who live in their area.

23. Amendment 149 places a new duty on Monitor to exercise its functions with a view to enabling services to be provided in an integrated way, where this would improve their quality or the efficiency of their provision, or where it would reduce inequalities for patients. This is encouraging, although the continuing emphasis elsewhere on competition and choice runs a real risk of undermining integration., there will need to be an ongoing review of its role by the Bill committee. The fear is that it will no longer be possible to deliver integrated services in practice, especially where integration relies on close collaboration between different NHS providers and commissioners, and could be seen as anti-competitive.

24. Our definition of integrated care is primary care led, multiprofessional teams, where each profession retains their professional autonomy but works across professional boundaries, ideally with pooled budgets and ideally with a shared electronic (GP) record. The teams help create seamless care, with the social and specialist practitioners able to link back to their host organisations.

25. Whilst commissioning has to be extremely well done - it is not the sole answer and the provision must be designed around modern concepts of service delivery, by doctor from both primary and secondary cares, other clinicians, managers and patients to meet the needs of the patient and their journey through the system.

26. There are perverse incentives that still need to be addressed. Hospitals are incentivised through the tariff whereas GPs are performance managed to reduce patients going into hospital. In the present day, these two systems are still working in opposite direction. There is a need to look at tackling this issue through provider reforms, such as pooled budgets for primary, secondary and social care and the development of the GP record.

Health Inequalities

27. Amendments 68 to 70 and 109 to 111 emphasise the importance of the NHS Commissioning Board and clinical commissioning groups' duties in relation to reducing inequalities and promoting patient choice and patient involvement by separating them out. However, in order for the reforms to have a real effect in this area there should be an emphasis on the National Commissioning Board commissioning extra GPs in under-doctored areas.

28. For example the North West SHA region has a shortfall of 13% or 630 full time equivalents (FTE) GPs, while South Central SHA has an excess of 27% or 570 GPs. Statistics also illustrate a strong north/south divide in GP provision—the five southernmost SHAs have 23% more GPs per weighted population than the five northernmost SHAs.

29. The situation for PCTs is just as bad. Very substantial inequity exists with a greater range than at regional level. The range is from 30% under-provided to 70% overprovided compared with the England average.

30. However, there is still a lack of sufficient financial incentives for GPs to work in deprived areas and this must be addressed.

31. These amendments (68-70 and 109-111) introducing the new clause 13FB and 14NB change the duty on commissioners and the NHS Commissioning Board regarding choice from "having regard to the need to" promote patient choice and public involvement to "act with a view to enabling patients to make choices". In the explanatory notes (paragraph 59, pp 14-5) it states that "act with a view to" is a stronger duty than "have regard to the need to". However, the duties on both CCGs and the NHS CB to tackle health inequalities and unfair access remains at the "have regard to the need to" level of duty. The RCGP believes it is wrong that tackling health inequalities and unfair access is now a lower priority for CCGs and NHS CB than promoting choice.

Better use of NICE guidelines and PROMS

32. We welcome that amendments clarify that the NHS will be required to fund drugs already recommended by NICE, and that NICE will continue to provide definitive guidance to the NHS for the use of new drugs and health technologies.

33. The RCGP believes it is essential that a fair, national and transparent framework is established for making the difficult decisions about the best use of (limited) resources – and believes if anything the current role of NICE should be strengthened.

34. As well as this, there will need to be better use of NICE guidelines. These guidelines are currently disease specific but as patients in many cases have several related problems, there are resultantly four or five different guidelines for one patient – and some of these guidelines are mutually exclusive. As a result, GPs are led to concentrate on measurement rather than clinical judgement.
35. With specific reference to the use of Patient Reported Outcome Measures (PROMs), we have expressed previously our reservations about their accuracy and efficacy, and would press for much greater trialling before widespread and expensive implementation. It is vital to avoid crude ratings-based systems and the kind of skewed information gathering (wherein only aggrieved patients are motivated or encouraged to contribute).

36. We also note the necessity that feedback be collected anonymously and analysed independently, to avoid unnecessary and distressing patient-clinician conflict. GPs themselves would welcome improved options to offer feedback to other clinicians and services – for example the ability for rapid access e-mail feedback to care pathway leads.

Federated GP practices to help share expertise, share resources, reduce variation

37. The RCGP will continue to promote the development of high quality, effective patient centred care, with GPs at the heart of NHS service delivery. The RCGP believes that provider side reforms could deal with many of the issues without the need for repeated organisational change or by many of the proposed reforms.

38. We would strongly recommend the development of the RCGP Primary Care Federations model. Federations, or provider organisations, are made up of GP practices as well as other providers from social, mental health; community and secondary care (as appropriate), and include private and third sector providers. Federations can form the basis for locally determined education and training activities, peer support, service development and service improvement etc. Federations allow for a local focus as well as ensuring joint working and planning meeting the needs of the population. Under this system most health problems would be dealt with in primary care close to patients' homes, with hospitals reserved for acute illness, specialised investigations and major surgery.

39. As well as commending the Federated model of care, we believe the way forward should be to:
    - Ensure joint responsibility for patients within a geographical area, removing the perverse incentives for hospitals to maximise income by increasing activity and GPs to reduce expenditure by restricting access to specialist services. It seems that, at the second decade in the 21st Century that we should be considering patients in an area as “our patients” “our services” and “our care” rather than continuing this artificial divide between hospitals, community, primary and social care.
    - Improve the role and scope of generalist practitioners by building teams of generalist nurses, doctors and other health and social care professionals who have a range of broad-based skills;
    - Increase the number of general practitioners with the understanding that better investment in general practice improves patient outcomes, improves public health and is better value for money; (Since 2009 the number of full time equivalent (FTE) practitioners has fallen by 2.4%. The Treasury Minute on the Public Accounts Committee Report (16 February 2011) has already identified that there are considerable GP shortages in areas of highest need. We agree with the conclusions of this report that, ‘The Department should identify, as a matter of urgency, what measures can be implemented to drive up the numbers of GPs in deprived areas … to encourage GPs into areas of greatest health need’. Workforce issues should be dealt with alongside the new commissioning responsibilities such that GPs, in under-doctored areas, will be able to continue to offer frontline, personal and accessible care. The workforce also continues to age with only 14,938 (42.5%) of practitioners in 2010 under the age of 45 compared with 14,028 (49.1%) in 2000 while those over 55 number 7,812 (22.2%) of the total compared with 7,834 (21.8%) in 2009 and 4,990 (17.5%) in 2000.)
    - Ensure that general practitioners have sufficient training to meet their increasingly complex work by extending the current three-year training;
    - Ensure that patients are able to register with a good GP of their choice, close to their home, who is able to provide accessible, personal and co-ordinated care;
    - Have a greater focus on shared working across primary, secondary and social care;
    - Improve care systems for patients that promote total care, rather than disease-led care pathways;
    - Maintain the focus on improving patient outcomes - especially for those disadvantaged by personal and socioeconomic circumstances;
    - Support initiatives which allow for a better patient and public voice within the NHS and which enable people to play a greater part in their society;
    - Support initiatives, such as Teams-without-walls that allow generalists and specialists to work together to provide treatment closer to patients' homes;

- Invest in better end-of-life care, such that patients receive tailored care at the end of their life that reduces the reliance on unnecessary and unwanted hospital care;
- Ensure continued investment in research and development;
- Continue to invest in high quality general practice premises.

40. This model of care puts the needs of patients at the heart of the NHS and is one we would commend to the Committee.

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