The NHS reforms:

what they will mean for generalist and specialist clinicians

The need for better collaboration between primary and secondary care and other sectors of the NHS workforce was one of the key messages that came out of the Future Forum, which considered the government's plans for reform of the NHS. We asked six professional leaders for their views on how they see the specialties working with primary care in the future.

WHAT WILL THE NEW NHS MEAN FOR GPs?

Clare Gerada, Chair of RCGP Council

In the first instance, the new NHS will give GPs responsibility, not just for providing (primary care) services to their patients, but also for commissioning the vast majority of secondary care for their registered patients. In reality, commissioning health services requires more than just GPs to be involved. GPs must commission in partnership with other secondary care, public health, and NHS management colleagues and with the support of those in local government. As it is currently constituted, GPs will have the majority of places on the Board of Clinical Commissioning Groups and will have the lead responsibility, over and above any other single specialty group. Through commissioning GPs will largely determine what services should be bought on patients' behalf.

Whatever the future, GPs must focus on improving the care they provide to their patients. They must focus on improving access, continuity, and care. GPs must not be distracted from promoting the core values of general practice; that is commitment to excellent medical generalism, treating the patient as an individual, providing continuity of care, and providing advocacy on behalf of our patients and communities. Commissioning must not detract us from our duties as clinicians. The focus must not just be on commissioning but also on provider reform.

The Royal College of General Practitioners (RCGP) believes that the way forward includes:

- Working together as Federations of practices, sharing best practice through peer support, joint continuing-professional-development events and sharing services and staff, while maintaining practice independence.
- Improving integration through joint working between different professional groups, with care that extends across professional boundaries (so GPs extend their care to patients in hospitals and vice versa) and across social and community care. This will involve enhanced communication beyond the simple exchange of letters, and ideally involve pooled budgets and the use of a single electronic record. The emphasis on patient choice and competition will do little to address the needs of the majority of our patients who have complex, chronic, and relapsing health needs, each requiring a much more integrated approach to their care, with providers that understand each other's strengths.
- A commitment to give all healthcare providers a responsibility for the geographical population they serve and the removal of the perverse barriers to joint working; including the dual pressures of foundation trusts' need to increase activity to balance their books, and on GPs to reduce their patients' access to specialists in the quest to save resources. That done, we can begin to talk about 'our patients, our resources, our NHS'.

Good commissioning is about being a good GP. It is about understanding the impact of clinical decisions on the public's health and purse, understanding the duty to practice safely, effectively, and in an evidence-based manner and about understanding how the needs of patients can be best served through the design of services that meet those needs. For commissioning to be deemed successful, investment in general practice must be part of the agenda, and it must address health inequalities and redistribute resources, including staff, to areas of greatest demand. This will require courage and commitment.

Strong primary care has been shown to improve patient health outcomes, including a reduction in mortality rates from cancer, heart disease, or strokes; reduce costs while still maintaining quality (such as, hypertension and diabetes); and reduce health inequalities to the point that primary care, in contrast to specialist care, is associated with a more equitable distribution of health in populations. Strong primary care has been proven to reduce demand on other services and, to that end, more GPs (especially in areas of greatest need) and longer training must be given the highest priority.

The NHS reforms will demand and require new ways of working for all clinicians, new skills for GPs, and an ongoing commitment to putting the patient at the centre of what we all do. We become medical practitioners because we care, and we need to be able to concentrate on patients, concentrate on delivering high standards, and concentrate on raising quality for all of our patients, every day.

Clare Gerada,
Chair of RCGP Council, Royal College of General Practitioners, London, UK.

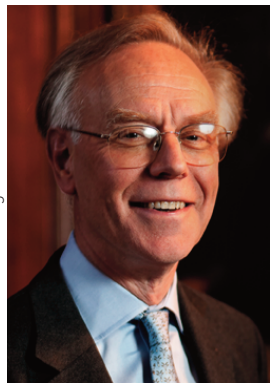
E-mail: clare.gerada@rcgp.org.uk

DOI: 10.3399/bjgp11X593992

"The NHS reforms will demand and require new ways of working for all clinicians, new skills for GPs, and ... putting the patient at the centre of what we all do."

"I hope that in future we can take away the 'primary/secondary care divide', as we work closely together in multidisciplinary teams and cross-boundary projects."

TIME TO REMOVE THE 'PRIMARY/SECONDARY CARE DIVIDE'



Credit: Jonathan Perugia

Sir Richard Thompson, President, Royal College of Physicians

The last 6 months of relentless parliamentary activity, media speculation, and reforms to the reforming Health and Social Care Bill have taught us this: it is time for GPs and hospital doctors to join forces and work together in the interests of patients. While integration will now be officially promoted by Monitor, as medical professionals we must take the initiative and design such integrated services together, building on the innovative good practice that already exists, and pre-empting any top-down solutions.

Since I became president last year, I have been promoting the concept of 'commissioning without walls', which follows a well-received joint RCGP/Royal College of Physicians (RCP) report showcasing good practice in primary and secondary care integration entitled 'Teams without Walls'. I hope that in future we can take away the 'primary/secondary care divide', as we work closely together in multidisciplinary teams and cross-boundary projects. We need a framework that will allow us to develop integration for the care of our patients, underpinned by a focus on quality, and supported by adequate and flexible funding. An impossible call, given the effective budget cuts we are facing, but we do need to develop innovative new services, some of which may require investment. We shall be able to use our increased influence in commissioning structures to push forward these new initiatives, designing, for instance, pathways for care across boundaries, with secondary care doctors involved in the community, and vice versa.

It is intended that the secondary care doctor appointed to each clinical commissioning group will bring their experience and knowledge of the hospital environment to the table, taking an overview of commissioning issues generally, and not simply in their own specialty area. We are seeking reassurances from the government that they should not have to be from outside the area or retired, but should be appointed from the local secondary care community. These local appointments should not be more of a conflict of interest than the local appointment of GPs to clinical commissioning groups. Conversely, I have suggested that a GP should sit on the board of foundation trusts to contribute accordingly. This has not yet been adopted in statute, although it is already happening in some trusts.

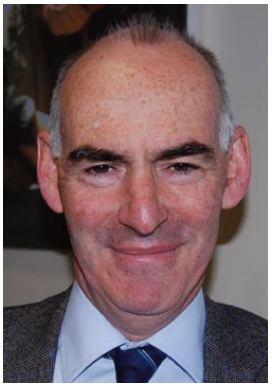
I am still concerned that, despite the welcome change in focus from competition to collaboration, and the renewed emphasis on quality of care, we could still be facing fragmentation and destabilisation due to the expansion of the 'any qualified provider' model to bid for services. Patient choice is important, but it must be clinically appropriate, and we must do more to understand when patients want choice, which they often do not, and to ensure that it does not destabilise services. We are looking to the government to insert safeguards to prevent cherry picking, but strong leadership locally will strengthen and improve the quality of existing NHS services and providers.

Which leads me to another of the RCP's pressing concerns, namely the balance between specialism and generalism. The RCGP Commission on Generalism has come at the right time, as we face a relentless rise in demand for acute care, coupled with an increasingly older population. Both generalists and specialists, such as geriatricians, will be needed in hospitals. Generalists will provide a much needed general service for referrals from primary care, and continuity of care for inpatients. They may also advise on perioperative care on surgical wards. By working in partnership we will have an ideal opportunity to bridge the current divide between primary and secondary care and thus improve pathways of care for our patients.

Sir Richard Thompson,
President, Royal College of Physicians, London, UK.
E-mail: richard.thompson@rcplondon.ac.uk

DOI: 10.3399/bjgp11X594009

A LIFE COURSE APPROACH TO WOMEN'S HEALTH CARE



Anthony Falconer, President, Royal College of Obstetricians and Gynaecologists

The proposals to the Health and Social Care Bill are the most fundamental changes the NHS has seen since its inception. In parallel, the four critical drivers for the Royal College of Obstetricians and Gynaecologists (RCOG) to introduce change in women's reproductive health service provision are: to improve quality of care, and to meet the required financial savings, the crisis in the workforce, and the increasing demand on services through the significant rise in the number and complexity of maternity patients.

Current commissioning arrangements for women's services create tensions over tariff, which distort priorities, with individual trusts relying on gynaecological services to compensate for financial losses in the maternity sector. The new commissioning arrangements are to be welcomed, provided that the NHS Commissioning Board incorporates governance of quality standards through the Care Quality

"The current inconsistency in clinical quality is unacceptable and must cease forthwith for the safety of all patients."

Commission to deliver a uniform, quality service. The current inconsistency in clinical quality is unacceptable and must cease forthwith for the safety of all patients. Advice from institutions like the RCOG to the National Children's Bureau, Monitor, and clinical commissioning groups, and our input in the 'clinical senates' about the pattern and structures of healthcare delivery could be a significant gain to developing integrated services. Our multiprofessional quality standards, already published, should form the basis for future commissioning.

Women's services, including maternity, require configuration on a network-managed basis, similar to current services in neonatal and cancer care. A 'life course' approach to women's healthcare should incorporate elements of the public health agenda which would fit neatly into a Healthcare Quality Improvement Framework. New, safe, and cost-effective patterns of maternity care should be developed including midwifery-led units and units for complex care providing 24-hour on-site senior medical cover. Any qualified providers with appropriate governance arrangements are likely to remain as part of this tapestry; for example, abortion services.

Informed choice is a fundamental right for patients. All patients want services close to home. With reconfiguration of services this issue may create significant challenges and we anticipate that the National Children's Bureau will facilitate difficult political decisions. However, we believe that quality is the biggest determinant of choice for patients. Competition aimed at raising the quality of service should not be a threat but an opportunity for improvement.

The interface between primary and secondary services in women's healthcare will become less clear with many more 'gynaecological issues' being managed within the community. The challenges to the RCGP and RCOG will focus on training and defining clinical pathways with standards of care. The recent joint statement on the role of primary care in maternity services clearly defines the expectation without addressing the training issues necessary for implementation. It seems fundamental that secondary-based training experience, with defined competences, for those in primary care needs a refocus with an increase in training time for trainees in primary care to accommodate a larger syllabus. The training needs of future specialists in women's health services need to be planned nationally. Workforce planning and skills mix are central to local planning. Changing the current deanery structures is counterproductive and independent quality assurance must be strengthened and separate from the provision of training.

Creative central leadership should be a responsibility of the RCOG, together with a recommendation to appoint a national clinical lead for women's services.

Anthony Falconer,
President, Royal College of Obstetricians and Gynaecologists, London, UK.

E-mail: president@rcog.org.uk

DOI: 10.3399/bjgp11X594018

THE REFORMS ARE A REAL CHANCE FOR CLINICAL LEADERSHIP TO FLOURISH — IF WE LET IT

Andrea Spyropoulos, President, Royal College of Nursing

The NHS faces some of the most significant changes and challenges in its history; and those working for our health service have seen a White Paper, a consultation period, a Health and Social Care Bill, the 'listening exercise', and now amendments to the original Bill. It's fair to say it has been a long journey, and it's not over yet.

Now, we must think about allowing clinical leadership to shine through, despite the challenges we face; for those who deliver care, to control care. We need to seize on the progress made following the amendments and look at the commissioning of services, the role of primary care, and the support available for staff, including GPs and nurses.

The Royal College of Nursing (RCN) has a very good relationship with GPs and is proud to call the RCGP one of its most important stakeholders. That said, we believed that other professionals needed to be involved in commissioning decisions, so we were pleased with the amendment that widened the playing field. The decision that a nurse, hospital doctor, as well as a layperson, will now sit on the boards of clinical commissioning groups (CCGs) is a positive move and one that will benefit patients.

The case for multidisciplinary commissioning speaks for itself. By pooling our knowledge, working together, and empowering staff to shape the care of those they treat, we can offer patients complete care plans and ultimately seek to improve the quality of care. In 2009, a report by the RCN and National Voices revealed that patients believed nurse specialists to be the best-placed to make commissioning a success. In fact, 74% of patients said that these nurses were effective at designing care pathways.

Changes to healthcare also require public 'buy-in' and the RCN has welcomed news that there will be 'clearer duties across the system to involve the public, patients, and carers'; assuming of course this turns into something substantial and isn't mere rhetoric.

In this vein, we must consider how to manage services effectively across the

"... we believed that other professionals needed to be involved in commissioning decisions, so we were pleased with the amendment that widened the playing field."

primary and secondary sectors. Two-thirds of the healthcare budget is spent on long-term conditions, many of which can be treated in the community. Billions could be saved by effectively and innovatively treating patients in their own homes. The CCGs could provide an ideal opportunity to strengthen the much needed links between primary and acute care.

The needs of patients are constantly evolving and healthcare is continually advancing, which means a real need to develop the skills of those working in healthcare. Training must be prioritised among clinical leaders in commissioning groups and rolled out in services across the country.

What's more, there must be national oversight of the training available to staff and a guarantee of continuing professional development. Almost one-third of our members said that they were unable to access their mandatory training last year and 34% are using annual leave to complete training. Clinical staff recognise the value of training, and employers must do the same. At a time of cuts, training is often seen as an easy target, but we must ensure that it is nationally available.

In spite of the challenges ahead, we must seek to work with the reforms that will be put in place. It is essential to promote patient-focused commissioning, integrated care, and ultimately to offer more scope for excellent clinical leadership.

Andrea Spyropoulos,
President, Royal College of Nursing, London, UK.
E-mail: Andrea.spyropoulos@rcn.org.uk

DOI: 10.3399/bjgp11X594027

NHS 'REFORMS' — FORWARD OR BACKWARD?

Dinesh Bhugra, Immediate Past President, Royal College of Psychiatrists

"... psychiatrists must be a part of the commissioning group to ensure that parity is given to mental health with physical health."

During the past few decades we have experienced 'reforms in the NHS every 3 years or so. By the time the dust starts to settle from one set, another dust storm is created. During these periods of dust storms everyone's energy goes into battening down all the hatches and ensuring that dust does not enter the delicate machinery of health care. Why our political masters are so keen to interfere with the NHS is a debate for another time and place. In spite of the overuse of the word 'reform', which makes it sound as if things are not working, these changes always are costly. Here is the response of the Royal College of Psychiatrists (RCPsych) to the latest wind of change.

Although few people would argue with the basic premise of the Bill to place patients at the core of health care and professionals at the core of the commissioning process, the danger really for the profession is that without adequate support and resources the possibility of matters going awry is high. Furthermore, variability in the level of interest by GPs across the country needs to be addressed. It is possible that those who are committed to urgent adaptation of the changes are more energetic and charismatic. As with any research study, those who agree to participate may not be typical of those who get the treatment.

There is a serious danger that all secondary care specialties are seen as having similar problems and solutions. Mental health service providers are not part of acute care trusts and are likely to be ignored, notwithstanding psychiatric morbidity in the general population and across all age groups.

With GPs commissioning mental health services, it is vital that they know and understand the therapeutic needs of a large number of patients with varying diagnoses and outcomes. Difficult-to-engage patients and those with severe complex comorbid needs will bring with them additional factors that need to be considered.

In April 2011, the RCPsych conducted a survey of its membership as part of the listening exercise. About 12% responded and a vast majority agreed with the College that psychiatrists must be a part of the commissioning group to ensure that parity is given to mental health with physical health. Also, there was considerable support for patients even in the case of involuntary patients. However, concerns were expressed about 'any willing/qualified' providers which could result in different providers in different parts of the pathway and disjointed services leading to a postcode lottery.

Sue Bailey, President, Royal College of Psychiatrists

The challenge to the commissioners and any qualified provider also affects training and education; not only for psychiatrists but also for other mental health professionals. A vast majority (88%) did not agree that any qualified provider model would improve patient care. There have already been concerns related to addiction psychiatry. The RCPsych is keen to ensure that commissioning involves psychiatrists and ideally would like to see a gradual introduction of changes rather than a 'big bang' one.

The collaboration between primary care and secondary care is absolutely crucial if difficult-to-engage patients are to be looked after. Urgent clarification is needed on how far any willing/qualified provider will apply to mental health. The findings from the survey are not scientific, but provide insight into concerns raised by members.

Dinesh Bhugra,
Immediate Past President, Royal College of Psychiatrists, London, UK.
E-mail: dinesh.bhugra@kcl.ac.uk

Sue Bailey,
President, Royal College of Psychiatrists, London, UK.

DOI: 10.3399/bjgp11X594036

STRENGTHENING PUBLIC HEALTH

Credit: Jonathan Perugia

Lindsey Davies, President, UK Faculty of Public Health

Alongside its reforms of the NHS, the government plans to put in place what are arguably the most far-reaching changes to the English public health system since the first medical officers of health were appointed in the middle of the 19th century. County, unitary, and London Borough local authorities (LAs) will be given new responsibilities for protecting and improving the population's health. To help them discharge these, they will be required to appoint directors of public health (DPH; currently employed by primary care trusts [PCTs]), manage ring-fenced public health budgets and establish multiagency Health and Wellbeing Boards to provide strategic leadership and coordination. The DPH will be the LA's principle advisor on health. They will report annually on the health of the population and will work with colleagues from all sectors, including clinical commissioning groups, GPs, and NHS providers, to identify and address health needs.

A new organisation, Public Health England, is being set up as an executive agency of the Department of Health to support national and local government; and there will be a new emphasis on outcomes, encapsulated in a public health outcomes framework.

Health needs and expectations are increasing. Epidemics and disasters do happen. The economy shows no sign of imminent recovery and health inequalities are likely to be exacerbated by the increasing disparity in income between the very rich and the poor. Now, perhaps more than ever, we need a robust public health system that protects people from harm, encourages healthy lifestyles, and ensures that effective and appropriate treatment and care can be accessed easily when needed. The UK is already recognised as a worldleader in public health. Will the benefits of this major reorganisation outweigh the risks?

At its heart, public health is about the organised efforts of society: coordinated activity across whole populations to make a significant and sustained impact on health. It depends fundamentally on reliable evidence, clarity of purpose, constructive relationships, and active participation. The new system could enhance each of these, but this will require changes to the planned legislation, adequate resources, and inspired implementation. At worst, existing relationships will be fractured, expert resources lost, and no one will know who is in charge when disasters strike.

If, for example, the DPH is part of the LA's most senior executive group, and is supported by a well-resourced expert team, they will be in a strong position to increase the health impact of every LA activity. A DPH in a less senior position, or with insufficient staff, will struggle to make their voice heard. Similarly, Health and Wellbeing Boards populated by senior local leaders who take this responsibility seriously could be a tremendous force for good health, bringing challenge and coherence to an increasingly fragmented NHS. Without that level of engagement, Boards may deliver little more than hot air.

Nationally, if Public Health England is, as proposed, part of the civil service it could be seen as an arm of the state rather than a trusted source of expert advice. Transparency in its working arrangements and independence for its professional staff and scientific committees will be essential if it is to inspire confidence. This should not be impossible, but would be a new and challenging way of working for any government agency.

There are further challenges in that the future employment arrangements for public health consultants and trainees are unclear, the continuing uncertainty is becoming dispiriting, and reductions in PCT budgets are now having a real impact on public health staff numbers. Public health observatories are a case in point: their analyses support public health activity across the UK and worldwide, but their funding has been cut and their future remains opaque.

National negotiations continue. The Bill is not yet law and it will be at least 2 years before any new system is in place. Meanwhile, the public's health demands action and we must all do what we can to ensure that the many excellent initiatives already in place are not lost in the turmoil of transition.

Lindsey Davies,
President, UK Faculty of Public Health, UK.
E-mail: President@fph.org.uk

DOI: 10.3399/bjgp11X594045

"Health and Wellbeing Boards populated by senior local leaders who take this responsibility seriously could be a tremendous force for good health."