Putting the pieces together
Removing the barriers
to excellent patient care
Introduction

We need an NHS that puts patients first. We need a system that enables doctors, nurses and others on the front line of the NHS to deliver the safest, most effective care, in whatever setting is most appropriate for each patient’s needs. It must empower healthcare professionals and NHS managers to work together and to innovate, ensuring that our changing health needs can be met through new and better ways of providing care – within and beyond the hospital walls.

‘I just want the right care for me, in the right place, at the right time’ Patient

Some parts of the NHS are already starting to make this vision a reality. Some clinical commissioning groups (CCGs) are leading powerful strategic partnerships to transform the health and wellbeing of local people. Similarly, some NHS providers are working together to join up patient care through innovative partnering arrangements that reach across the patient pathway. These local leaders have already started to map the course towards excellent patient care.

Government and regulators must now support the system to scale up these efforts. Examples of joined-up, sustainable care are not the norm. Physicians have expressed major concerns that the systems and structures underpinning the English NHS can get in the way of good patient care. Their feedback tells us that, too often, the way that health services are planned, commissioned, contracted and funded leaves them unsustainable, fragmented and unable to respond to changing patient needs.

As the NHS faces some of the greatest financial pressures in its history and an ageing patient population with complex care needs, it is vital that policymakers and system leaders dismantle the barriers to a stronger, more sustainable and more patient-centred NHS. The system of commissioning and paying for healthcare services in England was radically reformed in 2013 when the Health and Social Care Act came into force. Now, more than 2 years later, we must work together with partners at every level to empower that system to deliver the excellent care that people need.

This report draws on experiences from the front line of patient care, from physicians working in hospitals and communities across England. Based on their feedback, and drawing on insights from across the system, this report explains why change is vital to the future of the English NHS.

From dismantling the barriers to joined-up commissioning to empowering local health economies to plan for the long term, urgent action is needed now to make our commissioning, contracting and funding structures work for patients.

We look to our partners across the system – government, regulators, commissioners and providers – to work with us to find the solutions. Only through our collective action and expertise can we remove the barriers to excellent patient care. If we are to deliver the ambitions of the Five Year Forward View, then:

- we must empower commissioners to collaborate
- we must value quality of care above competition
- we must value clinical engagement and joined-up leadership
- we must not make short-term plans for long-term problems
- we must build a better payment system
- we must foster a sustainable workforce
- we must promote innovation.

‘It’s a fragmented mess with no engagement and everyone reinventing the wheel’ Respiratory physician
Our core principles: how the system can support excellent patient care

The Royal College of Physicians (RCP) believes that a sustainable, joined-up and person-centred health and care system is necessary to achieve the best health and healthcare for everyone. To translate this vision into reality, the following principles should form the foundations for the service planning, commissioning, contracting and payment mechanisms that underpin the way care is provided.

Deliver the best outcomes for local populations: the resources of each local health economy should be used collectively to achieve the best health outcomes for the local population.

Plan services around the people that use them: health and care should be commissioned in coherent, joined-up pathways that make sense to patients and consider their holistic health, care and wellbeing needs.

Tailor local solutions, deliver consistent quality: in each local area, care may need to be provided in different ways to meet the specific needs of local people, but every patient should be able to access the same high-quality standard of care, wherever they live.

Make decisions that support a sustainable NHS: for decisions made in the short term, their impact in the long term on NHS finances, patients’ future care needs, the medical workforce and the sustainability of local health economies must be considered.

Join up planning and payment: commissioning processes, funding systems and financial incentives should be designed to foster integration. Activity in one part of the system must not cause intended adverse consequences for patients or organisations in other parts of the system.

Prioritise collaborative clinical leadership: doctors and other healthcare professionals from all parts of the NHS must be empowered to plan and commission services collaboratively at every level – locally, regionally and nationally.
What are the challenges?

All parts of the health and social care system have a crucial role to play in leading the change needed to improve patient care, foster a sustainable and efficient NHS, and meet the growing and more complex care needs of communities.

As the RCP’s independent Future Hospital Commission\(^6\) set out in 2013, we need to dismantle the barriers to joined-up patient care.

Commissioning, contracting and funding arrangements must empower the different parts of the health and social care system to work together, flexibly and sustainably, for the patients of today and of the future.

Yet the doctors, managers and commissioners who lead our NHS face unnecessary barriers to making this vision a reality. Physicians on the front line of patient care have highlighted some of the key challenges.

Systems and structures must support joined-up care

**We must empower commissioners to collaborate**

In most areas of specialist medical care, there are structural divisions in commissioning between the NHS, public health and social care. This means that different organisations are responsible for commissioning different sections of the patient pathway – from NHS England, which commissions highly specialised care, to CCGs, which commission local health services. There are many excellent examples of commissioners working together across these boundaries, delivering innovative and joined-up solutions to healthcare challenges.\(^7\)\(^–\)\(^10\)

In Sheffield, for example, the CCG and the city council are working towards joint commissioning in major areas of care, including emergency admissions.\(^11\) In Greater Manchester, emerging plans for ‘Devo Manc’ aim to bring together the city region’s £6 billion combined annual health and social care budget and, ultimately, to plan and commission all health and care in a joined-up way.\(^11\) Nationally, the growing involvement of CCGs in the commissioning of primary care and specialised services is an important development, and one that has the potential to help join up patient pathways in many parts of England.

However, research from The King’s Fund suggests that integrated commissioning (not to be confused with integrated care) remains rare, and tends to be restricted to a small number of service areas.\(^11\) The intensive work, negotiation and innovation required to achieve joined-up commissioning pose a substantial barrier to already stretched commissioners who are also grappling with financial challenges and rising demand. Put simply, ‘some local commissioners may not have necessarily had the time or been equipped with the knowledge and skills to commission in collaboration with local partners to take a whole-system approach’.\(^12\)

There are well-documented examples demonstrating how this can lead to disjointed care and fragmented clinical pathways.\(^12\)\(^,\)\(^13\) In some areas of patient care, physicians have found that services are planned and commissioned in a fragmented way, looking at one small part of a much wider patient pathway without due consideration of other, closely related areas of patient care. Without clear lines of accountability for each part of the patient pathway, this process can disrupt patients’ experience of care. At its worst, this can lead to unnecessary referrals, delayed diagnoses, and patients ‘lost to follow-up’ as they struggle to negotiate the complexity of accessing many diverse services, often in different places and with different healthcare professionals.\(^5\)

In the most concerning cases, fragmented lines of accountability have meant that patients are unable to access services at all.\(^13\)

**‘Pathways are fragmented with different parts of pathways being commissioned from different providers’**\(^15\)

Sports and exercise medicine physician
Case study: disjointed care for people with HIV

The different services that make up sexual healthcare are commissioned by CCGs, NHS England and local authorities. Some local areas are leading the way, with integrated sexual healthcare that brings together the whole patient pathway. These exemplars enable patients to access seamless care at every stage of their journey. Unfortunately, this patient-centred approach is not available everywhere, despite national guidance. As a result, in many areas of England patients are facing the serious consequences of fragmented care.

As the All-Party Parliamentary Group on Sexual and Reproductive Health found, ‘in some cases STI [sexually transmitted infection] services have been relocated away from the acute trust where HIV treatment is delivered without the involvement of NHS England HIV commissioners. These integrated services were a key point of contact in the lives of people living with HIV and relocating STI testing potentially reduces the quality of care they receive.’ This poses a serious risk to safe, effective patient care. For example, in one service in south-east England, more than half (55%) of patients with HIV said that they’d be less likely to be screened for STIs since the two services were separated, leaving them vulnerable to undiagnosed, untreated conditions that could cause serious harm.

Fragmented commissioning arrangements can produce disjointed clinical pathways that threaten the quality of patient care. In contrast, joined-up care improves clinical outcomes and has been shown to promote efficiency.

The RCP believes that:

> Government and NHS England must translate the rhetoric of collaborative commissioning into reality by supporting commissioners with the resources, capacity and accountability arrangements necessary to work collaboratively and to commission whole pathways of joined-up care.

> ‘Place-based’ commissioning, where organisations work together to commission health and care for an entire local population, must become the norm.

> Clear lines of accountability must define which commissioner is responsible for each area of patient care. No services should fall through gaps between commissioning organisations. Patients must be able to access the same high-quality standard of care wherever they live.

> Physicians must help to identify fragmented patient care and, most importantly, must reach out to help CCGs, local authorities, and health and wellbeing boards to find ways to join up services.

‘Currently, commissioners are unsure whether they need to run formal tendering processes to select new service models, while providers are unsure whether they can collaborate with competitors to deliver the networks and integrated models being proposed’ The King’s Fund

We must value quality of care above competition

We must enable commissioners and providers to prioritise the quality of the care that they deliver over and above all else. Currently, confusing rules around competition and procurement can be a distraction from their efforts to improve care.

Competition is not problematic in itself. Competitive tendering is not a new feature of the NHS or of social care. Used well, it can help to promote innovation and efficiency by, for example, introducing new providers or creative new models of care. From cancer care to mental health, there are many examples of new providers working as part of an effective, joined-up patient pathway to drive high-quality services.

However, competitive tendering can also compound the fragmentation of clinical pathways. Coherent packages of care are sometimes broken up into smaller components and tendered as separate services, without effective ways to join up care and ensure that providers work together. NHS trusts, private providers and charities compete for the opportunity to run services separately, rather than collaborate to provide integrated care for patients.

As a result, services can be destabilised. In some areas of medical care, this has meant that outpatient services are separated from acute and inpatient care for patients with complex or urgent care needs, without effective arrangements to join up these different parts of the pathway. NHS trusts are left to deliver unpredictable and expensive acute care for the most seriously unwell patients. This risks undermining the financial sustainability of providers as they struggle to manage the complexity and risk of providing acute inpatient care.
To avert these risks, some providers are already working together under outcomes-based contracts, backed by creative approaches from local commissioners. From Staffordshire to Salford, models such as alliance contracts and prime provider contracts are being deployed to try to overcome fragmentation.

To translate these examples into common practice, CCGs must be granted clarity about competition and procurement rules, and providers must be incentivised to collaborate for higher quality in patient care. Care across the patient pathway must be joined up and sustainable, irrespective of who holds the contract to deliver each service.

The RCP believes that:

- Improved patient outcomes should be the shared goal of all partners in the local health economy.
- Levers to share risk and reward across the system must be embedded into contract monitoring and compliance arrangements.
- Rules and regulations must be clarified so that commissioners are empowered to use competition in the best interest of patients.
- Tendering decisions must be required to take account of the impact of change on the sustainability of the whole local health economy.

We must value clinical engagement and joined-up leadership

The bodies that plan and provide care do not operate in isolation. Health and care are delivered by a networked system of organisations, and there is a growing political and clinical impetus to drive closer integration that improves patient care. This makes it vital that there are relationships of trust and strong engagement between partners. Indeed, whole services can be disrupted owing to poor communication between physicians, providers and commissioners. Such disruption can last for many years, particularly in specialties where there are workforce challenges, such as dermatology. Joined-up leadership and effective clinical engagement are therefore key.

There are many excellent examples of commissioners, service planners and clinicians building strong, collaborative relationships. As highlighted in the RCP’s 2015 report with NHS Clinical Commissioners, Collaboration in clinical leadership, many CCGs are achieving powerful partnerships with secondary care doctors. In London and the West Midlands, commissioners have drawn on the front-line expertise of local dermatology consultants to capitalise on the value of collaborative clinical leadership in solving local commissioning challenges. In Cheshire, acute physicians have reached out to build relationships with local commissioners to tackle shared problems and improve patient care.

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**Who commissions what?**

**NHS England**
- primary care (e.g., GPs, pharmacies, dentistry)
- specialised services – specialist secondary care services that treat a relatively small number of patients and are usually provided in relatively few hospitals
- highly specialised services – specialist secondary and tertiary care services that treat a very small number of patients (usually fewer than 500) and are provided in very few hospitals
- healthcare for people in the armed forces and for people in prison
- some national public health services on behalf of Public Health England (e.g., screening).

**Public Health England**
- public health research and data
- public health advice to national and local government
- health improvement campaigns (e.g., Change4Life).

**Clinical commissioning groups (CCGs)**
- local secondary care services (e.g., hospitals, mental health, community health services)
- some CCGs co-commission GP services in partnership with NHS England
- in future, some CCGs may also co-commission specialised services through collaborative arrangements.

**Local authorities**
- local health improvement services (e.g., weight management, drug and alcohol services)
- services to address the social determinants of health (e.g., warm homes, employment support, early years)
- social care for children and adults
- some sexual health and HIV services.

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In other parts of the system, however, joined-up leadership and effective clinical engagement are far from the norm. Physicians describe whole services being redesigned or commissioned with ‘almost no clinical involvement’ from local secondary care doctors. At worst, there have been ‘known instances where clinicians have been specifically excluded’. This excludes the hospital and community doctors who do not only know front-line medical care best, but whose leadership and buy-in are also key to achieving improvement and innovation. Providers and commissioners must involve the clinical workforce whenever services are facing major changes or challenges, or are being recommissioned.

Physicians themselves must be proactive in getting involved in their local health economies. As clinical leaders, they should seek out opportunities to help shape the design of patient care, and professional bodies – including the RCP – must support and empower their members to do so.

The RCP believes that:

- Collaborative clinical leadership must be the norm in commissioning and service planning.
- Providers, CCGs, and health and wellbeing boards must engage local specialist doctors so that they can help to lead strategic improvement in medical services.
- Physicians must reach out to NHS trust managers and local commissioners with positive solutions to local challenges.
- Physicians should work to understand and influence the system that they work in, and the RCP should support them to do so.

Short-term decisions must support long-term sustainability

We must not make short-term plans for long-term problems

Short-termism blights our health service. One-year funding settlements, single-year tariff arrangements and short-term contracts destabilise services on an annual basis, and risk destabilising patient care too. This drives inefficiency, as staff time and resources are spent managing the yearly challenge of predicting, renegotiating and implementing new funding and contract regimes, rather than planning for a sustainable future.

Short-term planning can inhibit innovation, too. New models of care take time to ‘bed in’, so commissioning and service planning need to allow sufficient time to test out and refine new ways of working. To meet the challenges set out in the Five Year Forward View, commissioners and providers must be empowered to plan for the next 5 years. They must have a clear view of the road ahead in terms of finances and contracts.

Locally, where newly commissioned providers are taking on services for the first time, they must be required to work with existing providers to ensure a smooth transition and help to prevent patients falling through the gaps. Commissioners must support this joined-up working by making decisions early, so that local health economies can make planned transitions to new models of care. Short-term contracts for medical services must no longer be used; providers are unlikely to invest in improving patient care if they are contracted to provide it for only 3 years.

‘Any system that is not underpinned by reliable data and analysis ... risks leading to unintended and unwanted consequences’

Future Hospital Commission

Only if local health economies are empowered and incentivised to plan for the long term will the NHS be sustainable in the long term. Most importantly, people’s health does not conform to an annual planning cycle: our health and care system must be rewarded rather than penalised for investing now to deliver good care in the future.

The RCP believes that:

- Payment systems, including the national tariff, should be implemented on a multiannual basis to stabilise both NHS finances and services for patients.
- CCG and public health funding settlements should be published on a 5-year rolling basis, so that local health economies can plan and invest over the medium term.

We must build a better payment system

The system of funding and incentives in the NHS is complex, fragmented and inconsistent.

At a time when patients need more care to be delivered outside the conventional hospital setting, we have a tariff-based payment system that incentivises more hospital-based activity, disincentivises care closer to home and, in turn, impedes transformation.

The data upon which tariff payments are made are highly problematic and are plagued with gaps and inconsistencies. Despite welcome efforts from NHS England and Monitor to work with physicians to improve data quality, tariff is still based on ‘reference costs’, which are widely considered to be inaccurate. The process of gathering these data and turning them into payment is hugely bureaucratic and resource intensive. The estimated cost to the NHS runs into tens of millions of pounds, for a process that produces unreliable information.

In turn, investment in patient care can be wildly inconsistent – particularly for outpatient care and complex chronic conditions, where there are fewer nationally set payment levels. The payment received for an outpatient consultation with an audiologist, for example, varies by 571% across the country.
Financial incentives and payment schemes sometimes put a barrier in the way of new, more effective models of patient care. For example, current funding arrangements favour hospital admissions over community-based ambulatory care, even though the latter can enable patients to recover at home with structured support at a lower cost to the NHS. In diabetes care, patients are more likely to attend appointments if they can use innovative tools such as Skype to talk to their physician over the internet, yet our current tariff system means that no payment is made for this type of care. This prevents physicians from providing cost-effective care in the way that patients prefer.

At the same time, community health, mental health, primary care and social care have entirely separate funding arrangements. This makes it difficult for local health economies to shift resources to where patients need them most, posing a further barrier to joined-up care.

Some form of mixed economy of fixed-value contracts, capitated payments and activity-based payments may well be appropriate in a system as complex as health and social care, no single payment method is likely to be suitable for all purposes. However, any payment system that creates barriers to joined-up care should be considered an obstacle to an effective, efficient and sustainable NHS.

Financial incentives and NHS payment systems must promote joined-up care, enable innovation and improvement, and use reliable data that accurately reflect patients’ health and care needs.

The RCP believes that:

> NHS England and Monitor must conduct a root-and-branch review of the way that funding flows through the NHS. Barriers to joined-up care must be removed.

> Payment should enable and reward good patient outcomes, with greater use of ‘year-of-care’ and ‘pathway’ tariffs to support people’s health, wellbeing and care needs as a whole.

> Government must empower commissioners and providers with the power — and the checks and balances — to move resources around local health economies, so that they can deliver care in the right place at the right time for local people.

**Care shouldn’t be designed according to how the money flows. It should be driven by what patients need, and supported by financial structures**

Hospital consultant

**We must foster a sustainable workforce**

It takes nearly 10 years to train a specialist physician after they leave medical school, so good patient care in the future depends on good medical education and training now. There are excellent examples of commissioners and providers working together in innovative ways to support a sustainable clinical workforce with the skills to meet 21st-century patients’ needs. In Waltham Forest, for example, the local dermatology provider delivers training to GPs with a special interest, helping to make sure that patients can access appropriate dermatology care in the community.

Yet physicians have told us how contracting arrangements can treat training as an optional extra, rather than a core component of sustainable patient care. Feedback tells us that, in some areas, ‘despite clear guidance on the need to include education and training in service specifications, this is at best lightly mentioned and at worst not mentioned at all’. Unfortunately, some medical training schemes have been seriously diminished or closed entirely, as new providers rely on doctors who are not on the specialist register and therefore cannot provide training. These gaps seriously threaten the sustainability of the medical workforce. Moreover, these gaps undermine patients’ access to high-quality care provided by doctors with specialist knowledge and training.

Medical education and training constitute a mainstream component of service delivery, not an optional extra. To protect patient care and ensure that services support a sustainable and qualified medical workforce, medical education must be prioritised in the planning, commissioning and monitoring of services.

The RCP believes that:

> Health Education England should conduct a review of how commissioning and service planning support medical education, including an assessment of how effectively the secretary of state, CCGs and NHS England are meeting their statutory duties to promote medical education and training.

> NHS England should consider how the NHS standard contract could support medical education and training.
We must promote innovation

Innovations such as medical genomics have the potential to revolutionise care and to position the UK as a world leader. Medical research thrives in many large teaching hospitals and pioneering centres, where commissioners and providers are working together to promote innovation. This vital work is fundamental to an effective NHS that is sustainable and able to provide good care long into the future.

All medical services should be able to promote research in some way – from large trusts that can host major clinical studies, to district hospitals that can refer patients into clinical research network studies hosted by larger organisations, to smaller providers that can simply integrate research evidence into practice.

However, feedback from physicians tells us that many commissioners and providers are struggling to find the resources and levers to support research. Careful planning and decision making are needed to ensure that research activity is incorporated into mainstream service delivery, rather than marginalised as a tokenistic or optional activity. As both commissioners and NHS trusts face growing financial pressures and ongoing organisational change, research risks being neglected.

Improvements in quality and patient safety rely on innovation, and innovation itself helps to attract external funding and high-quality staff into the NHS. Only through research will we find more effective, safer and more efficient ways of improving health and treating disease. We must find effective levers to embed medical research into our system of planning, commissioning and funding NHS services.

NHS England must work with the National Institute for Health Research to identify more effective levers to promote research. Innovation must be a valued component of service delivery.

Key facts and figures

> There are **209 CCGs** that commission specialist medical care locally.

> In April 2015, over **70% of CCGs took on greater responsibility for commissioning primary care**, through ‘co-commissioning’ arrangements with NHS England.

> NHS England hosts **over 70 clinical reference groups**, which advise on the commissioning of specialised healthcare services.

> About **14% of the total NHS budget** (£13.8 billion annually) is spent on specialised services.

> There are **152 upper-tier local authorities** that commission social care, public health and some medical services such as sexual health.

> Annually, **about £30 billion of NHS care is funded through the national tariff**, which sets standardised funding levels for providers of many types of NHS care.

> A further **£40 billion of NHS care is funded through local agreements**, where providers and commissioners negotiate funding levels locally.
The way that we commission, contract and pay for healthcare services in England was radically reformed in 2013 under the Health and Social Care Act. Now this system must be supported and empowered to deliver the excellent, joined-up care that people need.

10 priority areas for action

For national partners

1 Dismantle the barriers to joined-up patient care

Give local commissioners the resources, support and power to plan whole pathways of care. Integrated commissioning must bring together primary, secondary, specialised and social care to create holistic packages of health and care. Place-based commissioning and a shared focus on patient outcomes must become the norm. For providers, contract monitoring and compliance arrangements should share risk and reward across the local health economy.

2 Make long-term planning a reality

NHS England and Monitor should empower and incentivise local health economies to plan for the long term. Only then will the NHS be sustainable in the long term. Five-year rolling funding settlements, multiannual tariff arrangements and longer-term contracts must be standard practice.

3 Prioritise quality and collaboration over cost and competition

Monitor should clarify competition and procurement regulations so that competition can be an effective lever to drive up quality in patient care. Tendering decisions should be required to take account of the impact of change on the sustainability of the whole local health economy. Providers should be incentivised to collaborate for better quality of care.

4 Make tariff fit for purpose

NHS England and Monitor should carry out a wholesale review of financial incentives, payment mechanisms and funding systems in all parts of the NHS. We need a new payment model that enables local health economies to use their collective resources flexibly to deliver care in the right place, at the right time, to meet the needs of local people. Perverse incentives must be removed. Funding systems must not be a barrier to joined-up care. Payment must be based on accurate, up-to-date and relevant data about patients’ care.

5 Increase transparency in NHS contracting

Tendering decisions should be required to take account of the impact of change on the sustainability of the whole local health economy. Local impact assessments should be published. All non-commercially sensitive contract information should be publicly available.

6 Meet statutory duties on medical education and training

Health Education England should conduct a review of how effectively service planning and commissioning arrangements support a sustainable medical workforce. This should include an assessment of the extent to which the secretary of state, NHS England and CCGs are meeting statutory duties on medical education and training.28

For commissioners and providers

7 Make patient outcomes the measure of success for all

For patient care to be joined up, health and care providers and commissioners need to work towards shared goals. Patient outcomes should be the measure of success for all. We must collaborate to achieve the best possible clinical outcomes and patient experience.

8 Join up clinical leadership

Strong relationships between clinicians, managers and commissioners should be the bedrock of joined-up care. Collaborative clinical leadership must become the norm. Trust managers, CCGs, and health and wellbeing boards must reach out to involve specialist doctors in local service planning and commissioning decisions – and physicians must reach out in return.

For physicians

9 Get involved – help to strengthen the system

Physicians offer invaluable insights into the front-line realities of providing care. They can be powerful advocates on behalf of patients and the public. As clinical leaders, they can work across organisational and professional boundaries to help improve the way that the NHS plans and commissions care. Physicians must help to break down the barriers to excellent patient care. As clinical leaders, physicians must strengthen their involvement in service planning and commissioning.

For the RCP

10 Help to deliver the solutions

We are committed to working with partners across the system to help put the pieces together and remove the barriers to an excellent NHS. We will support physicians by building their understanding of the system, promoting opportunities for physicians to play their part, and sharing their insights into the realities of patient care.
References

9. NHS Clinical Commissioners. Taking the lead: How clinical commissioning groups are changing the face of the NHS. London: NHSCC, 2014.
About the RCP

The RCP aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 30,000 members worldwide work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

Involving patients and carers at every step, the RCP works to ensure that physicians are educated and trained to provide high-quality care. We audit and accredit clinical services, and provide resources for our members to assess their own services. We work with other health organisations to enhance the quality of medical care, and promote research and innovation. We also promote evidence-based policies to government to encourage healthy lifestyles and reduce illness from preventable causes.

Working in partnership with our faculties, specialist societies and other medical royal colleges on issues ranging from clinical education and training to health policy, we present a powerful and unified voice to improve health and healthcare.