All Party Parliamentary Group on Primary Care & Public Health

Report of 23rd October 2012 Roundtable Discussion

Experts call on government for urgent decision on GPs' freedoms

The government needs to decide – and urgently - whether or not its NHS reforms will truly put local GPs in charge of making decisions about their patients' care, or if they will remain under the central control of Whitehall – a bureaucratic structure which ministers had pledged to abolish, MPs have been told.

Initially, Ministers' plans for the new clinical commissioning groups (CCGs) were driven by moves to devolve power from the centre to local clinicians – empowering them to make local decisions for local people, based on local needs. But the Department of Health's traditional "command and control" approach has now resurfaced, and this is making things very difficult for GP commissioners, GP and former Labour MP Howard Stoate has warned, speaking at a recent roundtable discussion held at Westminster by the All-Party Parliamentary Group (APPG) on Primary Care and Public Health.

Dr Laurence Buckman, chair of the British Medical Association's GPs' committee, agreed. "The centre cannot let go, but if it did it might find that localism can generate a lot more than central control is going to do," advised Dr Buckman, who is a GP in Barnet, north London.

CCGs "shadow-running" since 1 October

On 1 April, 2013, CCGs will take over responsibility for direct commissioning of most NHS services, but many have in fact been "shadow-running" since the beginning of October, Dr Stoate told the meeting. These include Bexley, where he is chair of the Clinical Cabinet.

Another is the NHS Cambridge and Peterborough which, as the third-largest shadow CCG in the country, prompts people to ask: "how can you be local?" said Dr David Roberts, a GP who serves on the CCG's governing body. "We do it by delegating areas of interest to eight local groups, and we have a large organisation to deal with major statutory issues which local groups cannot," he explained. This creates no extra bureaucracy and allows the "work on the ground" to continue, he said.

How do GPs see the reforms now? Can they be persuaded to embrace change?

Most GPs "not engaged"

In his role representing the nation's GPs, Dr Buckman said that he is seeing a huge range of views across the profession – from those who are very hostile to the changes to those who are very supportive. But the majority of doctors are neither - they are not interested and they don't feel engaged. Apart from those whose political allegiances will require them to strongly support or, equally strongly, to oppose the reforms, most GPs will

engage only if they feel they are a participant. And whether they do or not depends on the CCGs, most of whom have not engaged particularly well with them, he pointed out.

However, Dr Roberts said that in Cambridge and Peterborough, engagement has been "incredibly good," and this is due to the leaders on the ground. And he urged clinicians to work smarter – making better use of practice staff such as nurse practitioners can take away some of the GPs' workload and enable them to focus on priorities such as helping frail elderly people who will probably have multiple long-term medical conditions.

"Older people tend to collect illnesses, while younger people throw them off quite quickly," he pointed out.

Harvey Ward, who chairs the Royal College of General Practitioners (RCGP) patient participation group, told the roundtable that he is also involved in the College's centre for commissioning, and his experience is that, across the country, GPs are generally very enthusiastic.

GPs are passionate in their hatred of bureaucracy - it makes their hearts sink says Dr Howard Stoate.

But do they have specific concerns? If so, what are they?

GPs are "passionate in their hatred of bureaucracy - it makes their hearts sink," said Dr Stoate. While getting rid of bureaucracy had been a central part of the government's initial reform plans, doctors are now having to deal with "much, much" more of it as the new systems

develop - "far more than they had anticipated, and with not much in the way of clinical improvement to show for it," he said.

But in Bexley at least, a corner may have been turned, he believes. Local GPs are putting organisational concerns to one side and beginning to work on the redesign of services – and, as a result, they have become engaged once again.

Again, Dr Stoate emphasised that what is crucial is how much control Ministers decide Whitehall will have. "If they decide this will be 'light touch," it can work, and this will put quality of engagement between the CCGs and its members. But if they go for 'heavy touch,' they will kill it," he warned.

Building on GPs' unique "clinical nous"

GPs are not there to be proto-managers, added Dr Paul Watson, regional director for the Midlands and the East at the NHS Commissioning Board (NHSCB). They bring something unique to the table – their "clinical nous," which enables them to inform their colleagues about how things really are and to be able to tell them: "there is a better way."

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Dr Watson agreed that bureaucracy should be kept to a minimum, but reminded the meeting that CCGs are statutory bodies which spend public money, so there has

to be proper governance. But we need to be able to turn GPs' nous into system change, so their time must be used wisely and their role protected, he said.

Health and social care: the new relationships

As the new structures form, how are relations developing with CCGs, local authorities and health and wellbeing boards (HWBs), APPG member Labour MP Debbie Abrahams asked the experts. Engagement between health and social care is very important, said Dr Roberts. His CCG is now involved in strategic HWB discussions, not on operational issues but on integration of care. "Everyone working together is really critical," he stressed.

HWBs are a very good idea, they bring everyone together to make the big strategic decisions, and we've never had that before, added Dr Watson. But, he emphasised, the central issue is that CCGs are now in charge of commissioning. So, if for example Bexley wants to commission services differently from, say, Birmingham, it can – within limits. Apart from dealing with certain "must dos" – such as overspending, waiting lists and ensuring that recommendations by the National Institute for Health and Clinical Excellence (NICE) are being implemented - CCGs have the freedom to innovative and act.

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Allied healthcare professionals

Widening discussions on the new relationships, APPG member Baroness Emerton sought information on the development of multiprofessional input into CCGs, and particularly the role of nurses in relation to hospital discharge policies and the development of community care. She asked: "how is this working out in practice?" In Bexley, such relationships are "building up smoothly," Dr Stoate replied. His CCG governing body will include a nurse, a consultant, lay members, the chair of the patient council and the local director of public health. There is good engagement, he said, and pointed out that "this is what is required of us by law."

The RCGP is "very much in favour" of such developments in holistic care planning, added Harvey Ward.

Specialist nursing posts "being decimated"

Amanda Cheesley, long-term conditions adviser at the Royal College of Nursing warned that whilst savings have to be made, they are leading to job losses and this is very worrying for quality patient care.

"Innovation is totally the way forward, but you cannot do it without the right professionals. But many specialist posts are being decimated because they are seen as expensive," she said.

"Engagement so far has been patchy and focused on GPs," said Ms Cheesley, who cautioned that if we make "massive" service reforms without engagement with other members of multidisciplinary teams, we do so "at our peril."

Dr Buckman agreed. GPs want to change community services, and most of the government's reforms are dependent on putting people back into the community rather than hospitals, but in many parts of the country the services are not there, he said.

GPs must be helped to make the best possible referrals says Dr Paul Watson

He was cautiously optimistic that CCG commissioning might be able to change this, and stressed that more nurses and other professionals such as physiotherapists are needed - not less.

Changing the culture

Dr Roberts said that, in Cambridge and Peterborough, district nursing has increased rather than reduced, but he also called for a culture change which considers the patient in a holistic rather than a "task-orientated" manner.

APPG co-chair MP Nick de Bois, expressed his concern that allied healthcare professionals (AHCPs) have no direct engagement on CCGs, and Dr Helena Johnson, chair of the Chartered Society of Physiotherapy, asked how physiotherapists and other AHCPs can engage with the new commissioning structures, when they currently have no mandatory role.

"As we take patients out of secondary care, we will need more of their skills," said Dr Stoate. "We need to ensure people get the most appropriate treatment the first time and end inappropriate referrals."

In Bexley, the new care pathways will be designed by a multidisciplinary clinical roundtable, including professionals brought in because of their particular expertise, and then sent out to GP groups for them to "modify and tweak," he said.

The NHS has many different professional groups, and this is about them saying: "we are part of the solution," said Dr Watson. Redesigning clinical pathways, developing better ways of providing services – "let's get stuck in with new ideas," he urged.

The skills of community nurses and hospital nurses are different, and they need to be integrated, with sharing of best practice to help keep people out of hospital, the meeting was told.

"Upskilling" needed across the board

In many places, specialist nurses are already working across hospital and community services to prevent people from having to come into hospital in the first place and to help them leave as soon as they can. Upskilling is required right across the board, in order to be able to manage patients on the whole pathway, said Amanda Cheesley.

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- Dr Laurence Buckman

Empowering patients

If the government does decide that the system should continue to be run from Whitehall, CCGs will in fact have very limited powers. And what will this mean for patient empowerment?

"We've still got a long way to go - people who are in control of all other areas of their lives go to jelly when they have to deal with the NHS – it is a frightening process," Dr Watson acknowledged. But, he added, there are lots of opportunities in areas such as shared decision-making, and part of the NHSCB's mission is to do what it can to move forward with this agenda, putting patients more in control. "One thing I hope the reforms

will achieve is faster movement in this direction," he said.

Dr Stoate pointed out that there is "a vast amount more" patient engagement with the CCG system than under the care trust system, while Dr Roberts stressed that "one of the great advantages of being a GP is that we are seen as the patient's advocate – and we must keep this."

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Understanding costs and value in the NHS

The discussion then turned to the enormous financial challenges now facing the NHS, and the fact that the general public still has very little understanding of what the Service costs – and what it spends.

People value the NHS - but, said Nick de Bois – they have no idea that England spends around £120 billion a year on healthcare - three times as much as it does on education.

"If you don't appreciate the costs of something, it can be difficult to appreciate its value," he said, and asked: should the culture changes which are being called for include educating the public about the costs of healthcare? Will this help people understand the problems that healthcare professionals are facing and the decisions they have to take?

And should this include doctors telling patients about costs of medicines, and encouraging them to choose the cheapest option?

What to tell patients

Experts at the roundtable generally agreed that they should, but pointed to the need for caution and balance. Dr Roberts told the meeting that he often advises patients about drug costs during consultations. He tells them that using a cheaper drug which saves just 30 pence per person per month can, if extended to 10,000 people, "pay for your and other people's cancer drugs in the future," he said.

Dr Buckman agreed that patients should know, in general terms, the costs of what they are asking for, but added that this conversation should not take part during the consultation - or at the bedside - because it places inappropriate pressure on people when they are ill.

Dr Watson also stressed that provision of this kind of information has to be targeted. It is right to point out to a patient that, out of two identical drugs, one costs six times more than the other, but to send patients "a bill" after their hospital treatment, itemising the costs, sends the subliminal message that "you're a drain on the nation, on the public purse," he warned.

Doctors may also not always know the cost of what is being prescribed, he added.

People should know how much things cost - treat them like adults and they will respond like adults agreed Dr Stoate

People should know how much things cost - "treat them like adults and they will respond like adults," agreed Howard Stoate. Harvey Ward suggested that this could be a role for political leaders, while Dr Watson said the challenge would be to have an "honest discussion," involving the whole community, on these issues.

Has the government failed to make its case?

But does this public ignorance mean the government

has failed, and is continuing to fail, to communicate the scale of the challenges which the NHS is facing and the need for change?

Yes, said Dr Stoate - the government has failed to make its case to the public for the need to reform the NHS. It has not explained the reasons, and the public is still confused, he said.

Nick de Bois said perphas ministers had assumed "pretty much that everyone accepts that the NHS has to change," and that the government's proposals for change would be accepted. Taking steps to educate people about the costs of healthcare could help them understand the changes which the government is trying to make, he suggested.

Will the money actually move differently under the new structure?

"This is a huge challenge," said Dr Roberts. We haven't decommissioned treatments and procedures which should no longer be used, so we are paying for things two or three times - this is huge waste." The NHS in England is not short of money, "but we are short of the sensible use of it," he said.

The NHS can no longer continue the way it is, and to secure its future there are just four possible scenarios, said Howard Stoate. These are: - the government finds it some more money – which is very unlikely; - the NHS stops providing "certain things;" - CCGs redesign patient pathways to make them much more cost-effective; and - patients change their behaviours, and rapidly.

This last scenario is about self care, and this is the one we can really do, he said.

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The only sustainable route for the NHS is to make sure that fewer people end up in A&E and that they visit their GP's surgery only when they really need to.

Toto Gronlund of NHS Connecting for Health, agreed. A key role for CCGs will be getting people more involved in their own health care. People and patients are the most underused resources in the NHS, and CCGs must work out ways to get them on board, said Ms Gronlund, who is responsible for patient and public involvement in informatics at the agency.

It's only worth doing if there is a prize and there is one - Dr Watson on the changes in the Health System.

And in the end, what are the biggest reforms in NHS history seeking to achieve? Why are we doing this?

"It's only worth doing if there is a prize – and there is one," said Dr Watson. Under the former system, the Department of Health would pass its annual "wish list" down through the NHS with the instruction to "go away and do it."

But the new system will, for the first time ever, be clinically-led and locally-led, allowing groups of doctors who know their local situation better than anyone else to decide the best use of NHS resources for their populations. By law, intervention by the NHSCB in this process would be permitted only under certain circumstances.

"The eyes of the world are on us now, and if we get this right, we can get back to the NHS being the envy of the world," he told the meeting.

For more information about the work of the All-Party Parliamentary Group on Primary Care and Public Health , please go to http://www.pagb.co.uk/appg/intro.html or contact Libby Whittaker at libby.whittaker@pagb.co.uk or on 0207 421 9318.

Conclusions from the Discussion:

•The government's health reform to eliminate Whitehall control is in danger of becoming mired in legislation, creating problems for local GP commissioners. The meeting concluded ministers should look again at Government's original commitment.

• CCGs were encouraged to look at ways to engage with GPs since they don't feel part of the new structures

• GPs could make better use of other practice staff such as nurses to help ease their workload, allowing them to focus on priorities.

• GPs' time and roles must be protected, so that their unique "clinical nous" can be used to create real system change.

• Treating patients in the community rather than in hospital will require a culture change and collaboration between healthcare professionals, with up-skilling and sharing of best practice, but many essential specialist posts are being lost through job cuts.

• Patient engagement will improve under the new structures, but there is still a long way to go to reach real empowerment.

• The public have no idea of how much the NHS costs, and what it spends, and they need to be aware of the huge financial challenges which it is confronting. They should be told when identical drugs have very different price tags, for example, but not made to feel that they are "a drain on the public purse."

• The government has failed to make its case to the public for the need for NHS reforms.

• Securing the future of the NHS will require people taking greater control of their own health, only using GP and hospital services when they really need to. Moving this agenda forward will be a key issue for CCGs.