

# BMJ GUIDE TO COMMISSIONING FOR DOCTORS IN ENGLAND

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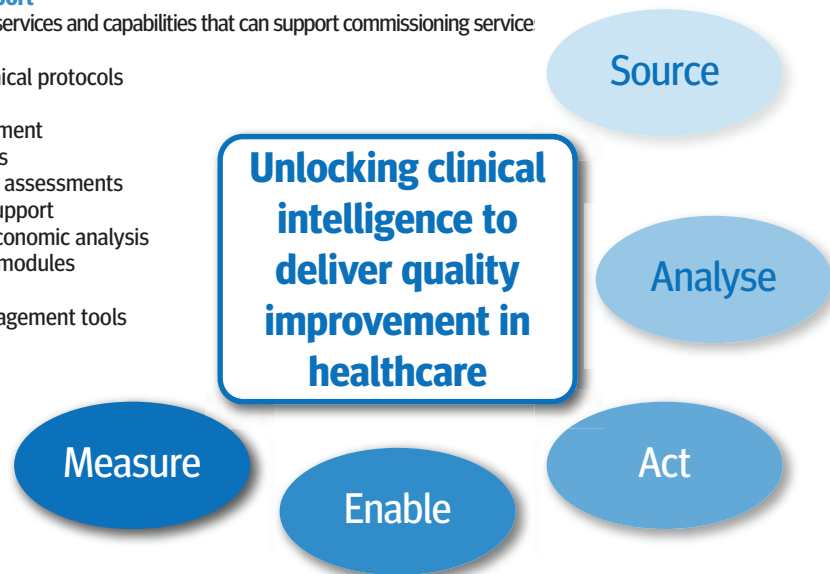
# Empowering effective commissioning

In the changing NHS landscape, the BMJ Group is already helping doctors, consortiums, and commissioners face the challenges of shifting clinical and financial responsibility for healthcare provision. Committed to supporting the highest standards of clinical practice, we provide coherent, connected resources and services to support patient-focused, clinically safe, and cost-efficient decisions that improve local health outcomes.

## Commissioning support

We provide a range of services and capabilities that can support commissioning service

- peer reviewed clinical protocols
- audit design
- guideline development
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- health technology assessments
- clinical decision support
- data and health economic analysis
- bespoke learning modules
- health informatics
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## Evidence-based commissioning

As well as providing the best available evidence on clinical effectiveness, we are now helping commissioners make strategic decisions about the best ways to provide cost-effective and clinically safe services. We do this by providing a complete suite of evidence-based services, including evidence summaries, systematic reviews, health technology assessments and health economic analyses.

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We provide clinical data analysis, decision support and performance management tools to help manage and improve performance and provide better outcomes for patients. Our clinical data audit tool, Contract+, has been providing GMS analyses on over 8 million patients daily. The Welsh Assembly Government relies on our Audit+ technology for its Primary Care Data Quality Service.

## BMJ Group & commissioning

BMJ Group has a heritage of clinical experience and expertise. The many doctors and clinicians on our staff help us remain in touch with the changing needs of healthcare professionals at all levels. Their first-hand knowledge and commitment to facilitating improvements in healthcare drives us to produce products and services that make a real difference in clinical practice and ultimately improve outcomes for patients.

**If you would like to talk to us about how we can help you unlock clinical intelligence to deliver high quality commissioning, please contact us at [primarycare@bmjgroup.com](mailto:primarycare@bmjgroup.com)**



Commissioning is everyone's business. It will touch patients, GPs, and secondary care doctors, whether they get actively engaged or not.

How far the reforms will go is still unknown, but the basics of commissioning should be politically neutral. These basics are, as some of the contributors to this book say, about providing the best care for patients. As one doctor writes: "All GPs are involved in commissioning. Every time a GP sees a patient, they decide whether to prescribe medication, refer them to another part of the NHS, or admit them to hospital."

This book is full of wisdom from people who know about commissioning. From Paul Zollinger Read, GP director of commissioning development, East of England and Clare Gerada, RCGP Chair, to the *BMJ*'s own Edward Davies (*BMJ Careers* editor) and *BMJ* blogger Martin McShane, a former GP and Deputy CEO and Director of Commissioning for the Lincolnshire PCT cluster. We also have thoughts from patients and secondary care doctors. And answers to commonly asked questions ("What will happen to my pension?"). What's more, we'll even be updating it on [doc2doc.bmj.com](http://doc2doc.bmj.com).

**Fiona Godlee, editor, *BMJ***

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MANY challenges lie ahead for general practice. The NHS in England is changing rapidly as proposals in the Health and Social Care Bill seek to profoundly alter the way primary care is run. The many changes proposed make it hard to predict what effect there will be on key issues such as clinical governance, practitioner performance, GMC Responsible Officers and a host of ethical issues around commissioning.

Whatever the future holds, MDDUS will be ready to guide members through these uncertain times. We offer 24-hour access to assistance, support, and, if necessary, legal representation to members who find themselves in professional difficulties, ensuring complete peace of mind.

We are delighted to sponsor this informative book as it is full of valuable insights on the commissioning process and should better prepare practices for the challenges ahead.

**Jim Rodger, medical adviser and head of professional services, MDDUS**



## A history of commissioning

“Commissioning” is simply about buying services and in some sense has always existed in the NHS. It became a distinct “function” 20 years ago following the NHS and Community Care Act, which explicitly divided healthcare purchasers and healthcare providers.

Since then, commissioning has been tweaked by successive governments, but all formats have had the same principal aim of buying the best care at the best cost.

The earliest form of GP commissioning was **fundholding**, where GPs:

- Were given real budgets to buy elective and non-emergency care.
- Could seek and create new services to apply competitive pressure to hospitals in order to get the best services at the best costs.
- Could keep the financial gains they made through commissioning cheaper services.

By 1994 practices started grouping together into Total Purchasing Pilots, not dissimilar to consortiums. However, fundholding was optional, and fears it was creating a postcode lottery between good commissioners, bad commissioners and non-commissioners meant it was abandoned by the in-coming Labour government of 1997 despite some reports of local improvements, particularly around reducing hospital admissions.

Following the demise of fundholding, commissioning was given to primary care groups, and then to Primary Care Trusts (PCTs). While GPs had some involvement, central managers took responsibility from practices.

In 2004 **Practice Based Commissioning (PBC)** was introduced. There was some derision that this was a return to fundholding, but the

government made adjustments:

- GPs were not allowed to hold real budgets. Responsibility for commissioning services remained with PCTs, but they handed practices “indicative budgets” to alter spending.
- All profits were to be reinvested in patient care. However, GPs, instead of using their own purses, could invest indicative budgets in their practices, effectively supplementing their income.
- Although PBC remained voluntary—making GP engagement a struggle—it was mandated that PCTs should ensure all practices were in commissioning groups and had indicative budgets.

In its latest form, **NHS commissioning**, in the Health and Social Care Bill, aims to build on the above previous models:

- It seeks to avoid the lottery and inertia that afflicted fundholding and PBC by making consortiums compulsory.
- While not all GPs will be intricately involved in running consortiums, all will have some interest as part of a wider group.
- With the complete removal of PCTs, responsibility sits more squarely with GPs than fundholding or PBC ever did.
- GP incentive at this stage is still opaque, but they will be given per capita management budgets to run the scheme and backfill GP posts for any time taken out of practice.

*Edward Davies, editor, BMJ Careers*

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## What's the evidence?

### Why ask doctors to commission?

Why put clinicians in charge of commissioning when their prime concern, and the first rule of the GMC Good Medical Practice, is to do the best for the patients in front of them? However, doing the best for patients is not as simple as it seems. Clinicians' actions commit resources. Resources are finite and need to be used cost effectively.

Commissioning is about more than understanding health needs, involving people and professionals in planning services to meet those needs, and then procuring and performance managing the commissioned services. It is also about politics, perceptions, leadership, and changing clinical behaviour.

Chris Ham, chief executive of the King's Fund describes the NHS as having an “inverted pyramid of power,” where real decisions are made by those working with patients every day. Unless those with the financial power endorse and support this, it is doomed to fail. This is, perhaps, the rationale for putting clinicians in charge of commissioning.

So is there evidence that having clinicians committed to commissioning is a good idea? Probably. The trouble is, while providers remained relatively stable, commissioning structures underwent frequent reforms, making it difficult to evaluate the effectiveness of commissioning.

### Why GPs?

GPs see most of the population regularly and witness their experiences with processes and outcomes. With long term conditions and frailty consuming NHS resources, work with social services, the third sector, and public health is required.

Variation in practice has a significant impact on the effective use of resources. Bringing GP practices together to focus on transforming primary care is intended to drive improvements in quality right



through the healthcare system. It simultaneously creates influence and accountability for a part of the system that previously has lacked both.

### What about other professionals and the public?

Although GPs might be given considerable influence over commissioning, they must engage with other professionals and the public to navigate its complexities. Specialists already have enormous influences on commissioning. The Royal Colleges' standards and NICE guidance are just two examples of this (eg the “improving outcomes” guidance transformed cancer commissioning).

### Why commit?

Clinicians are not inspired by the idea that commissioning is simply about managing money but should bear in mind Porter and Teisberg (authors of *Redefining Healthcare*) who propose that value for money is determined by quality and cost, and that effectiveness and patient experience are the main components to quality. The reforms imply that having clinicians committing to commissioning will be the best way to create a safe, effective system that delivers good patient experience.

*Martin McShane, former GP, and deputy CEO and director of commissioning for the Lincolnshire PCT cluster*

## The shape of consortiums

### Structure

Decisions about the shape of commissioning consortiums have been pretty much left to GPs. The 200 odd trial or “pathfinder” consortiums range in size from three surgeries covering 18,900 people in Hertfordshire to a group of 83 practices covering 672,000 patients in Oxfordshire. The average pathfinder consortium is expected to comprise 35 practices and serve 239,000 people, but the BMA’s General Practitioners Committee says this will be informed largely by:

- The health community within an area.
- How the consortium relates to constituent practices, and external organisations such as acute trusts and local authorities.
- How financial risk can be managed.

A practice is free to join any consortium, not necessarily one that is geographically near to it. Each practice will nominate a clinician to represent it on the consortium, who will be asked to be involved in decisions such as where to invest or disinvest. It’s unlikely that most GPs will have hands on, executive roles. Practices will be allowed to decide among themselves the level of involvement required of individual GPs.

Consortiums will look after their own commissioning budget, including management of financial risk and planning for capital investments. They will be overseen by an independent NHS Commissioning Board.

### Functions

By cutting PCTs and SHAs out of the picture, the health and social care bill expects general practices to band together into consortiums, which will commission services such as elective hospital care, out of hours services, and community health services. Each consortium must meet the needs of patients registered at the constituent practices, as well as those of unregistered people who live within the consortium’s defined geographic area. In practice this means consortiums need to:

- Assess their population’s healthcare needs.
- Identify likely trends.
- Design and commission services accordingly.

Consortiums can choose to commission services from local NHS providers or to contract other organisations, such as private healthcare companies or voluntary bodies, to do the work. This is where the “any willing provider” concept comes in—consortiums will need to adopt competitive bidding practices to enable patients to choose from willing qualified providers. To facilitate this consortiums can determine prices or payments for services subject to tariffs to be set by Monitor and the NHS Commissioning Board.

Helen Jaques, deputy editor, BMJ Careers

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“Consortiums will inherit several statutory duties previously undertaken by PCTs and SHAs, including adhering to anti-discrimination law, following EU procurement law, cooperating with local authorities to improve children’s well-being, etc.”

*Tauseef Mehrali, London GP partner and doc2doc GP clinical champion*

## What is good commissioning?

GPs have incredibly diverse roles, but we are united by a single principle that underpins and guides all our efforts, that is to achieve the best possible care for our patients.

Healthcare commissioning is no different—it is a process by which GPs and others can apply their knowledge and experience to use precious resources effectively to deliver high quality patient care.

The health reforms place GPs at the centre of this activity, allowing them to have greater control over resources, which will in turn enable them to respond better to the healthcare needs of local communities.

GP-led commissioning is only one part of a complicated and complex health and social care bill—but it is not new. It is already happening very successfully across many parts of the country, delivering substantial benefits to patients and delivering partnership working with the primary, secondary, voluntary and social care sectors.

It is about understanding the impact of clinical decisions on the public’s health and purse, the need to practise safely and effectively based on evidence, and how the needs of patients can be best served through designed services that are meeting their needs. Good commissioning is about engaging in clinical dialogues with colleagues in health and social care, and establishing effective channels of communication between patients, the public, and elected representatives.



**It is about understanding the impact of clinical decisions on the public’s health and purse**

It is heartening to know that patients are also being given an opportunity to take an active role in determining and shaping the healthcare provision in their local area. The RCGP supports the principle of ‘shared decision-making’ with patients, emphasising that the unique long-term relationship between patients and GPs needs to be retained in the provision of care as well as in the commissioning of services.

The future presents many challenges for GPs. Last year we moved quickly to establish the

RCGP Centre for Commissioning, which draws on the unique relationship that the College has with GPs and their primary care health teams, our excellent track record for education and quality improvement, and our support for GPs and GP consortiums.

We have been clear that while we support the overarching aims of the reforms—clinical leadership, patient centred care and commissioning—we must also continue to engage with the government about the aspects of the changes that concern our members and our patients.

GPs are pragmatists who will always act in the best interests of their patients. We must work together to ensure that whatever is enacted in the bill brings about real improvements in the services we deliver.

The stakes are too high not to get this right.

*Clare Gerada, chair, Royal College of General Practitioners*

**Rational or not?**

I'm a commissioning ostrich. My views are informed by Radio 4, Local Medical Committee briefings, and medical media. If asked to balance my hopes and fears for commissioning, the scales would tip heavily towards fear. But are my negative feelings rational or are they the product of laziness, ignorance, and fear of change?

So Primary Care Trusts will be abolished and the commissioning boards will take over their roles. That includes patient allocations services, prescribing advisers, GP appraisals, and a host of other roles we take for granted. There will be no interface between us and patients. Rationing and cuts will be blamed on us, and we will have nowhere to hide. We can blame the commissioning board, but patients will know—and government will surely remind them—that, as Louis XIV didn't say, "Le roi, c'est nous."

I may understand my population needs in suburban Finchley to a certain extent. We were great at fundholding because we had to make decisions only for our 4000 patients. But I haven't a clue about what's going on in the estate 2 miles down the road. And I wouldn't presume to judge all the needs on my patch either. There may be unmet needs that I don't know about. Or I may have a skewed idea of needs because I have some particularly assertive patients. Healthcare provision is surely the domain of public



health and policy experts. They have stats and know how to use them. We're trained to be advocates for our patients. I fear that the GPs and lobby groups who shout the loudest will get their voices heard in the commissioning process.

So perhaps we have a duty to forgo the luxury of being ostriches, and get involved? Friends who have spent a lot of time as members of "shadow consortiums," awaiting transfer to power once the bill is passed, are demoralised. Politicians are fighting among themselves. The bill has become a battle of wills between coalition partners. Excuse me if I don't give up my family time—or new box set of "The Killing"—while they squabble and brawl.

*Ann Robinson, London GP*

**Self interest**

The Royal College of GPs is concerned that patients might think decisions made about healthcare will be based on GPs' self interest. Clare Gerada, Chair of the RCGP says, "At worst, the negative impact for GPs could be patients lobbying outside their front door saying, 'You've got a nice BMW car but you will not allow me to have this cytotoxic drug that will give me three more months of life.'"

*Amanda Hoey, consultant editor, BMJ Group Executive*

**Mixed views**

Some clinicians appear to be totally in favour of the proposed reforms—including the abolition of PCTs. The remainder is either undecided or deeply sceptical.

*Tauseef Mehrali, London GP partner and doc2doc GP clinical champion*

**Hospital doctors**

**Will it widen the rift?**

As a hospital SHO, I may think commissioning needn't concern me: "I'm not a GP. I don't handle the budgets, choose providers, or make referrals." Actually, looking deeper, there are a number of issues that may affect my training, practice, and career.

I need the necessary experience to one day be the consultant putting forward the name of my establishment as worthy of a GP's budget. But what if the GP chooses to contract to private healthcare providers instead? Will trainees lose out on experience they need, or will deaneries send them to greener pastures? If trainees (the workhorses of the modern NHS hospital) are moved, efficiency

will be affected and even fewer GPs may refer to that hospital. Closure of hospitals unable to provide value for money may leave juniors without training posts and patients travelling further for care.

And what about cross-team referrals? Now, if a patient requires non-urgent input from another specialty, I recommend the GP refers to a suggested colleague whose office is 20 yards down the corridor from mine. That way funding for the next treatment is from the GP, not my department. Will this situation continue with the new commissioning system? I expect so.

Cutting out management, we are promised, will save vital funds for clinical priorities.



"No redundancies for nursing staff," they say; but what about the future GPs and hospital consultants expected to lead this revolution? I understand the BMA is still fighting our corner.

I hope commissioning will be the "breath of fresh air" the NHS needs, but fear that, rushed through and without all on side, it may widen the rift between primary and secondary care.

*Sarah Jones, paediatrics ST1, West Midlands*

**What about referrals?**

I worry about whether commissioning means hospitals will become poorer and care more disjointed. Will it mean patients go to one hospital to see a cardiologist but another to see a gastroenterologist? Will it make interspecialty referrals more difficult? I know we're supposed to go through GPs when we do this now but sometimes we don't and just do it ourselves—it's quicker that way.

*Dr\_T, gastroenterology ST6, doc2doc*

**Pre-operative assessments**

I've already had questions about pre-op clinics. Why? "Do the pre-op assessment at the surgery, more convenient for our patients. Our GP records already include BP and weight, and we know what they are taking—what more do you want?"

That my clinic nurses picked up four critical aortic stenoses last month should not be a source of pride—clumping happens—but it is.

*John D, consultant anaesthetist, doc2doc*

**Backfiring?**

The worry is this latest reform will backfire by lowering standards of care and pushing up costs. Those of us who practise medicine know experimental treatments based on new hypotheses cannot be relied upon to succeed. The important thing after any "reform" is to ensure patients get looked after properly.

*Huw Llewellyn, honorary fellow in medical probability theory, Aberystwyth University, and former consultant physician, King's College Hospital, London*

**On the ground**

A GP colleague describes his local practice based commissioning meetings, which are a taste of things to come: “We all turn up because we’re paid to. The chairperson understands local issues, and another GP is involved nationally and brings news from the big, wide world. Two people heckle. Three can be relied on to deliver spontaneous, random, unedited streams of consciousness. The rest nod, eat, and nod off. When asked to raise their hands, they do. Or not. That’s democracy. You don’t need to be a Libyan dissident to know that it’s hard to achieve and fragile.”

In another area, a GP friend tells me the contract for community ear, nose, and throat services has been awarded to a private provider:



“Two NHS trusts lost out in the interviews. One worries that these NHS providers, which are centres of excellence, will lose their capacity to train junior staff, attract excellent consultants, and maintain their infrastructure as they lose this revenue stream.”

*Ann Robinson, London GP*

**Social enterprise story**

In City and Hackney, through its GP commissioning arm, ELIC (a social enterprise set up in 2006 covering 30 practices and 220,000 population), there has been emphasis on using practice based commissioning to influence clinical behaviours. Focus has been on reducing activity in secondary care through collaboration with secondary care clinicians. Money has been saved and referral numbers reduced by the use of several initiatives (see p. 12). We are now comparing practice referral rates for specialties and looking for variation, but recognising a need to understand reasons for outliers. High referring practices are invited to buddy with low referrers in that specialty to see what can be learned. Practices are also encouraged to review referrals, especially those made by trainees and locums, and to use existing clinical skills as an alternative to making hospital referrals.

*Kate Adams, London GP*

**Two success stories**

1. Several groups, for example, Tower Hamlets in London, have made striking improvements in the health of their populations by adopting the holistic approach of focusing on the whole population rather than the patients in front of them, thus releasing the power of primary care.

2. Way before the 2010 election, the board of Cambridgeshire calculated they would face a £100m debt within three years. After listening to GPs in the area they concluded commissioning decisions should be handed over to GPs. Lead GPs on the exec team and had the power of veto within the PCT; the whole budget (£40,000- £100,000) was devolved to cluster groups of GPs. They developed nine joint hospital-community projects co-chaired by GPs and consultants and redesigned different areas. Over half the county is involved.

*Paul Zollinger Read, GP director of commissioning development, East of England, and medical advisor, King’s Fund*

**Why locums must be involved**

Locums and sessional GPs make up a substantial percentage of the general practice workforce.

I, like many of my generation, struggled to get a permanent job after completing GP training so fell into locuming as the best alternative. I gradually built up a portfolio career including clinical sessions at local practices and in urgent care at a local hospital, teaching GPSTs, and a part time role at the *BMJ*. Working across two boroughs I often saw inefficiencies in patient care through primary, secondary, and urgent care. Rather than becoming frustrated I decided to get practical. I could see the logistical and educational challenges facing commissioners and, based on my experience, wanted to share my ideas on improving patient pathways safely and cost effectively, on reducing secondary care referrals, and on offering patients improved access to community run services.

After counselling from GP colleagues, I realised I was not the bottom rung of the GP ladder but a valuable part of delivering care in my locality.

Getting involved in GP commissioning has given me an opportunity to improve patient care.

Portfolio careers bring in depth understanding of key clinical areas of commissioning: leadership and management skills, and evidence and data analysis. These skills can only strengthen NHS commissioning groups.

I urge consortiums to engage with as many and as broad a cross section of their workforce as possible. Sessional and locum GPs are valuable, often untapped, resources, not only for leading commissioning, but for implementing clinical improvements into daily practice.

*Zana Khan, locum GP and clinical editor, BMJ Learning*

**“Locum GPs have a unique understanding of local patient populations and how different practices work.”**

*BMA GP Committee*

**A partner’s perspective**

The bulk of involvement in and leadership of consortiums is coming from GP Partners. This may reflect recruitment strategies of consortiums, actual and perceived seniority, being placed at more direct financial risk and greater general experience, and specific experience of previous NHS restructuring programmes.

However, in certain urban settings salaried and sessional GPs form the majority of the GP population and consortiums are being encouraged to reflect this in the composition of their boards.

Each consortium appears to have unique means of recruiting GPs to their boards with some actively involving salaried GPs and partners whereas others have exclusively involved partners.

It must be borne in mind that some GPs have opted for a salaried position in order to be excused from the managerial/administrative burden that comes with partnership.

*Tauseef Mehrali, London GP partner and doc2doc GP clinical champion*



## Public and patient engagement

Consortiums should not view patient engagement in isolation from their other work; it should be integral to their business plans. Business decisions of the most successful organisations are informed by the views of the users of their products and services. Why should NHS commissioning be any different?

Many consortiums envisage having a patient “representative” as a board member. It is often not clear whom the lone patient is supposed to be representing, or even on what basis they will be appointed. If governance requires GP members of boards to be elected, should not patients also be elected? Could not patient panels be the electorates?

Consortiums need to tackle **five key questions**:

- 1. What patient engagement practices happen at each surgery?** You may identify great work that can be replicated.
- 2. Are we agreed about what we want to do?** How can health professionals be sure they know what patients want and need without going through the total experience of being patients?
- 3. What are we going to address in each of the following areas: public involvement, patient engagement, and patient experience?** There is often confusion about this. (See box opposite.)
- 4. Have we prioritised forming a truly representative group of patients?** You need to support them to become a valued reference group that informs key consortium decisions.
- 5. Do we know the expertise in our area?** Ask the local authority, PCT, SHA, and community groups to work with you.

*Douglas Smallwood, GP commissioning support team, East of England SHA*

**Public involvement** is the collective involvement of the community, eg through panels.

**Patient engagement** is the individual interaction between health professional and patient, eg shared decision making.

**Patient experience** is about obtaining structured feedback about the service to be used to influence future decisions about the service.

**Patient panels** can provide helpful input to service design, but there is little point establishing these prior to deciding which pathways to review.

It takes time to establish a representative panel, but consortiums may decide there is time to spend on integrated planning in order to carefully structure the job description and person specification; advertise widely; and interview, appoint, and support successful applicants.



## Five things patients hope for from NHS commissioning

### 1. Patients, carers, and the public really must be involved in decisions about healthcare commissioning.

The health and social care bill carries with it an ominous sense of déjà vu and of paying little more than lip service to patient involvement. Since the gratuitous abolition of the imperfect but reasonably objective and effective Community Health Councils in 2003, we have seen the rise and fall of a string of faltering, ill explained and ill advertised acronymic patient involvement organisations: ACHCEW, Patient Forums, CPPIH, LINKs, and PALS. Ask any patient or member of the public what these organisations did or do, and I’ll guarantee the question will be met with blank incomprehension.

### 2. Equity of service provision across the UK, in terms both of the range and quality of services, and of cost.

The Quality and Outcomes Framework (QOF) shows all too clearly how target setting and associated financial incentives can disadvantage substantial groups of patients, distort clinical priorities, and drain primary care of flexibility.

### Patient choice

Evidence shows many patients want more involvement in decisions about their care. My view as a patient with a long term condition is that patient choice is patients making informed decisions about treatment, but much of the policy seems to be about choice of provider, professional, and location of treatment.

I want an organised service where I see the right professional (specialist or generalist) at the right time at a suitable, convenient location. I do not want to go several miles to see a consultant for 10 minutes a year only to be told I should

### 3. Prescription charges must go.

These are now unique to the NHS in England and make a mockery of “healthcare free at the point of delivery.”

### 4. Safeguards should ensure that excellent specialist treatment is available and both readily and promptly accessible.

Given that more services are being moved “closer to home” (a euphemism for devolving specialist care to GP practices), this is essential.

### 5. Any move away from target driven healthcare must under no circumstances be allowed to extend waiting times.

Having spent the past 8 months in severe pain and increasingly immobile as a result of a failed emergency whole hip replacement, and having waited 6 months for the necessary revision surgery, I say this with real feeling—and I am well aware that there are a great many people with problems far more severe than mine.

*Peter Lapsley, patient editor, BMJ*

keep taking my tablets. Why am I not being seen by my GP at the surgery?

Surveys suggest only a small percentage understand their medication options and the associated benefits and side effects, illustrating the need is not just for “choice” but “informed choice.” Is it any wonder there is so much waste and non adherence if patients are not properly informed?

*Douglas Smallwood, GP commissioning support team, East of England SHA*

## Quick wins

Many PCTs have large deficits as GP commissioning bodies evolve. In order to be a successful commissioner you need to start with healthy finances. Through our work in City and Hackney for 2010-2011, there was a 4% reduction in secondary care referrals (PCT average for England and Wales was a 16-25% increase) and a £2.1 million reduction in spending on outpatient services. These savings were achieved using the following strategies:

### 1. Reducing referrals by creating joint clinical pathways with secondary care

- We identified high referring specialties such as gynaecology.
- Practices audited referrals and presented findings at educational support meetings.
- Seventeen clinical pathways were developed jointly with secondary care colleagues for conditions such as menorrhagia, infertility, and polycystic ovarian syndrome, which give GPs confidence in managing more patients in the community. (Ten more are currently being developed.)
- We referred only when all evidence based management and treatment options were tried.
- Appropriate work up was done before referrals.

### 2. Reducing referrals by creating advice services with secondary care

- Sixteen consultant telephone advice services (including cardiology, neurology, and paediatrics) were set up with our local provider.
- These advice services also reduced referrals by offering an alternative to outpatient visits and supported GP management.

### 3. Reducing emergency admissions

- We audited recurrent emergency admissions then discussed if any of them could have been avoided.

- Our consortiums groups jointly audited cases with our community geriatrician and a vulnerable patient living alone who lacked mental capacity was identified who had previously been missed.
- GPs shared innovative strategies for supporting certain challenging patients: a management strategy was put in place to support an 80 year old man with ischaemic heart disease and anxiety who frequently phones the ambulance and out of hours services, causing his A&E attendances and admissions to halve over the past year.
- We identified the need for a special emergency response for patients with sickle cell disease.
- Our community geriatrician was contactable by phone during working hours for support in avoiding admissions.
- There was a first response team and community matrons.
- Practices allocated vulnerable patients to named GPs, recognising that multiple admissions in frail elderly patients with multiple comorbidity are often prognostic indicators for end of life care.
- We improved information sharing between primary and secondary care: our hospitals now fax same day discharge summary information, and GPs have agreed to provide timely medical information for patients in A&E.
- Multiple attenders were flagged at a practice level.
- In Tower Hamlets, two GPs stream all walk in A&E patients and were able to triage 50% of patients away.

### 4. Reducing outpatient activity

- A GP and consultant reviewed outpatient followups over 12 months to identify barriers to patient discharge. This was used to develop discharge arrangements and new pathways.

Kate Adams, London GP

## Starter for five

In these hectic times how do we focus on those important issues that will deliver the “holy triad” of improved quality, cost effectiveness, and patient satisfaction?

The most logical approach is to focus on clinical areas we know could be commissioned and delivered more effectively, eg urgent care; ambulatory conditions like cellulitis, heart failure, asthma; end of life care; and primary and secondary prevention. However the following will provide a strong foundation for consortiums.

### 1. Ask why it is so difficult to spread best practice from one location to another?

If we understand this we can develop the foundations of effective commissioning bodies.

### 2. Focus on the following priority areas: quality in primary care, population based approach to health, systematic and proactive approach to long term conditions, integration of services, and developing healthy organisations.

Rather than chapters in a book, these are values and behaviours that need to be transcribed into every fibre of developing consortiums’ structure. We need to develop from groups of independent practitioners working within the NHS to a synergistic group of practices working collectively together in a collective “corpracy;” these are in effect federations.

### 3. Look at the need for a population based approach.

Focus on the whole population and move away from simply the patient in front of you.



### 4. Have a proactive and systematic approach to the management of long term conditions.

This is fundamental to managing the significant challenges arising from our ageing population. It is a value not an action: a way that you approach the commissioning of care in your consortium. Start with stratification tools to identify those at risk and then support them in their homes; then move to a comprehensive system that “pulls” patients out of hospital and also manages them in nursing and residential homes.

### 5. Develop “healthy organisations.”

Healthy organisations are those with shared values, a clear sense of direction, clear culture, accountability, innovation, external facing, and learning opportunities.

The evidence is clear that organisations built upon these foundations lead to improved performance.

*Paul Zollinger Read, GP director of commissioning development, East of England, and medical advisor, King’s Fund*

## If you need to do one thing, consult

Possibly the single most important issue there is in getting a bunch of strong willed and opinionated doctors (aka GPs) all working in unison is to ensure that everyone is consulted before taking any further steps. While most of us are nominally happy to go along with most things—being also pragmatic by nature—and most of us are keen to keep seeing the patients and letting others do the “other stuff” (commissioning, managing, etc)—we really take offence when big decisions are made on our behalf, or when others think they know best. Of course, others may know best, but please explain why you’re advising your membership to do things, and why you are pushing them to make big decisions, even in the light of a lot of dissension from the ranks. There’s nothing like a rush to the goal without adequate information to create a great conspiracy theory before you’ve even started.

We are lucky—we already had a formal commissioning group up and sort of running before the government in its wisdom foisted the white paper on us last year. We’re watching, in somewhat bemused fashion from the sidelines, as the NHS becomes the latest and most contentious political football. But while the final picture changes daily, and our own beloved Primary Care Trust has disappeared off the face of the earth, we are now being faced with a lot of pressure from within our own consortium.

They (we?) are asking us to take a vote about whether “in principle” we (the membership) want to sign up to a pilot project that comes with its own significant layers of complexity and responsibility—without any real explanation about why. OK—so it’s being sold as “probably better



for patients,” and the consortium now say they’ll take the financial hit if it all goes horribly wrong. Yet no one can or will explain to us why they (we?) are so keen for us as members of the consortium to sign up, nor what the “hidden agenda” is. There must be one, given all the enthusiasm from on high, to get us all signed up before we know what it entails.

We can’t afford to fall out at such an embryonic stage of “commissioning,” and it would be childish to do so. But if you really want to work together well—make sure you have the entire membership of the group engaged in the debate. Your professional lives and the lives of your patients depend on it.

Abi Berger, London GP and associate editor, BMJ

### Good written communication

A practical tip for maintaining quality of care and communication is to make sure that all tests, treatments, and followup appointments are put in writing and followed (in brackets) by the identifying number of the possible diagnostic indication. Also, each such (numbered) diagnosis is followed in brackets by the evidence so far that includes how it presented, was confirmed, and is being monitored. This is what I do and teach. This written explanation can be given to the patient and passed on to the next doctor (in the primary, secondary, or private sectors) to provide continuity, integration, and coordination of care and to avoid duplication or rushed thoughtlessness.

If everyone did this, it would make things easier for us all and safeguard patients (and doctors). This would be a cheap, cost saving, and sensible reform that improves quality of care, information, and training. However, it does require organisational support if it is to be done routinely and by everyone. So my last tip is to keep asking politely for any “competition” to be based on “quality of care and communication”.

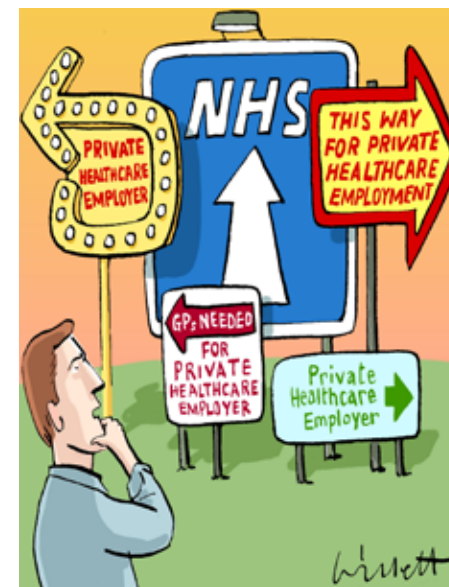
Huw Llewellyn, honorary fellow in medical probability theory, Aberystwyth University, and former consultant physician, Kings College Hospital London

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When you’re in your consulting room and you see something has not worked, you can feed it back and if the consortium feels that that’s a pathway that’s not working, you can redesign it.

BMJ Learning module:  
 GP commissioning—how your role could change

The BMJ General Update Masterclass for GPs includes a session on GP roles and opportunities in commissioning care  
[masterclasses.bmj.com/GPs](https://masterclasses.bmj.com/GPs)



### Who will deal with consortium level management support? What are these business support units?

The future shape of consortium level management support could take many forms. Until the roles and functions of the GP commissioning consortia (GPCCs) and their relationship with PCT clusters—if they remain past 2013—and the new National Commissioning Board are confirmed following the “listening exercise” and the required political decisions, it is only possible to speculate.

The customers of the Commissioning Support Units will be the GPCC—or whatever they may be called. Their size and responsibilities could vary and require different levels of support. Some services may be commissioned through lead arrangements/federations if the GPCC are smaller or if lower volume specialist and more costly services can more efficiently be commissioned for a much wider geographical area.

A business review stocktake is being undertaken on the clusters’ ability to take on Commissioning Support Organisation (CSO) functions. There is considerable commissioning experience in clusters that could be lost, but while this option would provide continuity and save on redundancy costs,

it might be seen as perpetuating a bureaucratic model that the government has been determined to abolish. This could be seen by some GPs as undermining their clinical leadership role and preventing them from securing support from the private sector; they will understandably say that, as the customer, they should be able to make the decision. The legislation could, however, prevent some of the choices if there are restrictions on private sector involvement in the NHS.

Support will need to be met in a number of ways. There are core functions, such as management and governance, public engagement, and business intelligence, but also requirements including finance and HR, which could be regarded as back office and provided by third parties or in partnership with other GPCCs, public bodies, including local government, and the private sector.

The organisation could be formed as a social enterprise. The commissioning of services based on need—using the local Joint Strategic Needs Assessment—could be combined or separated from the contracting/procurement function.

Some discussions seem to imply clinician leads will be able to make a fresh start, but it is important

to remember that budgets are already committed to providing treatment and support to many people. Redesigning care pathways will be important, but it will take time to improve outcomes and reduce costs. Many of these initiatives should already be included in the QIPP plans.

Some GPs may not be aware of the extent of some joint/integrated commissioning with local authorities. Joint commissioning is defined as “working together to jointly secure the highest quality health and social care services to meet the identified needs of a population within available resources.” For example, in Hertfordshire over £300m is spent on jointly commissioning mental health, learning disability, and substance misuse services. There are also jointly commissioned re-ablement/intermediate care services across the country. There seems to be increasing interest in integrated services, so the move towards joint or integrated commissioning could potentially reduce duplication, build on local success, and pool expertise in these challenging financial times.

### How much time will GPs be spending on this? Will they need to be backfilled if they are involved?

This will depend on the functions and size of the GPCC. Management allowances will constrain the number and types of posts. Providing clinician leadership does not require an undertaking of some of the essential management tasks. Acquiring some commissioning knowledge and skill will be necessary, but micromanagement by GPs would not be a sensible use of time and would detract from the leadership role. Delays or watering down of some the changes could have a negative impact on the initial enthusiasm of some GPs. The pace and extent of staff assignments/transfers from clusters will also be a factor. Backfilling could be a problem in some parts of the country, especially where there is shortage of GPs.

How and when to engage with rank and file GPs will need careful consideration. If they are not fully on board, the benefits of change will be limited. For example, new referral arrangements might not be followed and new contracts not fully utilised.

### If we are a small practice and need to concentrate on patient care, how will we manage to be an active part of a consortium?

Again this will depend on political decisions and on the shape and functions of GPCCs. Some areas such as Cambridgeshire have been establishing senates or forums to gain the views of GPs and represent them at cluster and consortium level.

### Are there any good models for how teams work across primary and secondary care?

Recent pronouncements suggest that a rigid divide between commissioning and provision may be giving way to a more collaborative model promoting greater cooperation between primary and secondary care and local authorities. The development of care pathways and the establishment of clinical networks—multiprofessional and usually regional groups overseeing the care of particular conditions—may be a useful way forward.

More information on joint commissioning and the work undertaken in the East of England is contained in the regional Network Bulletins which are available at [www.jipeast.org](http://www.jipeast.org). Follow the link to the work streams, then select GP Commissioning. An overview of joint commissioning activity across the region will shortly be available on this website.

*David Jones, project lead for East of England Network Bulletins, former director of social services, and current interim manager and consultant in health and social care*



### What will happen to my salary?

GP remuneration through GMS and PMS contracts has not been significantly changed to reflect the new commissioning roles. At the moment there is no nationally agreed rate for the involvement of GPs in management and leadership roles. In the transition to when consortiums go live, each PCT has a fund of £2 per patient to support GPs in the development of consortiums. The lead roles in consortiums (eg accountable officer) will have clear job descriptions, selection processes and remuneration; other roles supporting consortiums are likely to have their remuneration determined following decisions of the governing body of the consortiums.

### Can I get fired from a consortium?

It is good practice for those in management roles to have clear job descriptions and objectives and for assessment to be measured against these. Those experiencing difficulty achieving their objectives are offered support and reviewed to see if their development needs are being met.

It is rare for repeated performance failures to lead to an individual being sacked; however, these will be decisions for each consortium team.

It is very unlikely that nonmanagement individual GPs will be asked to leave a consortium; the only likely possibility being through consistently poor performance that was detrimental to the local population's health, despite all attempts from the consortium to support improvement.

### Can I still refer patients if I'm not on the commissioning board?

All GPs in a consortium are advocates for their patients and able to refer them in the most appropriate ways in order to meet their health needs. Many consortiums are developing agreed referral pathways with secondary care that provide the best quality and are the most cost effective. It is likely that consortiums will work with individual GPs to achieve agreement on referral pathways.

### Who will monitor consortium GPs?

The National Commissioning Board will be responsible for commissioning primary care. However it is likely that local consortium leaders will play a significant part in helping to ensure that the provision of primary care is of the highest quality. In particular they are likely to work closely with GPs on areas such as prescribing and referral management where we know there is marked variation and marked variability in appropriateness.

### Is there any way GPs can dip their toes in the water without being heavily involved?

It is likely that there will be 3 to 4 GP leaders who spend 2-3 days per week on commissioning work in a moderate to large sized consortium. One GP in each practice is likely to spend half a day a week on commissioning work connecting into the central team. Most GPs are unlikely to have a significant time commitment other than to be involved in discussions about how local services can be improved, and also to discuss clinical audits and audits on referral and prescribing.

*Paul Zollinger Read, GP director of commissioning development, East of England, and medical advisor, King's Fund*

### Will I be able to refer patients where they want?

One of the key benefits of the proposed reforms is the opportunity to offer patients even greater choice. Currently, patients can choose where to have elective surgery. Reform suggestions include extending patient choice by scrapping practice boundaries so that patients can register with any GP they wish—whether local or not.

If consortiums are entrusted to commission healthcare locally and institute local service redesign as part of this process, it's difficult to envisage GPs referring patients outside of these new pathways, thereby in effect limiting patient choice. Consequently clinician referrals may be more directed and directive too.

The provision of home visits and out of hours care for patients who may not live locally would also need to be addressed. Home visits from preferred GPs are unlikely if the practice is a 2½ hour drive away.

*Tauseef Mehrali, London GP partner and doc2doc GP clinical champion*



### Will working with private companies affect my NHS pension?

At present it is possible to pay into the NHS pension scheme only if you are working for an NHS Employing Authority. Generally speaking any GP with a GMS or PMS contract can be a member of the NHS Pension Scheme and offer it to their practice staff. Similarly a GP who could hypothetically hold a GMS or PMS contract who is awarded an APMS contract would be in the same position.

The government's intention is that in the future there will be more private sector involvement in primary care. At the same time the government looks likely to use Lord Hutton's recommendations on the future of public sector pensions as a basis for consultation for change.

One of Lord Hutton's recommendations is: "It is in principle undesirable for future nonpublic service workers to have access to public service pension schemes, given the increased long term risk this places on the government and taxpayers."

This means that scheme members who are transferred to work for a private provider could well lose access to the NHS pension scheme.

As this book goes to press, it is unknown what will happen to pensions. The **main threats** from the Hutton recommendations are:

- Existing method of pension accrual to be replaced by an inferior Career Average Revalued Earnings (CARE) scheme.
- Increase in the normal pension age to be linked to state pension age which would mean that members' normal pension ages would in future increase to between age 65 and 68.

**Other pensions concerns** include:

- CPI replacing RPI as the basis used to increase pensions in payment and also the dynamising factor.
- Changes to pensions taxation from April 2011.

*Andy Blake, head, BMA pensions department*

## IN SUMMARY

### What the polls say

BMJ poll: Will GP commissioning improve patient care?

No: 269 (74%)

Yes: 96 (26%)

doc2doc poll: Are GPs the right people to control England's £80bn NHS commissioning budget?

No: 97 (62%)

Yes: 60 (38%)

"We have many different *tribes* in the NHS, and there is an absolute need for us to collaborate in health care delivery, one example being the implementation of referral management systems. These work effectively when primary and secondary care agree the pathway jointly; then they hold their members to account in using it rather than unilaterally developing a pathway."

*Paul Zollinger Read, GP director of commissioning development, East of England, and medical advisor, King's Fund*

### The rap

A rap about the reforms has had around 400,000 hits on YouTube. Here are some of the lyrics:

So the budget of the PCTs  
He wants to hand to the GPs  
Oh please. Dumb geeks are gonna buy from any willing provider  
Get care from private companies  
They saw the pie and they want a piece  
Got their eyes on the P's like mice for the cheese.  
...

Lansley's white paper: "Liberating the NHS"  
Sets out a plan where we'll become more like the US  
And care will be farmed out to private companies,  
Who will sell their service to the NHS via GPs,  
Who will have more to do with service purchase arrangements  
Than anything to do with seeing their patients.

*From "Andrew Lansley Rap" by MC NxtGen*

### Benefits of commissioning

- GPs at fore of service redesign
- Improved efficiency
- Less bureaucracy
- More patient choice
- Alignment of clinical decisions and financial consequences

### Drawbacks of commissioning

- Risks of privatisation through the "Any willing provider" clause
- Potential to breach EU competition law
- Greater bureaucracy and administrative burden
- Less patient choice
- Direct responsibility for overspends and deficits
- Erosion of public trust
- Paucity of commissioning skills
- Pace of reforms
- Minimal evidence base for reforms

*Tauseef Mehrali, London GP partner and doc2doc GP clinical champion*

### At best

Commissioning will give patients greater say in which services they access through their GPs and the ability to switch secondary provider will give GPs a route by which to directly control the quality of service to which they refer their patients. It could reduce waiting times, improve quality of provision, and make the NHS more locally responsive.

### At worst

GPs may find themselves out of depth and unable to effectively commission. They could find the dual role of purchaser and provider creates a conflict of interest and that they lose the trust of patients whose care they could be perceived as rationing. It could also undermine hospital stability as services are picked off and have an impact on workforce training as certain procedures are relocated.

*Edward Davies, editor, BMJ Careers*

## TIMELINE AND LINKS

### May 2010

Andrew Lansley becomes health secretary for the new Conservative-Liberal Democrat coalition government



### July 2010

NHS white paper, *Equity and Excellence: Liberating the NHS* proposes GP consortiums will be responsible for commissioning

### October 2010

Pathfinder consortiums identified



### January 2011

Health and social care bill reaffirms GP commissioning proposals

### June 2011

Government announces GPs to be part of consortiums when they are ready (the deadline of April 2013 is "relaxed")

### April 2012

NHS Commissioning Board to become full, nondepartmental public body



### July 2012

SHAs to be abolished

### BMJ Group NHS reform resources

[doc2doc.bmj.com/pages/nhs-reform](http://doc2doc.bmj.com/pages/nhs-reform)

### BMJ Learning module: GP commissioning—how your role could change

[learning.bmj.com/learning/modules/module.html?execution=e1s1](http://learning.bmj.com/learning/modules/module.html?execution=e1s1)

### BMA guidance for GPs: NHS reform

[bma.org.uk/healthcare\\_policy/nhs\\_white\\_paper/gpcwhitepaperguidance.jsp](http://bma.org.uk/healthcare_policy/nhs_white_paper/gpcwhitepaperguidance.jsp)

### BMA SRM NHS reform briefing papers

[bma.org.uk/images/srm2011healthbillbriefingpapers\\_tcm41-204671.pdf](http://bma.org.uk/images/srm2011healthbillbriefingpapers_tcm41-204671.pdf)

### BMA GP Committee: the form and structure of GP-led commissioning consortia

[bma.org.uk/images/whitepapergpcguidance5nov2010\\_tcm41-201578.pdf](http://bma.org.uk/images/whitepapergpcguidance5nov2010_tcm41-201578.pdf)

### BMA GP Committee: GP consortia commissioning—initial observations

[bma.org.uk/images/whitepapergpcguidance4sept2010\\_tcm41-199838.pdf](http://bma.org.uk/images/whitepapergpcguidance4sept2010_tcm41-199838.pdf)

### King's Fund: ten priorities for commissioners

[www.kingsfund.org.uk/publications/articles/transforming\\_our.html](http://www.kingsfund.org.uk/publications/articles/transforming_our.html)

### Department of Health: the functions of GP commissioning consortia

[www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalasset/dh\\_125006.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalasset/dh_125006.pdf)

### Department of Health: health and social care bill

[www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011](http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011)

### JIP: Joint Improvement Partnership for the East of England

[jipeast.org](http://jipeast.org)

### RCGP: Centre for commissioning

[www.rcgp.org.uk/centre\\_for\\_commissioning.aspx](http://www.rcgp.org.uk/centre_for_commissioning.aspx)

### GP Online: how GP consortia will work

[gponline.com/News/article/1048384/how-gp-consortia-will-work](http://gponline.com/News/article/1048384/how-gp-consortia-will-work)

### Guardian: map and data on GP commissioning pathfinder consortia

[guardian.co.uk/healthcare-network/datablog/2011/ja/12/gp-commissioning-consortia-map-data](http://guardian.co.uk/healthcare-network/datablog/2011/ja/12/gp-commissioning-consortia-map-data)

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