Professor Amanda Howe MA Med MD FRCGP,
Honorary Secretary of Council

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Professor Steve Field (Chair)
NHS Modernisation Listening Exercise
Room 605,
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London SW1A 2NS

27th May 2011

Dear Steve,

The Royal College of General Practitioners welcomes the opportunity to contribute to the NHS Future Forum Listening Exercise. We think it is a positive and constructive development that the Government is seeking additional input into its reform proposals, and hope that our contribution, along with those of other organisations, patients and the public will enable a greater sense of consensus to inform the eventual reforms.

Consultations:

As you will be aware, the College has been engaged fully in the conversation about the future of the NHS that was launched with the Department of Health White Paper *Equity and Excellence: Liberating the NHS* in July last year. We consulted widely with the College's membership and produced responses to this and the suite of supporting consultations, amounting to well over a hundred pages of considered argument. All of our responses to *Liberating the NHS* can be found on the College's website at http://www.rcgp.org.uk/policy/government_reforms.aspx .

Letter to the Prime Minister:

As you will be aware, we recently, wrote to the Prime Minister (copied to you) with our *Analysis of the Need for Clarification and Change* in the *Government's Health Reforms (*see Appendix 1 for ease of reference). In this we clearly stated the College's fundamental position:

> *The RCGP believes that whatever changes are introduced, the fundamental values and principles of the NHS must not be undermined. The NHS must remain:*
>
> - · ***a comprehensive service***
> - · ***available to all***
> - · ***free at the point of use***
> - · ***based on clinical need, not the ability to pay****.*
>
> *We acknowledge and welcome the focus on patient outcomes, choice and value for money. We welcome placing 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 where it adds value to existing services. We welcome the planned reductions in management costs and the focus on prevention, reducing health inequalities and improving joint working between health and social care.*

We went on to identify nine areas of change or clarification within the current Health Bill and other proposed reforms, under the following headings:

> **1: COMPREHENSIVE HEALTH CARE**
> **2: CHARGING FOR HEALTH CARE**
> **3: ISSUES RELATING TO MARKET FORCES IN HEALTH CARE**
> **4: ISSUES RELATING TO EU COMPETITION**
> **5: ACCOUNTABILITY AND CONFLICTS OF INTEREST**
> **6: RESOURCE ALLOCATION AND RISK POOLING**
> **7: PRACTICE BOUNDARIES**
> **8: WORKFORCE AND TRAINING ISSUES**
> **9: CONFIDENTIALITY**

Within this we highlighted a number of specific proposals which would make the current health reforms more acceptable to our members and better for patient care. We refer you to the full document for details.

Listening Exercise:

We have continued to consult with our members during the present 'pause' in the progress of the Health Bill, engaging in a wide range of consultation activities (see Appendix 2). We have also invited members to write directly to us with their comments in response to the Listening Exercise and our analysis document.

This engagement has confirmed that the College's approach does reflect the views of the majority of our members:

- Since the initial consultations last year, many of our members are now involved in commissioning consortia. Some of these are enthusiastic about the opportunities offered by consortia; others are participating out of a sense of obligation, as they feel they would be letting down their patients if they did not take a lead at this stage.
- Some of our most engaged members have been vocal in their concerns that the reforms may make the conditions of commissioning too permissive, so that the costs and complexities outweigh the opportunities they are embracing.
- There is still a concern that GPs will be diverted from clinical work to participate in commissioning activities, and that this will be harmful to patient care.
- Many of our members favour the involvement of other healthcare staff in consortia. There is a strong emphasis on the need to maintain and develop collaboration with colleagues in primary and secondary care, and concern that the currently proposed reforms do not appear to enable this.
- Concern over the extension of competition in the NHS remains widespread. Our members feel that this risks undermining the potential of clinical commissioning and fragmenting care to the ultimate harm of patients. They support our position with regards to the role of Monitor. Competition must always be over quality and not over price.

- Members agree with us that the Secretary of State must retain a duty to provide a comprehensive national health service.
- Many members have considerable concern over the proposals around practice boundaries. They emphasise the vital importance of continuity of care in the service offered by general practice, and the incompatibility of free patient choice of GP with other aspects of the proposed health reforms.
- Our members disagree strongly with the proposals to reform education and training, and believe that deaneries should be retained with their current range of functions.

Looking Forward:

We believe that, seen together, the statements we have made provide a sound basis for progress in shaping the health reforms in a direction that we can all support. Below we have outlined the College's own vision of how the NHS might better deliver on its potential in the future.

1. Irrespective of the outcome of these current reforms, the RCGP will continue to promote the development of high quality, effective patient-centred care, with general practitioners at the heart of NHS service delivery.

2. The future NHS must build on the strengths and values of today's health service, in particular general practice care. The benefits of modern general practice are well documented, with significant evidence that a good relationship with a GP, preferably over several years, is associated with better care, more appropriate care, better health, and much lower health costs.

3. The RCGP recognises that the NHS needs reform and that there are a number of problems with the existing system:

    a. The existing guidance and priorities place care of populations below acute sector rescue interventions as;
    b. Contracting currently favours organisations (particularly Acute Trusts) needs over other parts of the health service;
    c. The existing commissioning organisations have had insufficient ability to change investment leading to a situation where investment and

movement of services to the community and away from hospitals has not happened;

d. Evidence of the benefits of comprehensive coordinated delivery of common chronic disease medicine by practices is ignored;
e. There is over treatment of some patients because co-morbidity, patient views and social circumstances receive too little attention in service planning;
f. The needs of training and regulation drives service investment to enforce costs on the system;
g. This leads to a rise in acute sector funding above health service funding as a first call on resources at the expense of other services that will make more difference to population health care.

4. Moving into the future, the RCGP believes the key issues that need to be addressed are

- Fragmentation of care
- Health inequalities
- Co-morbidity
- Challenges brought about by the ageing population
- Changes in patient expectations
- Use of technological advances

5. We believe that these issues can be dealt with without the need for repeated organisational change or many of the proposed legislative reforms:

6. The RCGP recommends the developing of the RCGP Federation model, as this model provides considerable opportunities to maximise benefits for patients. 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, virtually all health problems would be dealt with in primary care close to patients' homes, with hospitals reserved for acute illness, specialised investigations and major surgery. This model of care puts the needs of patients at the heart of the NHS.

7. As well as commending the Federated model of care, we believe the way forward should be to:

- 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;

- Improve access to general practice by promoting extended hours, flexibility of access points (text, email, face-to-face etc) and by improving the use of skill-mix within the general practice setting;

- 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.

In Conclusion:

The RCGP is optimistic that the outcome of the Listening Exercise will be that we see changes to the proposed reforms of the NHS along the lines that we have suggested, and which our members will be able to embrace and support with their efforts in the difficult period ahead.

Whatever the outcome, we remain open to further discussions and keen to engage constructively in any proposals which enable GPs to deliver better patient care.

Yours Sincerely,

Professor Amanda Howe
Honorary Secretary

Appendix 1

THE GOVERNMENT'S HEALTH REFORMS

AN ANALYSIS OF THE NEED FOR CLARIFICATION AND CHANGE

BY THE

ROYAL COLLEGE OF GENERAL PRACTITIONERS

May 2011

Royal College of General Practitioners
Promoting Excellence in Family Medicine

Introduction

This paper is provided to inform the Prime Minister of the changes to the Health and Social Care Bill[1] and wider health reform proposals[2] that the Royal College of General Practitioners (RCGP) believes is necessary.

The RCGP is a registered charity committed to improving the quality of general practice for patients. The membership comprises over 42,000 doctors who have passed a higher professional examination in general practice.

General practice is the largest branch of the medical profession. It provides over 300 million consultations for patients in Britain each year and deals with 86% of the health problems experienced by the British population.

The RCGP believes that whatever changes are introduced, the fundamental values and principles of the NHS must not be undermined. The NHS must remain:

- **a comprehensive service**
- **available to all**
- **free at the point of use**
- **based on clinical need, not the ability to pay**.

We acknowledge and welcome the focus on patient outcomes, choice and value for money. We welcome placing 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 where it adds value to existing services. We welcome the planned reductions in management costs and the focus on prevention, reducing health inequalities and improving joint working between health and social care.

[1] Health and Social Care Bill 2011.
[2] Department of Health. *Equity and Excellence: liberating the NHS* London: DH, July 2010.

Concerns and clarifications

In order to protect the principles of the NHS, the College calls for the following areas of change or clarification to the Health Bill and subsequent legislation:

1: COMPREHENSIVE HEALTH CARE

1.1: That the Bill should make it clear that the Secretary of State has a duty to provide, or secure provision for, a comprehensive health service throughout England.

1.2: That it must be clear which organisations take responsibility for the whole range of services for a geographically defined population.

1.3: That there must be no possibility of discrimination against patients based on their current or perceived future healthcare needs.

1.4: That there should be sub-national bodies that can deal with less common conditions, reconfiguration, major asset planning and so on.

2: CHARGING FOR HEALTH CARE

2: That commissioners or providers should not be able to charge patients for healthcare services that are currently provided free by the NHS or are recommended by NICE.

3: ISSUES RELATING TO MARKET FORCES IN HEALTH CARE

3.1: That the Bill should place a duty on Monitor, the NHS National Commissioning Board (NCB) and GP Commissioning Consortia (GPCC) to enable collaboration to provide integrated services to meet patients' needs without fear of a competition referral.

3.2: Success in health care should be measured by a range including population and patient outcomes and process measures (e.g. waiting times, numbers seen, etc.), patient experience and patient satisfaction, and not by the number of providers for a given service.

3.3:Monitor's role should be amended so that it has a duty to deliver collaboration, co-operation and value for money for the taxpayer rather than focus on enforcing competition.

3.4: Given our serious concerns about the implications of cost, competition and the role of Monitor in the new NHS we recommend substantial review of all aspects of Part 3 of the Bill.

4: ISSUES RELATING TO EU COMPETITION

4: There needs to be clarity as to the legal implications of EU competition law (particularly when, and in what circumstances, it is enforceable) and other contractual and regulatory details.

5: ACCOUNTABILITY AND CONFLICTS OF INTEREST

5.1: Consortia must remain publicly accountable for all commissioning decisions, such that board minutes and financial decisions are open to public scrutiny, including details of payments made to GPs or practices for non-General Medical Services (GMS)

work, taking account of payments to private companies in which GPs have a financial interest.

5.2: That while GPs should be the majority of the board of the GPCC and remain in control by virtue of their voting rights, consortia boards should include places for a range of locally determined clinical, health and social care practitioners.

5.3: That there is a requirement of all decision-making bodies, including consortia, to be public bodies, with boards, meeting in public and publishing minutes, and that the Nolan principles be adopted by all relevant individuals.

6: RESOURCE ALLOCATION AND RISK POOLING

6.1: That there is clarity as soon as possible as to which allocation formula will be used for allocation to GP consortia for commissioning hospital care.

6.2:That the approach to the management of financial risk by consortia is made explicit, negotiated and agreed with consortia ahead of them going live in 2013.

7: PRACTICE BOUNDARIES

7: The proposal to undermine the relationship between a local GP and local patients by abolishing practice boundaries is revised.

8: WORKFORCE AND TRAINING ISSUES

8.1: Given that the education and training proposals mark a revolution in medical education and could be harmful in primary care, we urge a careful and detailed reconsideration ahead of any implementation.

8.2: We strongly support the retention of deaneries, or equivalent regional bodies with strategic oversight, with the range of functions they currently fulfill, as a tried-and-tested approach to medical education.

8.3: There is a need for enhanced training for GPs to meet the needs of a modern NHS. The length of training needs to be comparable with (hospital) specialist training.

8.4: That the reforms to workforce and training be used as an opportunity to introduce measures to address the shortages of GPs in areas of greatest need.

8.5: That there is stronger focus on generalist care, with the knowledge that medical generalism improves patient outcomes, reduces cost and improves public health.

9: CONFIDENTIALITY

9: That there is as an absolute assurance that the Bill will not force doctors to breach their duty of confidentiality.

Background

1. The RCGP is a registered charity committed to improving the quality of general practice for patients. The membership comprises over 42,000 doctors who have chosen a career in general practice.

2. General practice is the largest branch of the medical profession. It provides over 300 million consultations for patients in Britain each year, and deals with 86% of the health problems experienced by the British population.[3]

3. The RCGP has responded formally[4] to the initial consultation on the white paper *Equity and Excellence: liberating the NHS*, Command paper and the subsequent Health and Social Care Bill. The College has also consulted its members on all the subsidiary consultations and submitted detailed formal responses to the Department of Health.

4. Within the last few months, the RCGP has given evidence at The Health Select Committee, the Health and Social Care Public Bill Committee, and the Public Accounts Committee.[5]

5. This material is primarily to seek changes to the current Health Bill. The material may also be useful to the Prime Minister's Listening Exercise, though we will be responding to this separately.[6]

6. We acknowledge that the NHS needs to change. We acknowledge and welcome the focus on patient outcomes, choice and value for money. We welcome placing 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 commissioning where it adds value to existing services. We welcome the planned reductions in management costs and an increased focus on prevention, reducing health inequalities, and improving joint working between health and social care.

7. We have made a number of recommendations and welcome the opportunity in working together with the Coalition Government to improve the NHS.

[3] www.euro.who.int/en/what-we-do/health-topics/noncommunicable-diseases/mental-health/activities/mental-health-in-primary-care
[4] Response by the RCGP Honorary Secretary Professor Amanda Howe, sent on 5 October 2010.
[5] Details are available at our website: www.rcgp.org.uk
[6] Coalition Government Listening Exercise on the modernisation of the NHS launched by the Prime Minister on 6 April 2011, www.number10.gov.uk/news/topstorynews/2011/04/government-launches-nhs-listening-exercise-62933

1: Comprehensive Health Care

8. The NHS provides outstanding value for money[7] and provides comprehensive health care, regardless of the extent of need and one's ability to pay. It makes no charges for seeing a health professional for routine health care, and is a lifelong guarantee for every UK citizen. The NHS covers the poor, the homeless, those that are socially disadvantaged, and those with long-term illness.

9. Since 1948 the government has had a duty to provide comprehensive health care free at the point of delivery. This duty is underpinned by structures, systems and mechanisms that promote fairness and efficiency in resource allocation. It facilitates planning of services according to geographical healthcare needs through risk pooling and service integration. This duty is repeated in the NHS Acts of 1977 and 2006.

10. Under the current Health and Social Care Bill, the powers of the Secretary of State will be substantially curtailed, such that the Bill places the Secretary of State under an explicit duty to promote autonomy in the health service,[8] and removes his general power of direction. The focus of his role will shift to public health functions, which become the responsibility of local authorities. In order to achieve this change of function the ministerial duty to provide a comprehensive health service has been repealed.[9]

11. Therefore, the government will no longer be charged with a duty to provide a comprehensive National Health Service.[10]

12. We note the Health Committee recently recommended restoring accountability to the Secretary of State,[11] and support the Committee's recommendation that 'there can be no doubt that ultimate responsibility rests with [the Secretary of State] as accountability for the development of the NHS – there can and should be no doubt that ultimately responsibility rests with him'.

13. The new commissioning consortia's duty to arrange for health services provision applies to their enrolled (registered) populations. In contrast to Primary Care Trusts (PCTs) and all other structures before, the population of consortia will be drawn from patient lists of member general practices rather than all residents living within a defined geographical area.[12]

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[7] Talbot-Smith *et al*. questioning the claims of Kaiser. *British Journal of General Practice* 2004; **54**: 415–21.
[8] Department of Health. *Government Response to the House of Commons Health Select Committee Third Report of Session. 2010–2011: Commissioning. Cm 8099,* January 2011, paras 74–5.
[9] Although the Bill retains the Secretary of State's duty *to promote* a comprehensive health service, the duty *to provide* a comprehensive health service in England is abolished. It is replaced with a duty to 'act with a view to securing comprehensive services'. A consortium does not have a duty to provide a comprehensive range of services but only 'such services or facilities as it considers appropriate' [clause 10.1]. Even where consortia join together they are not required to cover all persons or provide comprehensive health care when doing so.
[10] If this is incorrect, the legislation needs to be clarified to be explicit that an elected politician retains this duty.
[11] House of Commons Health Committee. *Commissioning: further issues* London: The Stationery Office, 2011, p. 5.
[12] Clause 9 removes the duty on the Health Secretary to 'provide [certain health services] throughout England, to such extent as he considers necessary to meet all reasonable requirements'. Commissioning consortia will 'arrange for' the services necessary 'to meet all reasonable requirements' and determine which services are 'appropriate as parts of the health service' (clause 9, 2a). A consortium does not have a duty to provide a comprehensive range of

14. The combination of removing geographical responsibility for the provision of health care, together with the removal of practice boundaries, creates a number of risks. These include: allocating resources based on registered GP lists rather than geographical populations; risk of competing for patients across the whole country; inability to plan local services; risk of worsening health inequalities; fragmentation between social and health care (the former based on local authority boundaries, the latter based on England-wide catchment).

15. The Health Select Committee (April 2011, 121) emphasised the importance of aligning care to geographical boundaries, making the point that 'aligning geographic boundaries between local NHS commissioning bodies and social care authorities has often been found to promote efficient working between the two agencies. There will in the first instance be more local NHS commissioning bodies than social care authorities; the Committee therefore encourages NHS commissioning bodies to form groups which reflect local social care boundaries for the purpose of promoting close working across the institutional boundary. History suggests that some such groups will find the opportunities created by co-terminosity encourage more extensive integration of their activities.'[13]

Recommendations

1.1: That the Bill should make it clear that the Secretary of State has a duty to provide, or secure provision for, a comprehensive health service throughout England.

1.2: That it must be clear which organisations take responsibility for the whole range of services for a geographically defined population.

1.3: That there must be no possibility of discrimination against patients based on their current or perceived future healthcare needs.

1.4: That there should be sub-national bodies that can deal with less common conditions, reconfiguration, major asset planning and so on.

services but only 'such services or facilities as it considers appropriate' (clause 10, 1). In making these arrangements, commissioning consortia must ensure that their annual expenditure does not exceed their aggregate financial allocation (section 22, 223I–K). Consortia may join together to form a single commissioning group for England (section 21, 14Q, 2b), but they are not required to cover all persons or provide comprehensive health care when doing so.

[13] Health Committee. *Fifth Report. Commissioning: further issues*, 5 April 2011.

2: Charging for Health Care

16. As we understand it, the Secretary of State's duty to provide free services that are 'part of the health service in England', except where charges are expressly allowed, is undermined by the proposed legislation. This is because the power under the Health and Medicines Act 1988 to impose charges is transferred from the Secretary of State to consortia (clause 22). Consortia will determine which services are part of the health service and, by inference, those that are not – and thus may be chargeable (clause 9). In addition they have been given a general power to charge (Section 7, 2h, Health and Medicines Act 1988).[14]

Recommendation

2: That commissioners or providers should not be able to charge patients for healthcare services that are currently provided free by the NHS or are recommended by NICE.

[14] 1. The bill *transfers* to consortia a power to 'recover charges' under section 22 (14S) (i.e. this 'recovery of charges' is already expressly enacted but is currently vested with the Secretary of State):

14S Raising additional income

(1) A commissioning consortium has power to do anything specified in Section 7(2)(a), (b) and (e) to (h) of the Health and Medicines Act 1988 (Provision of goods etc.) for the purpose of making additional income available for improving the health service.

2. Section 7(2) of the Health and Medicines Act 1988 reads:

(2) The powers mentioned in subsection (1) above are powers (exercisable outside as well as within Great Britain)–
(a) to acquire, produce, manufacture and supply goods;
(b) to acquire land by agreement and manage and deal with land;
(c) to supply accommodation to any person;
(d) to supply services to any person and to provide new services;
(e) to provide instruction for any person;
(f) to develop and exploit ideas and exploit intellectual property;
(g) to do anything whatsoever which appears to him to be calculated to facilitate, or to be conducive or incidental to, the exercise of any power conferred by this subsection; and
(h) to make such charge as he considers appropriate for anything that he does in the exercise of any such power and to calculate any such charge on any basis that he considers to be the appropriate commercial basis.

3: Issues Relating to Market Forces in Health Care

17. The Coalition Government's overall reform agenda involves substantial deregulation of health providers in line with the principle: 'the Coalition's belief is that *the natural condition of organisations* ought to be one of freedom rather than being shackled'.[15]

18. Economic regulation of healthcare providers will be overseen by (new) Monitor, whose primary duty will be to promote competition. Monitor will set prices, license providers, promote competition and operate a failure regime to ensure continuity of essential services.

19. Monitor's view is that introducing more competition in health care is 'an important step in raising the productivity of the sector and delivering ever higher quality care for patients. However, competition must be seen as a means and not an end in itself.'[16]

20. Despite the increased use of market forces in the health service over the last two decades, the evidence that this policy improves outcomes is very limited. A recent review of the evidence finds that there is no conclusive evidence that market competition has any effect on the quality, equity or efficiency of healthcare delivery.[17,18]

21. In addition, markets in healthcare services are different from markets in commodities, such as cars, utilities and so on. For example:

    a. There is an asymmetry of knowledge (and power) between patients and doctors.

    b. Patients when ill are vulnerable, unlike most consumers.

    c. Patients and doctors, particularly in primary care where the diagnosis is not yet clear, often lack the necessary information to make precise informed choices.

    d. The biggest healthcare market in the world in the USA has failed as it provides worse life expectancy for its citizens than the UK, with the US health system costing considerably more than the UK per head of population. The USA now spends 17.6% of its GDP on health care compared with 9% in the UK. For-profit hospitals in the USA have worse results than not-for-profit.

[15] National Health Service. *Regulating Providers* London: NHS, 2010, para.2.2 [our emphasis].
[16] Monitor statement on the publication of the Health and Social Care Bill, www.monitor-nhsft.gov.uk/home/news-and-events/latest-press-releases/monitor-statement-the-publication-the-health-and-social-c
[17] Commission on a High Performance Health System. *The Path to a High Performance US Health System: a 2020 vision and the policies to pave the way* New York: Commonwealth Fund, 2009, www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Feb/The-Path-to-a-High-Performance-US-Health-System.aspx
[18] Brereton L, Vasoodaven V. *The Impact of the NHS Market: an overview of the literature* London: Civitas, 2010, www.civitas.org.uk/nhs/download/Civitas_LiteratureReview_NHS_market_Feb10.pdf

e. Most markets encourage activity to increase profits. In the NHS, additional activity results in a greater burden on the taxpayer. Current payment systems have proved to be poor at discouraging perverse behaviours.

22. In its 2008 annual report, the World Health Organization set out primary healthcare policy for the international community. It ascribed a worsening in the poor's access to health care to a 'worrisome' trend towards 'unregulated commercialization'[19] and argued that 'the proliferation of unregulated care' was wasteful and undermined health systems: 'multiple, fragmented funding streams and segmented service delivery are leading to duplication, inefficiencies and counter-productive competition for resources between different programmes',[20] which will inevitably lead to less integration and joint working across professional boundaries.

23. A review carried out in 2010 of the effects of the previous government's market reforms documented many improvements to health care, including reduced patient waiting times; increased access to GPs, better outcomes for cancer and heart disease, and improved satisfaction with the NHS. However, some analysts believe that these improvements had more to do with introduction of performance targets, increased spending on health, improved public reporting and stronger performance management than to enhanced operation of the market.[21] A highly privatised health system is possible and exists in the USA, but has failed to contain costs or match NHS outcomes.[22]

24. Market-style healthcare reforms have recently been introduced in the Netherlands, and regulations designed to prevent anti-competitive practice in the commercial sector have had an unexpected effect on health care. The Netherlands Competition Authority (NMa) has ruled that all healthcare providers including GPs are covered by Dutch competition law and that this 'means they cannot enter into any agreements that restrict competition' (www.nmanet.nl/engels/home/News_and_publications/Theme_files/Health_care/index.asp).

25. This decision has had a major impact on service integration, information sharing and innovations.[23] Examples of the impact of this decision include:
    a. Healthcare indicators had not improved over a five-year period, and with the backing of the health insurers GPs met with social welfare providers in 2010 to develop care plans and pathways to improve care for elderly people. The NMa ruled that these discussions were anti-competitive as they potentially put other providers at a disadvantage.

    b. The Dutch Medical Research Council (ZOM/MW) sought to establish and evaluate a scheme to keep frail elderly people living in the community. This

[19] World Health Organization. *World Health Report 2008* Geneva: WHO, 2008, p. xiii.
[20] *World Health Report 2008*, p. 85.
[21] Thorlby R, Maybin J (eds). *A High-Performing NHS? A review of progress 1997–2010* London: The King's Fund, 2010, www.kingsfund.org.uk/document.rm?id=8651
[22] Arrow K. Uncertainty and the welfare economics of medical care *American Economic Review* 1963; **53(5)**: 941–73.
[23] Source: Personal communication with Chris van Weel, Professor of General Practice, Nijmegen University. c.vanweel@elg.umcn.nl

involved the formation of networks between GPs, geriatricians, nursing homes and social care. The NMa recently ruled that this was anti-competitive, but agreed not to interfere as the networks were being established solely as part of a research project.

26. To date, no prosecutions have been mounted by the NMa, but the threat has become a major discouragement to local providers to work together. The approach of the NMa has been quite aggressive, and those who wish to co-ordinate care for increasingly elderly populations feel that they are being 'punished for collaboration'.

27. The introduction of the new Dutch healthcare system was accompanied by high expectations of 'market mechanism' to lower costs and improve quality. Five years on, there are no indications that the system contains healthcare costs and most political decisions have been directed to modify market effects; hospital costs have escalated despite excellent primary care services. A market, paradoxically, appears to be at odds with the promotion of cost-effective, evidence-based care. In addition, there are grave concerns about the lack of coherence in the system and the ability to collaborate between different providers.

28. To ensure that the NHS is able to provide the best care for patients we believe the ideal arrangement should involve continuity of patient care through partnership working (as in Scotland and Wales).

29. Care of patients with long-term conditions or complex issues requires a multiplicity of health, social care and third-sector practitioners and services. These relationships often are built up over many years, with high-quality care facilitated by enhanced communication, co-ordination and joint working. Services are often planned around the needs of the local population, with practitioners from different parts of the health service (community, primary care, hospital) working together for care that best meet the needs of local patients.

30. The Bill seeks both competition and better integration, which can be seen as mutually exclusive; it is difficult to see how competition rules could be framed to deliver both of these objectives. 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 providers and commissioners, and could be seen as anti-competitive.

Recommendations

3.1: That the Bill should place a duty on Monitor, the NHS National Commissioning Board (NCB) and GP Commissioning Consortia (GPCC) to enable collaboration to provide integrated services to meet patients' needs without fear of a competition referral.

3.2: Success in health care should be measured by a range including population and patient outcomes and process measures (e.g. waiting times, numbers seen, etc.), patient experience and patient satisfaction, and not by the number of providers for a given service.

3.3: Monitor's role should be amended so that it has a duty to deliver collaboration, co-operation and value for money for the taxpayer rather than focus on enforcing competition[24]

3.4: Given our serious concerns about the implications of cost, competition and the role of Monitor in the new NHS we recommend substantial review of all aspects of Part 3 of the Bill.

[24] Pollock A, Price D. *British Medical Journal* 2011; **342**: d1695, www.bmj.com/content/342/bmj.d1695

4: Issues Relating to EU Competition

31. Since the 1990s, the provision of services across the public sector has moved from one of primarily direct state provision to one provided largely by a mixed economy. This means that the NHS has moved from a position where most healthcare spending was essentially the state buying from itself to the current internal market and proposals for an extension of this through any-willing-provider (or any qualified provider) model, further distancing the state from NHS hospitals, and in time from commissioning organisations.

32. Under the new proposals, all providers of care, including the independent and voluntary sector, will be able to compete (on quality and in certain areas on price) for NHS (state) funded services on an equal footing, regulated by Monitor. Since the state will become less of a direct provider of health care, it has been argued that EU competition law would apply to the allocation of public spending with providers.

33. The Bill therefore potentially opens up the whole of the NHS to EU competition law, which will apply not just to foundation trusts, but to consortia as well. Consortia will be captured within the requirements of competition law (that is bound by procurement regulations concerning the spending of public money and EU competition law in general) as they will fulfil the three requirements of contracting authorities: a) they are set up for a specific purpose (commissioning health care), b) have a legal personality (groups of general practices working in consortia) and c) either receive more than half of their funding from state sources or be set up as statutory bodies.[25]

34. We would be keen for the Government to explore how legislation could be amended so that NHS could become the preferred provider of services. As Walshe and Ham argue[26] 'existing guidance on the principles and rules for cooperation and competition should be revised to set out more explicitly the circumstances in which competitive tendering is required – primarily where existing services are poorly performing, expensive, or do not meet patients' needs, or where there are credible alternative providers that can offer better value for money. If consortium do not use these opportunities to drive improvement, Monitor could use its powers to promote competition in areas where it is likely to improve performance.'

35. We would be keen to understand the basis on which the Department of Health believes that there are circumstances ('service integration and continuity of care') where general practice commissioners would be able to offer a tender to only one contractor.[27]

[25] Dunbar-Rees R, McGough, R. Challenges of EU competition law for general practice commissioning *British Medical Journal* 2011; **342**: d2071.
[26] Walshe K, Ham C. *British Medical Journal* 2011; **342**: d2038, www.bmj.com/content/342/bmj.d2038.full.pdf
[27] Nicholson D. *Equity and Excellence: liberating the NHS – managing the transition* London: DH, 2011, www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_124440

Recommendations

4: There needs to be clarity as to the legal implications of EU competition law (particular when, and in what circumstances, it is enforceable) and other contractual and regulatory details.

5: Accountability and Conflicts of Interest

36. Commissioning consortia will be accountable nationally to the NCB for performance on outcomes and finance, locally to overview and scrutiny committees and health and wellbeing boards for their commissioning decisions, and at practice level to their registered patients.

37. The NHS commissioning board is accountable to the Secretary of State; NHS Foundation Trusts are only accountable to their governors and members; and local authorities are accountable to their electorates.

38. The concern is therefore not how the new accountability systems differ from the old (in many ways they are similar), but rather how the new arrangements will work in practice. For example: will consortia have real influence on deciding what services will be designated at their local providers and then what will the failure regime look like and will consortia be expected to contribute to the provider risk pool(s)? How transparent will consortia decisions be? How will accountability to the NCB work in practice and will the NCB allow local innovation while providing a sufficiently robust role in ensuring a national framework of provision?

39. Similarly, there are uncertainties as to the governance and transparency of decision-making processes. Moreover, the substitution of market contracting for NHS agreements may well increase the proportion of decisions that are commercially confidential and not open to public scrutiny. However, the legislation places no responsibilities on commissioning consortia, merely making reference to the requirement of the NCB to develop guidance.

40. We agree with the suggestion made by Walshe and Ham that the commissioning function should be essentially a public responsibility that cannot be devolved or fully outsourced, and that consortia must remain publicly accountable for all commissioning decisions and resources, and information about commissioning and provision must be in the public domain[28] and minutes and agendas published with strict rules over conflicts of interest – commissioning is about allocating public funds and there must be appropriate public accountability.

41. The House of Commons Health Select Committee recommended (report published on 5 April 2011) that the boards of NHS commissioners should be required to meet in public, publish their papers and comply with the rules of the Committee on Standards in Public Life with regard to conflicts of interest amongst board members.

42. The new reforms build in conflicts of interest, for example from the effects of GPs being both providers and commissioners and, through GPs being accountable for financial balance of the GPCC, meaning that there might be competing interests such that of the duty of the GP being the advocate of the patient vs. the needs of the GPCC.

43. At the core of the NHS reforms is the concept of ‘no decision about me without me’. This, it seems to us, increases the important role that patient groups have to play. However, we are concerned that there is a potential conflict of interest as

[28] Walshe K, Ham C. *British Medical Journal* 2011; **342**: d2038.

pharmaceutical companies and special interest groups play a role in funding some of these. Where patient groups receive external funding they must declare funding sources and commit to the same culture of openness and transparency we expect of consortia boards.

Recommendations

5.1: Consortia must remain publicly accountable for all commissioning decisions, such that board minutes and financial decisions are open to public scrutiny, including details of payments made to GPs or practices for non-General Medical Services (GMS) work, taking account of payments to private companies in which GPs have a financial interest.

5.2: That while GPs should be the majority of the board of the GPCC and remain in control by virtue of their voting rights, consortia boards should include places for a range of locally determined clinical, health and social care practitioners.

5.3: That there is a requirement of all decision-making bodies, including consortia, to be public bodies, with boards meeting in public and publishing minutes, and the adoption of the Nolan principles by all relevant individuals[29].

[29] As recommended by the House of Commons Health Select Committee in their report published on 5 April.

6: Resource Allocation and Risk Pooling

44. NHS funds are allocated to PCTs and practices for commissioning hospital care in two main ways. Allocations from the Department of Health to PCTs to commission (most) hospital care are based on a needs-based weighted capitation formula that depends on the *number of people living in the PCT geographical area* (based on ONS census data) and their need for health care (e.g. age, gender and socioeconomic deprivation). This allocation is distributed from PCTs to general practices based on a slightly different 'fair shares' formula that depends on the size of the *population registered with each general practice* located within the PCT boundary (based on GP registration data) and their need for health care (based much more on the characteristics of the individuals such as age, gender and previous illnesses recorded from hospital visits, as well as other factors such as socioeconomic deprivation).

45. As PCTs are to be abolished, the intention is that a variant of the 'fair shares' formula, based on GP-registered populations, will be used in future to allocate resources for most hospital care to commissioning consortia. The fair shares formula is a more appropriate method of allocating resources to practices because it more accurately reflects health need for small populations. Precisely when the fair shares formula will entirely replace the existing weighted formula (for allocations to PCTs) depends on the accuracy of GP registration data, since it is known that in some urban parts of England the GP-registered population exceeds the ONS population by some margin.[30] We agree with the recommendation of the Health Select Committee that the government should publish a detailed timetable for the implementation of the fair shares formula as soon as possible.

46. The fair shares formula predicts expenditure by practices on hospital care in the budget year by using historic information on the health needs of the individuals registered. The current formula predicts over three-quarters of next year's expenditure on hospital care by practices, which is very good by international standards. Because no formula can provide perfect prediction, practices will be at financial risk for unpredictable swings in expenditure – underspends or overspends. The smaller the population size covered by the consortia, the more they are vulnerable to random swings. To help protect consortia from facing these random overspends, a robust risk management strategy will need to be developed by the NCB. For example, the NCB (not consortia) will be commissioning 'specialised services' – rare and high-cost services. But other mechanisms will also be needed to protect consortia, for example by pooling risks across larger populations in which the unexpected expenditure incurred by high-cost patients can be offset by lower demand from others, or by 'stop loss' arrangements by which consortia pay up to a total ceiling per annual cost per person.

47. Regarding budgets to commission most hospital care, we understand some options for risk management are currently being developed by the Department of Health as part of the work to develop the fair shares formula. To help reduce the potential for excessive financial risk, a number of options will need to be considered. For example, consortia could merge to form larger populations, or enter into risk-sharing arrangements with

[30] House of Commons Select Committee HC796-1 (paras 135 and 128), www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/796/79610.htm

other consortia. Another alternative is that the NCB could assume responsibility for a more comprehensive range of specialised services than is currently envisaged. We would like to emphasise that this is a new and complex area of analysis for the NHS but absolutely crucial to get right if consortia are to take appropriate responsibility for hard budgets in future. It will also be important that there is transparency, dialogue and negotiated agreement between the NCB and the consortia about the level of financial risk it is acceptable and appropriate for the consortia to bear.

48. Our worry is that enthusiasm for commissioning by GPs might wane if the arrangements for managing risk are not adequate, especially in the coming austere budgetary climate, and consortia are subject to overspends beyond their control. Another related fear, highlighted by the King's Fund (2011) simulation exercise, is that enthusiasm for collaboration between different consortia will wane once consortia begin to diverge in terms of financial performance.[31]

49. Jones's (2010) papers on risk pools[32,33] include a number of key messages for the GPCC based on the resource allocation formula existing at the time.

- Financial risk in health care is very high.
- Population groups of greater than 100,000 are required to reduce the chance risk to an acceptable level (currently PCTs average a population of 350,000).
- A substantial proportion of high-cost/low-frequency healthcare events and high-costs individuals need to be placed into a larger risk pool. This needs to cover more than 1,000,000 head to avoid the risk pool itself becoming a source of unacceptable risk.
- Additional risk above that from simple chance arises from emergency admission, which typically has two to three times higher risk than simple chance variations.
- The allocation of budgets is also subject to the risk of over- or under-funding relative to other groups.
- The high inherent variation in health care implies uncertainty in the allocation of budgets and leads to large-scale swapping of budgets to 'manage' chance pressures.
- For 100,000 population, the combined financial risk (after excluding high-cost events) implied for practice-based commissioning is around ±9% (95% confidence interval).

[31] Imison C, Curry N, McShane M. *Commissioning for the Future: learning from a simulation of the health system in 2013/14* London: The King's Fund.
[32] Jones R. The actuarial basis for financial risk in practice-based commissioning and implications to managing budgets *Primary Health Care Research and Development* 2009; **10(3)**: 245–53, doi: 10.1017/S1463423609990089.
[33] Jones R. Nature of health care costs and financial risk in commissioning *British Journal of Healthcare Management* 2010; **16(9)**: 424–30.

Recommendations

6.1: That there is clarity as soon as possible as to which allocation formula will be used for allocation to GP consortia for commissioning hospital care.

6.2:That the approach to the management of financial risk by consortia is made explicit, negotiated and agreed with consortia ahead of them going live in 2013.

7: Practice Boundaries

50. The white paper *Liberating the NHS*, published in July 2010, outlined the government's intention to abolish one of the cornerstones of general practice – the register of local patients. We are concerned that this policy will have unintended consequences and will be detrimental to patient care, in particular the fragmentation of care and risks to patient safety. As the professional organisation representing GPs, we understand the aspirations of patients and recognise the ideal of patient choice, but believe that the proposal to abolish practice boundaries will be detrimental to patient care. We believe that choice over access to services could be extended in a measured and balanced way that does not need to dismiss primary registration in one area.

51. While the abolition of practice boundaries is not part of the current legislative proposals, it does form part of the government's proposals and has to be viewed as part of the overall picture of health reform.

52. The abolition of practice boundaries will mean that practices can accept patients regardless of where they live, effectively allowing patients to choose their commissioner, or commissioners to choose their patients. The GP-registered list, based on a locally defined population, has been the bedrock of the NHS since its inception and is a valued part of our health service, as well as having a considerable, strong and measured research evidence for its efficacy in improving patient care outcomes. This does not mean that the RCGP is against patient choice with respect to registration, though we would assert that primary registration needs to be within a local geographical area. Additional arrangements can be made for individuals who for one reason or another find it extremely difficult to attend a GP close to home.[34]

53. The registered GP list in the NHS has the important advantage over and above medical care. By creating a precisely defined denominator of patients, which can be precisely categorised by age and sex, it gives the UK a major advantage of many healthcare systems, including in research and development. Weakening it by multiple registrations of individual patients or breaking up correlations with geographical factors will needlessly reduce the advantage of the UK for much research, to the detriment of the UK.

54. Research has shown that patients want good-quality, accessible primary care services close to home, with health professionals they know and trust making shared decision-making, enabling them to live independent lives through health and social care working together.[35]

55. Practice boundaries are a vital tool to allow GPs to see their patients in their homes, keep track of vulnerable patients and control demand. A geographically defined GP practice area is also relevant in relation to working with other specialised health services (such as mental health, midwifery/health visitor/district nurse) and local authorities (social care and public health).

[34] BMA response to the Department of Health consultation 'Your choice of GP practice', July 2010.
[35] Turner D, Tarrant C, Windridge K, *et al*. Do patients value continuity of care in general practice? An investigation using stated preference discrete choice experiments *Journal of Health Services Research and Policy* 2007; **12(3)**: 132–7, www.ncbi.nlm.nih.gov/pubmed/17716414?dopt=Abstract

56. Under the proposals, it is likely that those registered at a practice at a distance from their home will access more costly hospital care directly when they become ill. There will be additional costs of added staffing and the bureaucratic and financial consequences of new registration arrangements.

57. Continuity of care and medication may also be at risk if patients register and are treated for illnesses close to their work and then need treatment at home for an incapacitating illness. For those patients that live many miles away from their practice, home visits will be impossible. Additionally, patients will be at greater risk with the lack of prior knowledge to inform emergency decision-making. Currently, IT systems do not allow for the safe and secure sharing of relevant data.

58. Removing practice boundaries will threaten the viability of local, especially rural, practices that provide a vital service to those residents who are less mobile and potentially more vulnerable. It may also mean that practices in city centre locations are unable to provide the level of care they are presently able to offer due to an increased number of patients on their lists.

59. The right solution, which will address the needs of patients who wish to access health services away from their registered practice, without bringing the risks of removed practice boundaries, is to extend the temporary registration system that allows a walk-in service for acute care far from home, and to continue extending practice opening hours. The key feature of the temporary registration scheme is that a written report goes back to the registered doctor, thus maintaining continuity of information.

60. Over more extended areas, Primary Care Federations – an association of general practices and primary care teams coming together to share responsibility – have the potential to offer patients improved access, including access to out-of-hours care.[36]

61. In its previous consultation process, the College laid out why it opposes the proposal to abolish general practice lists[37,38], one of the historic strengths of British general practice and which underpin preventive care, medical audit, clinical review, and research. Nowhere else in the UK is it seriously suggested that patients be cared for by doctors hundred of miles away and in circumstances where the doctor is not familiar with local health problems, local hospitals, or local community services.

Recommendation

7: The proposal to undermine the relationship between a local GP and local patients by abolishing practice boundaries is revised.

[36] www.rcgp.org.uk/federations_toolkit.aspx
[37] Department of Health consultation, 'Your choice of GP practice', July 2010.
[38] *Equity and Excellence: liberating the NHS*, July 2010.

8: Workforce and Training Issues

62. The recent King's Fund-commissioned inquiry *Improving the Quality of Care in General Practice* found that, despite all the changes that have taken place within the system, general practice retains a core commitment to generalism that is manifest in two key concepts: patient centeredness and holism. Patient centeredness means that the individual patient's priorities must be identified and respected in order to reach an appropriate clinical decision – a process facilitated through the development of good doctor–patient relationships over time (Howie *et al* 2004[39]). It also means organising services for patients based on their needs, not on provider convenience. Holism represents a method of care where the decisions made on the diagnosis and management of a patient should reflect the entirety of a person's needs – it is also termed 'the biopsychosocial approach'. It is more than providing a service that addresses multiple health issues.[40]

63. The evidence, largely assembled by Barbara Starfield in her longstanding academic advocacy of a comprehensive healthcare system in the USA, is broadly in favour of primary care generalism. The underlying mechanism is that primary care gatekeeping reduces demand for inappropriate specialist care; many would add that it protects patients from this. The result is that generalism is favoured in comprehensive planned healthcare systems – such as either the NHS or an American HMO, but weak in the marketplace. Market-orientated reforms in the UK are therefore philosophically orientated against generalism and represent a threat. Generalism offers many other advantages to patients in terms of interpretation, co-ordination and advocacy.

64. The core of Starfield *et al*.'s (2005) argument in favour of a generalist primary care system is based on international comparisons. In successive studies the team classified countries according to the strength of their primary care and compared a range of health outcomes including all-cause mortality, and cause-specific mortality from asthma and bronchitis, emphysema and pneumonia, cardiovascular disease and heart disease. Primary care strength was assessed by 'the degree of *comprehensiveness* of primary care (i.e. the extent to which primary care practitioners provided a broader range of services rather than making referrals to specialists for those services) and a *family orientation* (the degree to which services were provided to all family members by the same practitioner)'. Studies mostly within the USA also showed that better primary care provision reduced inequalities in health even after controlling for income distribution.[41]

65. The new reforms will remove a significant number of GPs from front-line clinical work. The Treasury Minute on the Public Accounts Committee Report (16 February 2011)[42] 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

[39] Howie J, Heaney D, Maxwell M (2004). 'Quality, core values and the general practice consultation: issues of definition, measurement and delivery'. *Family Practice*, vol 21, no 4, pp 458–67.
[40] Goodwin N, Dixon A, Poole T, *et al*. *Improving the Quality of Care in General Practice: report of an independent inquiry commissioned by The King's Fund* London: King's Fund, 2011.
[41] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health *Milbank Quarterly* 2005; **83(3)**: 457–502.
[42] http://www.hm-treasury.gov.uk/d/minutes_3_13_reports_cpas_feb2011.pdf

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 front-line, personal and accessible care.

66. The College has many very serious concerns about the changes proposed in the consultation paper *Liberating the NHS*: *developing the healthcare workforce*,[43] and urges the government to reconsider very carefully before implementing the proposed changes. The purpose of education and training is to provide a healthcare workforce that is competent and safe, safety that must be assured both during and after training. We support the principle of seeking to improve quality and efficiency, but believe that reform should be evidence-based, and tested by rigorous evaluation for unintended consequences. It is our view that many of the proposals in this paper do not meet these standards, are likely to result in negative consequences for the future healthcare workforce, particularly in primary care, and ultimately may lead to poorer outcomes for patients.

67. It is worth noting that many GPs, including senior experts in the field of medical education, found aspects of the government's consultation paper confusing. There was a lack of detail, which makes a full appraisal of its pros and cons extremely difficult.

68. We do not believe that a sufficiently strong case is made for the failings of the current system, such that the proposed changes would mark an improvement. There is an assertion that 'the current system is too top-down'; but in many cases a standardised approach is likely to be appropriate to attaining a consistently high standard of output and fulfilling a number of additional but essential functions:

    a. The setting of standards.
    b. The implementation and monitoring of placements.
    c. The co-ordination of appraisal processes.
    d. The case management of doctors in difficulty.
    e. The quality assurance of education and training.

69. It seems to us that many of these deanery functions are ignored altogether, to the extent that the document portrays a very limited, partial view of the education and training role, one that the medical educators among our respondents would scarcely recognise.

70. We are concerned that the 'provider skills networks' as proposed will be unwieldy and uncoordinated – representing so many competing concerns that they will find it difficult to make decisions.

71. We are also concerned that, given the many other changes to be implemented in the NHS, there may not be sufficient drivers to compel providers to prioritise education and training. With all the other priorities for service development, it may not be possible for GP commissioners to isolate educational priorities and ensure that these are consistently implemented. How is it proposed that providers, who will of course have considerable financial pressures and an increasing range of competitors, will be

[43] This is drawn from the RCGP's response to the Department of Health consultation *Liberating the NHS: Developing the Healthcare Workforce*, which can be found at www.rcgp.org.uk

persuaded to plan education for the long rather than the short term?

72. We see a major risk that the large foundation trusts will dominate networks, and through control of education effectively blunt any initiatives that commissioning consortia propose – we assume that this is not the intention, given the Department of Health's strong support for clinical leadership and the vital need for more treatment to move into primary care settings. It is not helpful that the level of engagement of primary care in the proposed networks is not considered – is it expected that GPs will be represented at practice level, or by their GPCC, though these are not strictly providers? What about other primary care providers – dentists, optometrists, etc.?

73. Difficulties will be magnified when considering workforce development and transfer between the four nations of the UK, and consideration should be given to implications for trainees from Scotland, Wales and Northern Ireland. We are a four-country College, committed to the maintenance of standards across the UK and concerned about any imbalance that may occur between these.

Recommendations

8.1: Given that the education and training proposals mark a revolution in medical education and could be harmful in primary care, we urge a careful and detailed reconsideration ahead of any implementation.

8.2: We strongly support the retention of deaneries, or equivalent regional bodies with strategic oversight, with the range of functions they currently fulfill, as a tried-and-tested approach to medical education,

8.3: There is a need for enhanced training for GPs to meet the needs of a modern NHS. The length of training needs to be comparable with (hospital) specialist training.

8.4: That the reforms to workforce and training be used as an opportunity to introduce measures to address the shortages of GPs in areas of greatest need.

8.5: That there is stronger focus on generalist care, with the knowledge that medical generalism improves patient outcomes, reduces cost and improves public health.

9: Confidentiality

74. The Bill creates a number of new and powerful institutions, with new legal powers to demand information, and a new duty placed on GP consortia to comply. Legally new statute law, which this would be, will override the longstanding common-law duty of confidentiality.

75. The clauses in the Bill relating to the transfer and processing of medical information give the College concern that the confidentiality of the medical consultation could be undermined, for example: '1345. The Secretary of State will have power in the "standing rules" (clause 16, inserting new section 6E into the NHS Act) to use regulations to require the NHS Commissioning Board or commissioning consortia to disclose specified information to specified persons. This information is highly unlikely to consist of information, which identifies living individuals. It is likely to be used to require the NHS Commissioning Board or consortia to provide certain information to patients and the public, for example in connection with the exercise of choice."[44]

76. The Bill conveys very wide powers to the Secretary of State and also to the various administrative organisations within the health system. The difficulty is created by a failure on the face of the Bill to clearly define whether the information required for NHS management and various secondary uses will be protected by the existing laws (Article 8 Human Rights Act, Data Protection Act and the common-law duty of confidentiality), which relate to the use of personally identifiable medical information.

77. A further failure is the absence on the face of the Bill to distinguish between personally identifiable medical data and medical data that has been pseudonymised or anonymised. The Bill makes reference to flexibility, such that 'a regulation-making power is considered necessary, rather than specifying the information on the face of the Bill, in order to allow flexibility for unforeseen information needs to be dealt with in future'.

78. Under the new Bill, powers will be given to the NCB to demand information to monitor consortia rather than to deal with national emergencies or major public health issues: 'Under clause 22 the NHS Commissioning Board has powers to require information, documents, records or other items (section 14Z3) and to require explanations (section 14Z4). The legitimate aims pursued by such requirements include the protection of health (by ensuring that high quality health services are commissioned by consortia) and the protection of public funds (ensuring in particular that consortia are meeting their financial duties in respect of their use of public money and that the NHS Commissioning Board can intervene sufficiently early). The purpose of these powers is to enable the NHS Commissioning Board to assess how consortia are carrying out their functions where the NHS Commissioning Board has reason to believe that the consortium might be failing to discharge its functions.'

79. Similar power will be given to Monitor. '1349. Monitor will have power to require the disclosure of information, etc. by commissioners and providers of NHS services (clauses 90(1)(c) and 94, or regulations which include the power provided for in clause 64(1)(b)) and powers and duties to share relevant information with other regulatory bodies (e.g. the Care Quality Commission) (clauses 265 and 264). The power to

[44] Health and Social Care Bill, Explanatory Notes, HCB 132-EN 55/1 (January 2011).

require the disclosure of information is to enable Monitor to carry out its statutory functions and the power to share information is to enable other regulators to perform their statutory functions.'

80. Doctors have a professional duty, regulated by the General Medical Council, to preserve the confidentiality of information given in trust to them by patients. However, the Bill requires any provider in the NHS to supply to the Information Centre any information that the Information Centre deems necessary for its functions (clause 255). This creates a potential direct conflict for doctors between their professional duty and a legal duty, which goes far beyond the traditionally recognised duty to supply information in relation to serious crime, acts of terrorism or risk of serious infection.

Recommendation

9: That there is as an absolute assurance that the Bill will not force doctors to breach their duty of confidentiality.

Conclusion

81. The future NHS must build on the strengths and values of today's health service, in particular building on the strengths of general practice. The benefits of modern general practice are well documented, with significant evidence that a good relationship with a GP, preferably over several years, is associated with better care, more appropriate care, better health, and much lower health costs.[45]

82. Irrespective of the outcome of these current reforms, the RCGP will continue to promote the development of high-quality, effective patient-centred care, with GPs at the heart of NHS service delivery.[46]

83. The RCGP recognises that the NHS needs reform and we would welcome the opportunity to work with the Government to further develop proposals to maximise benefits for patients

84. In the meantime we shall continue to offer leadership and guidance to members as they seek to deal with the consequences of the NHS reforms. We are engaging with our members to provide input to the Prime Minister's Listening Exercise and will continue to develop further proposals for reforms of the NHS which place patients at the centre and promote family medicine. We shall also provide guidance, education and training opportunities, and through the RCGP Centre for Commissioning, shall ensure the sharing of good practice to assist GPs to develop the necessary skills to lead effective clinical primary care within the context of GP commissioning consortia.

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[45] Starfield B, Horder J. Interpersonal continuity: old and new perspectives *British Journal of General Practice* 2007; **57(540)**; 527–9.

[46] The RCGP's vision:

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

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 health care 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 GPs in partnership with patients and carers
- advancing and promoting the academic discipline and science of General practice
- promoting the unique doctor–patient relationship
- shaping the public health agenda and addressing health inequalities
- being the voice of general practice.

Our values:

The RCGP is the heart and voice of general practice and as such:

- we protect the principle of holistic generalist care that 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 health care for all
- we are committed to the theoretical and practical development of genera practice.

Useful references not otherwise in the document

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Appendix 2: RCGP Listening and Engagement – Summary

	Activity	Comments
1.	2 web conferences organised	• Dr Robert Varnam web conference was organised for 19/05/11 • Amanda Howe web conference for educationalists was organised for 23/05/11 • Web conference details were disseminated via the Chair's Update to Members, Twitter broadcast and by email to a select group
2.	Health Reform Analysis Paper	• Letter and papers were sent to PM and Prof Steve Field 6/05/11
3.	4 x Question Lead Meetings	• meeting held with Sir Stephen Bubb and Lois Whittaker Meeting • Clare Gerada met Kathy McLean on 13 May • Amanda Howe met Julie Moore on 17 May • Meeting to be set up with Geoff Alltimes (Patient & Public Involvement) so far unable to secure a response from his office.
4.	Live WebChat Steve Field Twitter & Facebook	• DH organised event was promoted on RCGP website, RCGP Twitter & Facebook
5.	Chair's Blog	• weekly blog encouraged Member engagement with Listening Exercise
6.	Listening Exercise digests produced and placed on website	• Completed
7.	Academy of Medical Royal Colleges (AoMRC) meeting on 19/05/11	• Andrew Lansley attended the AoMRC meeting.
8.	Dementia Alliance Listening Exercise with Steve Bubb on 17/05/11	• Clare Gerada attended

9.	DH Listening Exercise on maternity & newborn 16/5/11	• Clare Gerada attended
10.	Meeting with Andrew Lansley,	• This took place on 17/05/11
11.	Meeting with Sean Worth, Special Advisor to David Cameron	• This took place on 17/05/11
12.	Prime Minister's Speech at Ealing Hospital	• Non attendance from RCGP due to short notice
13.	Listening Events 18 May	• This workshop focused on the financial aspects of authorisation. Dennis Cox (Clinical Commissioning Champion) attended on behalf of the RCGP
14.	Listening Exercise meeting with Prime Minister	• Clare Gerada attended
15.	Meeting with Ben Dyson, Ian Dodge with David Price and Neil Hunt	• This took place on 17/05/11, Clare Gerada and Neil Hunt attended.