

November 2008

A review of the NHS Next Stage Review final reports

GPC guidance for GPs and LMCs
(England only)



INTRODUCTION

In July 2007 it was announced that Lord Darzi would lead the NHS Next Stage Review, 'Our NHS, Our Future'; a wide ranging review of the NHS in England at a local and national level. The first interim report was published in October 2007, with a second in May 2008. The final report, 'High Quality Care For All', was published on 30 June 2008, with a second report 'Our vision for Primary and Community Care' published on 3 July. A workforce strategy was also published.

This GPC review intends to brief GPs and LMCs on the proposals relevant to general practice and primary care that can be found in 'High Quality Care For All' and 'Our vision for Primary and Community Care'. These reports contain many positive recommendations in support of primary care, but also some proposals that may threaten the current model of general practice. This document offers an accessible distillation of these ideas so that GPs can appreciate how the Department of Health intends to shape primary care and the NHS in light of these reports.

'Our vision for Primary and Community Care' puts strong and effective primary care at the centre of healthcare provision in England. It states that primary care in England is admired across the world, while 97% of patients are satisfied with their last visit to general practice.

"The strengths of our system of primary care are recognised beyond England as well. NHS primary care was ranked top overall in a Commonwealth Fund survey of six OECD countries in 2006." [Our vision for primary and community care (OVPCC), 3.7]

Lord Darzi underlines the importance of the registered-list model of general practice:

"This system of registration forms the bedrock of our primary care system. GPs still often care for generations of the same family and are well placed to consider health needs in a family context. They and their patients greatly value the trust and personal continuity of care that comes from this relationship. The system of registration enables GPs to play a wider role in supporting the health of local populations, for instance through immunisation and screening programmes." [OVPCC, 3.8]

The positive effect that the 2003 contract has had on general practice is emphasised, in particular the development of the Quality and Outcomes Framework (QOF). Also praised is the improvement in GP access and the increase in average consultation times.

It is important to recognise that these reports provide a positive overview of general practice in England, and also contain many proposals that will benefit patients. However, for these benefits to be realised, constructive ideas must be matched with practical details for implementation and appropriate resources, to enable Primary Care Trusts (PCTs) to deliver these proposals. We understand there is to be little in the way of national implementation teams, but significant direction will be provided by the Department of Health and SHA in some strands of this work. PCTs have been asked to produce a five-year strategic plan by spring 2009. To see these proposals fulfilled, the profession must seek to ensure that there is effective local implementation and that proper resources are available, to enable the further improvement in quality of patient care in general practice. LMCs will have a crucial role to play in this.

CONTENTS

This review has collated the individual proposals contained within the two main Next Stage Review reports and grouped them loosely along thematic lines. Each proposal is followed by the considerations of the GPC.

CHOICE AND QUALITY	page 4
DEVELOPMENT OF NEW AND EXISTING SERVICES	page 7
COMMISSIONING	page 9
SERVICE PROVISION AND RECONFIGURATION	page 11
CLINICAL ENGAGEMENT AND CLINICIAN DEVELOPMENT	page 14
REGULATION AND ASSESSMENT	page 16
IMPLEMENTATION	page 17

Note

Textual references indicate either 'High Quality Care For all' – HQCFA, or 'Our vision for primary and community care' – OVPCC, and are recorded such that chapter 4, paragraph 18 is referred to as '4.18'.

CHOICE AND QUALITY

1. Patients will have a greater and more informed choice of GP practice, allowing the development of fairer rewards for practices that provide quality service and attract more patients. The NHS will work with local GPs to open closed lists and extend practice boundaries, and discussions with GP representatives will see more resources channelled into fair payments based on the needs of the local population. [OVPC, 4.16, 4.18; HQCFA, 3.27-28]

GPC comment:

These proposals represent the future direction of travel for GPC negotiations with the Department of Health and NHS Employers. The implications of such proposals on list-based general practice must be fully understood, but GPs must also be receptive to the widening of patient's choice of practices. This proposal has the potential to significantly change the way in which practices provide care, and will be considered in great detail in negotiations.

We must recognise that the government believes that it is GPs, and therefore practices, that are in the most powerful position in terms of choice and the provision of services offered to patients. The government is determined to change this so that the perceived balance of power lies more heavily in favour of patients. This lies behind the government's philosophy of choice and the introduction of a market to primary care. To meet the challenges presented by new APMS providers, practices will need to ensure that they are responsive to their patients in the future, or they may face unwelcome consequences.

Despite this, we welcome the opportunity to further demonstrate the high quality care that is provided by the independent contractor model of general practice.

2. A goal will be set for every NHS provider to systematically measure, analyse and improve quality. Providers will develop their own quality frameworks that combine national indicators with local ones. [HQCFA, 4.14]

There will be a new strategy to develop the Quality and Outcomes Framework (QOF), including an independent and transparent review of indicators. This will aim to reduce the number of organisational or process indicators and refocus resources on new indicators of prevention and clinical effectiveness, as well as the promotion of healthy living, following discussions with the National Institute for Health and Clinical Excellence (NICE) and with professional and patient groups. [OVPC, 6.13-14] The Department of Health will explore the possibility of giving PCTs greater flexibility in selecting quality indicators, from a national menu, that reflect local health improvement priorities. [HQCFA, 4.15] The use of patient reported outcome measures (PROMs) will also be explored. [OVPC, 6.13]

GPC comment:

The strength of the QOF lies in the fact that it is evidence-based. The quality indicators are independently developed and based on thorough evidence, and consequently, the QOF has the confidence and support of the profession. If this independent function were passed to NICE, then we fear evidence would be interpreted differently, and the confidence of the profession might be lost.

The development of preventative indicators is also concerning. There is a fundamental difference between being rewarded for delivering high quality care, and being rewarded for maintaining good health. The attainment of the latter depends on the willingness of patients to

engage with their care, on their right to make choices about their lifestyle, on the level of health at which care commences and on external social factors. These proposals are being addressed in ongoing negotiations with the Department of Health.

Local QOF indicators will undermine the fundamental principle that care is provided through a national health service. Such a framework would potentially exacerbate health inequalities and the 'postcode lottery' of care. Indicators must remain UK-wide, evidence based and fit for purpose. PCTs should look to offer an evidence-based LES if there are local care issues that need addressing.

Although we would support in principle the use of patient reported outcomes measures, we believe that they are incredibly complex to develop and that it is very difficult to interpret them usefully.

3. The Department of Health will "strive to accept and implement every recommendation for screening and vaccination programmes that the relevant national expert committees make". These relevant committees are the Joint Committee on Vaccination and Immunisation (JCVI) and National Screening Committee (NSC). [High Quality Care for All (HQCFA), 3.9]

GPC Comment:

We are concerned that the government appears to be moving away from national directed enhanced services (DESs) for clinical activities such as screening and vaccination. Developing a local enhanced service (LES) to deliver such programmes undermines the uniform approach across the country which would be expected of a national screening programme, as well as incurring unnecessary time and resources in local negotiation. We believe that to provide the most comprehensive and cost effective screening programme for patients, all such national programmes should be delivered via a DES.

4. All patients will have the right to NICE approved treatments and drugs where it is judged by their doctor that they would be of benefit. Patients should expect rational local decisions on the funding of new drugs and treatments, with an open and honest explanation if the local NHS decides not to fund them. [HQCFA, 3.48]

Improvements to the appraisal process and topic selection will lead to NICE issuing the majority of guidance within a few months of a new drug's launch. [HQCFA, 3.49]

GPC comment:

Guaranteed access to the most clinically and cost effective drugs is a very worthwhile proposal. However, there is danger here for PCTs and practice based commissioning localities. Although this will seemingly end the 'postcode lottery' of drug treatment, it will in fact shift the responsibility for making the decisions that caused this lottery onto PCTs and practice based commissioning (PBC) groups. Where previously the government was attacked for not being able to provide certain cancer drugs, for example, PCTs and PBC groups may come under equivalent attacks if they have insufficient resources to fund drug treatments that NICE recommend.

5. NICE will be expanded to set and approve more national quality standards, including relevant National Service Frameworks, from 2009. NICE will manage the spread of knowledge through a new website, *NHS Evidence*, containing clinical and non-clinical evidence and best practice. NICE will also establish a fellowship programme. [HQCFA, 4.7-8]

GPC comment:

This proposal will likely see NICE explore new drugs and technologies, as well as co-payment for secondary care. This will be important with regards practice based commissioning. The development of NHS Evidence is a positive step.

6. The Department of Health will develop 'Clinical Dashboards' to present selected national and locally developed quality measures to inform daily decisions taken by clinical teams. Three pilots are underway, one in a GP practice collecting information on patients attending A&E and out-of-hours services. [HQCFA, 4.12-13].

GPC comment:

Easy access to information is important, and this is a positive proposal. More information is needed to understand the role that clinical dashboards would play in general practice.

7. The NHS Choices website will be developed to include more information on the services offered by GP practices, practice opening times, the views of local patients and practice performance against quality indicators. A simpler way of registering electronically with a GP practice will be developed. [OVPC, 4.17] Access to the NHS Care Records Service will also be reviewed. [OVPC, 7.6]

Access to healthy living services through the NHS Choices website, such as advice on stopping smoking, control of alcohol use and improvement of diet and fitness, will be also improved. The Choose and Book system will be developed so that GPs can refer patients to a wider set of services. 'Health trainers' will work with people at greater risk of poor health. [OVPC, 5.13-14]

GPC comment:

The NHS Choices website, a potentially excellent resource, must be made fit for purpose. Adding more advice, information and patient choice to the software will likely make it harder to find desired information. Moreover, it would be dangerously misleading to use this practice information and turn the website into some form of practice league table.

We also continue to have concerns regarding the ability of patients to post their opinion of the primary care they receive onto NHS Choices, which we believe can lead to unrepresentative feedback with the potential to misinform and mislead. We have resisted the availability of this facility since the website was first developed.

8. Payments to hospitals will become conditional on the quality of care given to patients, and measured by safety (cleanliness and infection rates), clinical outcomes, patient experience and patient's views on outcomes of treatment (or patient-reported outcomes measures [PROMs]). The Commission for Quality and Innovation (CQUIN) scheme will form part of commissioning contracts and will become an overlay to the Payment by Results system. The national tariff uplift will be reduced in 2009-10 to allow funds for commissioners to pay for improved outcomes. In 2009-10, providers will be rewarded for providing data. From 2010-11, payments will reward outcomes. This scheme will be flexible to suit local circumstances and subject to independent evaluation. [HQCFA, 3.39-41]

GPC comment:

These proposals are largely aimed at secondary care: reducing MRSA and Clostridium difficile, for example, and potentially expanding the role of the National Patient Safety Authority (NPSA).

However, practice based commissioners will be central to the process of defining the parameters of these new quality measures, and to the commissioning process, and as such should be aware of these changes. These are very positive proposals, and the rewarding of quality in secondary care is a constructive development.

9. The NHS will recognise and reward quality improvement and high quality care. The payments system for providers of NHS services – the National tariff/Health Resource Groups (HRGs) is to be improved from April 2009 to recognise the complexity of care and support innovation. [HQCFA, 4.20-21]

Projected tariff uplifts and efficiency gains will be set on a multi-year basis aligned with future Spending Reviews and PCT allocation cycles to help providers plan ahead. [HQCFA, 4.22]

GPC comment:

Although this would not appear to be relevant to general practice, we would support the improvement of quality. However, this proposal may have significant implications for PBC. If high quality secondary care is rewarded with extra funding, where will this come from? Unless a reduction is made in payments to hospitals that are below average, then the rewarding of good quality hospitals may take funds away from practice based commissioning. It is also possible that the overall tariff will be reduced, with extra funding awarded separately for high quality care. Under either hypothesis, services will likely face a reduction in funding at some point.

'Efficiency gains' should also be seen as demands to do more work for without extra funding.

DEVELOPING NEW AND EXISTING SERVICES

10. There will be vascular health checks for everyone aged 40-74 from 2009 in GP practices, pharmacies and community clinics. By 2012, the Department of Health expects three million people to be offered a check each year. Pharmacies will have a key role to play as providers of prevention services. A nationwide 'reduce your risk' public information campaign will be launched in 2009 alongside the vascular health checks. [HQCFA, 3.12-13]

The Department of Health is undertaking a process of stakeholder engagement, including an assessment of sites where vascular screening is already taking place.

GPC comment:

The introduction of vascular screening by an appropriate health professional is to be welcomed – patients will benefit from this proposal. General Practice is well placed to provide screening services as an integral part of the general care that GPs provide. GPs are the only professionals that have a holistic understanding of the patient and the only professionals to provide personalised day-to-day care. Health checks should be seen as the start of a GP-managed care pathway, and not a pathway in itself.

We do not believe it would be cost effective for pharmacists to provide vascular health checks. Pharmacists provide a valued resource in terms of advice and medicine management, but vascular screening will be more effective if the clinician has access to the full GP patient record and can integrate the screening in to their routine care. There is a danger of duplication of screening and a waste of healthcare resources if pharmacists were to provide this service.

Mass screening on this scale will need to be properly resourced. Even if GPs were only involved after the screening had taken place, it would nonetheless result in a significant increase in general practice workload. The full implications of this proposal need to be understood, in terms of GPs' capacity to deliver this care and in terms of the funding available for them to do so.

- 11.** PCTs are to commission comprehensive wellbeing and prevention services, in partnership with local authorities. The services will be personalised to meet the specific needs of their local populations. Six key goals have been identified:

1. tackling obesity;
2. reducing alcohol harm;
3. treating drug addiction;
4. reducing smoking rates;
5. improving sexual health; and
6. improving mental health. [HQCFA, 3.14]

GPC comment:

The provision of care to address these key goals is already a mainstream element of general practice. This is a very helpful proposal and we are glad to see the Department of Health taking further steps to address these problems. It is important to acknowledge that each of these goals is affected by external social circumstances to some degree, and that to provide funding for these services based on outcomes only would be counterproductive. GPs have a significant role to play in providing this care but appropriate resources need to be available in general practice and in the community to do so effectively and achieve these goals. In particular, there must be much better access for patients to drug, alcohol and sexual health services.

As PCTs have been asked to develop or enhance the range of health living services that they offer, we expect that these services will be provided in general practice through the local enhanced services commissioning route. LMCs may wish to seek clarification from their PCTs on how they intend to implement this proposal.

- 12.** Sufficient early intervention for those who would have to stop work for health problems will reduce risks to long-term health. From 2009, the Department of Health will pilot musculoskeletal services, psychological therapies and other work-related health support services. [OVPCC, 5.9]
The Department of Health is in the process of identifying sites that have health inequalities to pilot these 'Fit for Work' services.

GPC comment:

These are positive steps, but the delivery of such statements is crucial. There is already a considerable mismatch between current policy and service provision in this area. We hope that it is intended that these services will also be available for those people not in employment.

- 13.** The Department of Health will establish a Coalition for Better Health, with a set of new voluntary agreements between the government, private and third sector organisations on actions to improve health outcomes. The Coalition's initial priority will be combating obesity. [HQCFA, 3.15]

The NHS health visiting service will be at the forefront of improving children's health. This service will lead the new Child Health Promotion Programme for its local population, and deliver preventative services to the most vulnerable children and families. [OVPCC, 5.5]

GPC comment:

In 2007, the Community Practitioners' and Health Visitors' Association found that one health visitor job was being lost each day in the NHS.¹ We do not believe that this situation has improved since then, to the significant detriment of patient care. In areas where health visitors are still employed, their effectiveness has in many cases been reduced by the move to providing care on a geographical rather than practice basis. The close working between GPs and health visitors, and corresponding continuity of care, has diminished as a result. The provision of health visitors needs a radical revision for this proposal to be effective.

Core elements of the Child Health Promotion Programme will be delivered in general practice. There must be close integration between the different aspects of primary care that provide child services to ensure quality and cost effectiveness, and avoid confusion for patients

COMMISSIONING

14. There will be stronger support for practice based commissioning in the form of incentives, to encourage a broader range of clinicians to be involved in the process, including community clinicians and specialists working in hospitals. [HQCFA 5.28-29]

"The purpose of PBC is to empower family doctors and community clinicians to assemble high quality care around the needs of the patients. It should put clinical engagement at the heart of the process. We have heard the message, however, that it has not lived up to this aspiration. This is why we will work with the NHS and with the professions to redefine and reinvigorate it. We will give stronger support to PBC... We will ensure that PCTs are held fully to account for the quality of their support for PBC, including the management support given to PBC groups and the quality and timeliness of data." [HQCFA 5.28-29]

Working with the professions, PBC will be redefined and reinvigorated. PBC will provide the clinical leadership central to WCC, focusing on high quality services. There will be incentives for clinicians to engage with PBC, so that family doctors and hospital specialists together develop more integrated care for patients. A clearer distinction will be made between the work of GP practices in commissioning care, and the role of practices in providing services for patients. [OVPCC, 7.10]

PCTs will be held to account for the quality of their support of PBC, including management support and appropriate data provision to PBC groups. PCTs will be expected to provide a management allowance to PBC groups to support innovation. [OVPCC, 7.11]

There will be different levels of engagement with PBC so that there is increasing autonomy for those groups that have demonstrated they can take on increased responsibility and freedoms in managing resources and designing services. PCTs must ensure that these groups have the support

¹ NHS workforce statistics revealed a loss of 433 full-time equivalent health visitor jobs between September 2005 and September 2006. Contemporary estimates put the loss between September 2005 and May 2007 at approximately 800 posts. See CPHVA press release: <http://www.amicus-cphva.org/Default.aspx?page=539>

they need, and will be able to hold them to account for how they fulfil these responsibilities [OVPCC, 7.12-13]

GPC comment:

These are very positive sentiments, but while the Department of Health continues to talk about PBC but not hold to account those PCTs that do not engage with the initiative, they will mean little. Many practices still do not have realistic budgets and timely and accurate information about referrals and hospital activity, nor sufficient resources to cover additional management costs, while the quarterly Department of Health PBC surveys consistently highlights poor engagement by PCTs with general practice. This is another opportunity to push forward PBC, and in areas where PCTs do not deliver, LMCs should consider challenging them with the sentiments expressed in the passage from HQCFA, 5.28-29 (above) to reinforce their argument.

15. The skills of PCTs in commissioning primary and community care will be enhanced. PCTs will need to:

- work with the public, local clinicians, local government and other partners to understand local needs;
- provide strong clinical leadership and ensure strong clinical engagement;
- develop primary and community contracts to ensure increasing incentives for investment in prevention and in early identification and management of risk;
- provide clear information to the public about the range and quality of care available; and
- develop markets in primary and community health services to stimulate choice and innovation. [OVPCC, 7.18-19]

It will be defined more clearly how PCTs can be held accountable, through the WCC assurance system, for their success in developing primary and community care. [OVPCC, 7.20] This is to be implemented by March 2009; first results will formally be published in March 2010. [HQCFA, 5.25]

GPC comment:

Patients deserve high quality, patient-focused care. We do not believe that the development of markets is the best way to achieve this goal, and is likely to be highly damaging to the delivery of such care.

LMCs should ensure they contribute to a 360-degree review of PCTs with regards their clinical engagement concerning the WCC initiative (competencies 3 and 4 of the WCC assurance system).

16. Over the next year, the support available to PCTs to transform their skills in commissioning will be improved. This support will assist PCTs in:

- the use of modelling to profile the needs of different segments of local communities;
- developing datasets that allow commissioners to publish information on performance;
- the better management of contracts; and
- better estate strategies, using private finance or arms-length property companies where appropriate.

[OVPCC, 7.21]

Arrangements for partnership working across Strategic Health Authorities and Government Offices of the Regions will be strengthened so that there is a joint approach to planning and prioritisation. [OVPCC, 7.24]

GPC comment:

The support available to PCTs, as outlined above, appears similar to the Framework for External Support for Commissioners (FESC) initiative. Although the FESC is available for use by PCTs, it is not clear how useful it has been thus far and so evaluation of this initiative should take place prior to further roll-out. These are positive proposals, but they must be followed by effective actions.

17. The principles of World Class Commissioning (WCC) will be applied to community health services. Commissioning will be informed by joint strategic needs assessments and services will be developed to meet the needs of the community. From 2009, a set of metrics will be piloted that commissioners can use to measure quality, clinical productivity and patient experience. The aim is to make the best use of professional skills and resources and release more time for direct patient care. Later in 2008, a standard flexible national contract will be published, which will enable PCTs to hold community health services to account for quality and health improvements. [OVPCC, 6.8-9] There is the intention to move away from block contract funding for community services. [HQCFA, 5.24]

GPC comment:

Clarification will be sought from the Department of Health regarding these new metrics and the proposed contract between PCTs and community health services.

18. As part of WCC, where PCTs demonstrate improvement on health outcomes, they will be given greater freedom over the priorities they set and methods and people they employ. These freedoms are to be set out in the autumn. [HQCFA, 5.17-18]

As national targets are achieved, they will become minimum standards. New national challenges will be met through minimum standards and by national priorities being reflected in local commissioning. There will be no additional top-down targets beyond the minimum standards. [HQCFA, 5.21]

GPC comment:

We welcome the move away from a target-driven culture which can compromise the effective delivery of care that is based upon clinical need.

SERVICE PROVISION AND RECONFIGURATION

19. Personal care plans will be offered to those with long-term conditions over the next 2 years. Plans are to be agreed between the individual and a named, lead professional, and to be regularly reviewed. They will provide a basis for the NHS and its partners to organise services around the needs of individuals. PCTs and local authorities will have the responsibility to ensure this is achieved. [HQCFA 3.34-35]

In some PCTs this will mean strengthening existing local good practice. For others, the Department of Health will be publishing guidance on commissioning a care plan approach.

GPC comment:

This is a positive idea in theory, but there are serious concerns regarding its practical implementation. The piloting of this proposal would be useful, so that the costs and benefits of its universal application could be evaluated and the views of patients assessed. The development of long term care plans will have a significant impact on general practice: GPs commission and provide much of long term care. Indeed, long term care is at the core of the work that general practice provides.

Some conditions will gain a greater benefit from such plans than others. It is not clear, for example, whether everyone with arthritis will need a long term care plan. The scope of this proposal is significant – 15 million people – but there is no guarantee that care plans will benefit all patients with long term conditions. It will certainly be important to consider the resources that will be available to initiate this sizable programme, and also how it will be implemented.

- 20.** A National pilot programme for personal health budgets will be launched in early 2009 and followed by rigorous evaluation. In most cases, the budgets will be held on behalf of patients. The programme will be voluntary, and tailored support will be given to those with personal budgets. The principles of the NHS will be upheld: the NHS will remain a comprehensive service that is free at the point of use; there will be no denial of treatment and there will be appropriate accountability. [HQCFA, 3.42-44]

The Department of Health will call for expressions of interest in piloting personal health budgets in the last quarter of 2008/09, with a view to pilots commencing by mid 2009/10. These pilots will be expected to run for three years.

GPC comment:

The employment of personal health budgets as part of the delivery of care puts the patient in a position to make wider judgments about their own treatment. This raises many serious questions. Although the report stresses that the fundamental principles of the NHS will be upheld, what will happen to the personal health budget once it has been spent? Would not the continued provision of care after this point render the use of personal budgets pointless? Similarly, what would happen if a patient under-spent their budget – would this not create an environment where patients felt they were entitled to spend up to the budget limit, regardless of need? Besides these unanswered questions, this raises the spectre of budget rationing and the restricting of treatment. It is also not clear how personal health budgets would affect the ongoing debate regarding co-payments.

Personal health budgets will provide scope for the use of alternative treatments that allow the patient to decide what type of treatment will be most beneficial to them. The value of alternative treatments for a patient will need to be evaluated. For example, an arthritis patient may prefer their budget to be spent on a stair lift instead of expensive drugs as such an acquisition may provide a tangible improvement to their quality of life. A method will need to be found to measure this. The pilots will need to find a way to determine whether personal health budgets provide better care, and whether they are cost effective.

- 21.** The Department of Health will consider nationally the costs and benefits of a new three-digit telephone number for urgent, unplanned care. Several of the SHA visions included proposals to develop such a number, and these plans will be monitored. Further details will be set out later this year. [HQCFA, 3.32]

Out-of-hours services will exemplify a new approach to integrated care, and there will be a new measure of patient satisfaction with urgent and out-of-hours care [OVPC, 4.12-13]

GPC comment:

General practice should be the first point of call for all non-emergency care at all times, either via the practice or the out-of-hours service. We do not believe that the addition of a new three-digit number will improve the current situation.

In terms of the provision of urgent care, this works best when primary and secondary care work together. However, urgent care remains the core work of general practice.

- 22.** The rate at which existing NHS trusts achieve foundation trust status is to be accelerated. The Department of Health remains committed to the ambition that in the future, hospital care will be provided by NHS foundation trusts. [HQCFA, 5.8]

To extend these freedoms, the Department of Health will explore options including social enterprises and community foundation trusts. For some providers, such as high secure units, foundation trust status will not be appropriate, but similar freedoms will be given to such organisations that are performing well. [HQCFA, 5.9]

GPC comment:

The spread of Foundation Trusts into the primary care sphere is concerning. Foundation Trusts have the ability to be more selective in the provision of services, which may lead to a degrading of the comprehensive nature of current local primary care services. The local population must feel the benefits of the income generation that Foundation Trusts achieve.

- 23.** NHS staff will have the 'right to request' to set up social enterprise organisations and PCTs will be obliged to consider such requests. The PCT board will be required to approve any business case, and if successful, the PCT will support the development of a social enterprise and award a contract for an initial period of up to 3 years. Where PCTs and staff set up social enterprise organisations, transferred staff will continue to benefit from the NHS Pension Scheme if working on wholly NHS-funded work. [HQCFA, 5.15-16]

GPC comment:

This is a very positive proposal and we would look forward to seeing it implemented.

- 24.** The Department of Health will pilot 'integrated care organisations' (ICOs) that will bring together health and social care organisations. These will be based on the registered patient lists for groups of GP practices. Proposals will be invited shortly. [HQCFA, 5.30]

The pilot process for these organisations will commence in 2008, and continue for two years, with a further year of evaluation.

GPC comment:

These proposals will be explored to gain a proper understanding of these new bodies. The progress of these pilots will need to be followed closely, and we look forward to seeing their eventual findings.

CLINICAL ENGAGEMENT AND CLINICIAN DEVELOPMENT

25. The Department of Health will establish, through competitive appointment, SHA Clinical Advisory Groups to support senior clinical leadership teams within SHAs. [HQCFA, 4.30]

SHAs will establish formal Quality Observatories to inform local quality improvement efforts. This information will be made available through the NHS Choices and NHS Evidence websites. [HQCFA, 4.32]

A National Quality Board will be established to provide strategic oversight and leadership on quality. This will oversee the work to improve the quality metrics and advise the Secretary of State on quality in England. The first report will be published by June 2009, drawing from the output of reviews published by the CQC. The board will be chaired by the NHS Chief Executive and membership will include representation from national statutory bodies. [HQCFA, 4.33-34]

By April 2009, new, dedicated SHA Medical Directors will be appointed, responsible for overseeing implementation of local clinical/SHA visions and providing medical leadership to NHS organisations in the area. These Medical Directors will work alongside regional directors of public health and closely with PEC chairs. They will have professional accountability to the NHS Medical Director at the Department of Health. [HQCFA, 4.28-29]

GPC comment:

These proposals raise many questions, but it is clear that they will impact upon general practice. Some PCTs are already calling their PEC Chairs the Medical Director, while it is unclear if there will be any role for LMCs. For these posts to be effective, they will need the confidence of local clinicians. LMCs may wish to approach PCTs and seek further information about the local processes.

26. The Department of Health acknowledges that stronger clinical engagement in commissioning is required. "This must go beyond practice based commissioning (PBC) and professional executive committees (PECs) to involve all clinician groups in strategic planning and service development..." [HQCFA, 4.26] PCTs will be held to account for the involvement of clinicians. The World class commissioning (WCC) programme will achieve this through a feedback survey from clinicians, the quarterly PBC survey, PBC governance arrangements, the five-year strategic plan and interviews between the PCT board and a panel of independent experts, one of whom will be a clinician. [HQCFA, 4.26-27].

GPC comment:

We firmly agree that stronger clinical engagement in commissioning is necessary. It has been continually shown in the PBC surveys commissioned by the Department of Health that PCTs need to do more to engage with their practices. We therefore welcome these proposals, but are very keen to know what changes will be made on this occasion to achieve these goals.

PEC Chairs are often seen by PCTs as the local clinical leaders, but do not always enjoy the support of local GPs. The LMC is generally seen as the local leader of general practice but not necessarily the clinical leader. The most effective delivery of care to patients occurs when these two local leaders work closely together. PCTs should also seek to constructively engage LMCs in this matter, while LMCs should utilise the WCC assurance process to provide 360-degree appraisal of their PCTs.

- 27.** The Department of Health will explore how to reflect the skills and demands of leadership in undergraduate curricula for all medical and nursing students. Leadership development will become an integral part of modernising careers programmes for other healthcare professionals. [HQCFA, 5.33] The Department of Health have identified the core elements of any approach to leadership: a) vision b) method and c) expectations. [HQCFA, 5.31]

SHAs and Health Innovation and Education Clusters [HQCFA, 4.42-45] will be encouraged to establish Clinical Leadership Fellowships. [HQCFA, 5.34]

There will be a new Leadership for Quality Certificate. This will have three levels of operation; level 1 for members of clinical and non-clinical teams interested in becoming future leaders; level 2 for leaders of team and service lines; and level 3 for senior directors (e.g. medical, nursing, operations). [HQCFA, 5.35]

The NHS Leadership Council will be established, chaired by the NHS Chief Executive, to oversee leadership across healthcare including the top 250 leaders. These leaders will get close support in development, mentoring and career management. The Leadership Council will focus on standards, including overseeing the new certification, development of curricula and assurance. It will have a dedicated budget with the ability to commission development programmes. [HQCFA, 5.36-37]

GPC comment:

More detail is needed to fully understand the implications of these proposals. It is unclear where GPs, PEC GPs, practice based commissioners or LMCs would fit in, but the intention of developing clinical leadership standards is to be welcomed.

The term clinical leadership may also need greater definition. This may mean independently leading the profession - challenging, interpreting and addressing policy developments, or it may mean leading the implementation of policy – taking the profession down an agreed path. Those two leadership functions are very unlikely to co-exist. At present, PEC chairs are the clinical leaders responsible for delivering and implementing policy, while LMCs respond to policy and help form opinion. Clinical engagement will become more effective when these two roles are more closely aligned.

Nonetheless, the professional development of clinical leaders is a positive proposal, providing that it is sufficiently funded. Value should be placed on those clinical leaders who develop and progress through this career pathway, but continue to practice clinically. It would be very encouraging to see such practicing clinical leaders recruited into levels two and three of the proposed new structure.

- 28.** GP training programmes will be expanded by 800 places; in future up to half of medical trainees may be in general practice. The RCGP, in partnership with NHS Medical Education England, will review the length and structure of GP training. [This proposal is made in the 'A High Quality Workforce' report, chapter 2, and is included in this review for completeness.]

GPC comment:

We support this proposal in principle, but have serious concerns regarding the capacity of GP trainers to deliver this training. The terms and conditions considerations of trainees who have a longer duration of training will need to be addressed before this proposal is implemented.

29. The Royal College of Paediatricians and Child Health has been commissioned to develop training for all doctors and nurses to help them adapt services to be more teen-friendly. [OVPC, 5.7]

GPC comment:

It is important to emphasise that all doctors need communications skills that are appropriate for all patients. Teenagers are a particularly important group, and it is unclear why the Royal College of Paediatricians and Child is better placed than the Royal College of General Practitioners to develop this programme, when a fundamental part of the preparation for general practice is communications training.

REGULATION AND ASSESSMENT

30. From April 2010, all providers working for or on behalf of the NHS will publish 'Quality Accounts'. These will be reports on the quality of the services they provide, examining safety, experience and outcomes. Information based on these accounts will be made available on the NHS Choices website. [HQCFA, 4.17]

GPC comment:

Although it is expected that this requirement will apply to GMS and PMS independent contractors, this is not clear. Nor is there any indication of the workload required to produce these reports. The development of Quality Accounts will provide useful information, but such data can be very subjective and must be presented in the social context in which healthcare is delivered. A 'value-added' score, akin to that used in school league tables, would be appropriate. However, there is a high risk that worthwhile data will be lost in a mass of figures, and that like school league tables, too much will be inferred from them, and that such tables will perpetuate their own results. On a more practical basis, genuine efforts must be made to ensure that this is not a tick box exercise, and that it does strive towards improving care. Aside from these considerations, GPs should not fear such quality indicators – general practice in the UK provides primary care to the very highest standards, and Quality Accounts will demonstrate this.

31. The Department of Health will support clinical teams and clinical directors to develop, through peer review, continuing professional development (CPD) and professional revalidation. [HQCFA, 4.25] "We will put a strong clinical voice at every level in the NHS". [HQCFA, 4.24]

An accreditation scheme for GP practices is being developed by the RCGP and now being piloted and, if appropriate, will be adopted nationally by 2010. [HQCFA, 4.25]

GPC comment:

These proposals will have significant and extensive implications for GPs. The GPC remains heavily involved in the RCGP Practice Accreditation Scheme.

We welcome the proposal to place a 'strong clinical' voice in the NHS, providing that these clinicians maintain an independent voice.

32. The Care Quality Commission (CQC) will, subject to consultation, regulate all GP and dental services, making them subject to a consistent set of quality standards. The Commission will work closely with professional regulatory bodies to ensure that practitioners are fit to practise. [OVPC,

6.20] The CQC will publish an assessment of comparative performance and an annual report to Parliament, assuring that information about quality of care is reliable. [HQCFA, 4.17-18]

GPC comment:

We have concerns as to the measurable quality standards that the Care Quality Commission may use. It is not clear how the role of the PCT will be formalised in this process, but the contracting and inspecting process will very likely be devolved to the PCT level.

The development of such quality measurements, and other proposals such as Quality Accounts, will create a positive opportunity for traditional independent contractors to demonstrate the high quality of care that they offer and thus enable a true comparison with APMS providers.

However, the development of the CQC as the regulator of GP services marks the increasing duplication of regulation, with the RCGP accreditation schemes and recertification/revalidation also regulating aspects of general practice. This will increase the extent of the bureaucracy that GPs face.

IMPLEMENTATION

- 33.** PCTs are to publish a five-year strategic plan by spring 2009 putting into practice the SHA visions. Meanwhile, financial allocations to PCTs for the next two years will be made later in 2008, to help with planning the implementation of these proposals. [HQCFA, 8.5-6]

In autumn 2008, an NHS Operating Framework will be published to enable the system that will deliver the review proposals. The Department of Health will develop the proposals in partnership with the NHS and stakeholders. [HQCFA, 8.6]

Nationally, the commitment to create the right environment for change will be followed through. A national clinical advisory group will be established to assess progress against the objectives of the primary and community care strategy. This will continue to work with national stakeholders. [OVPC, 8.5]

GPC comment:

It will be very important for GPs to remain closely involved in the implementation of these two reports. They contain many positive proposals, some of which will be developed over the next few years, while others will be acted upon in the coming months. The difference that these proposals make will be in their local implementation. Good intentions must not be neutered or allowed to be forgotten. The involvement of LMCs will be crucial to this process. We suggest that LMCs make early contact with their PCTs to explore how these proposals will be implemented locally.