



The essential guide to GP Commissioning



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Introduction

This document is intended as an introduction for professionals and managers in primary care who want to gain an understanding of the new world of *'Liberating the NHS'* and as a practical guide for those who wish to be involved in the development of the exciting opportunities presented by the changes. Commissioning is complex and challenging at the best of times but in this fiscal environment requires expert commissioners to utilise all the levers at their disposal. This document will help you achieve these aims.



...one of
the greatest
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the existing
NHS

The Coalition White Paper *Equity and excellence: Liberating the NHS* and the ten or so associated documents present one of the greatest challenges to the existing NHS since the early days of the market in the 1990s. Although consultations are still underway, much of the direction is relatively clear. This document is intended to give an overview of what the future is likely to hold, particularly for the professionals and managers who will be the lynchpin of the new clinically driven patient sensitive commissioning system.

We have used the term inclusive commissioning. Multiprofessional consortia encouraging maximum involvement of patients and the public will be the successful organisations. New relationships will be the hallmark of this success. These need to be worked on and the visions and values discussed as a first step in the formation of the consortium. Arguments about the relative merits of previous systems of Practice-based Commissioning (PBC) and World Class Commissioning (WCC) are interesting but will not take us forward. Each new development of the NHS will therefore, of necessity, be an informed experiment. Innovation by definition explores new areas and therefore can only ever have a limited evidence base.

In the new world of compulsory involvement in commissioning it is likely and desirable that a new generation of innovators and leaders emerges. As they do so, it should not be assumed that PBC organisations have legitimacy where they are used as a basis for the new organisations; they and the individuals within them will have to seek a new mandate from local practices.

In this document, PBC organisations are referred to as 'groupings' and the new organisations as 'consortia'. Once formed, practices will have to come to terms with the concept of corporacy – a responsibility towards colleagues in the consortium for delivery of shared aims with which they may not wholly agree.

We have used the following definition as a starting point for considering the range of capabilities required to deliver commissioning: *Securing the highest quality healthcare services to meet the identified needs of a population within available resources.* The simplicity of this definition belies the complexity of the task of effective commissioning. This document is intended as a positive, practical starting point as well as a brief reference to dip into as the new world of inclusive commissioning develops. It will guide you through your must read building blocks of successful commissioning culminating in a practical how-to guide for your next steps.

Dr Pete Smith
Vice President, NAPC
October 2010

"This is a very useful early document and I commend it to would-be GP Commissioning Consortia."

David Colin-Thomé, National Director for Primary Care, Department of Health

Chapter 1

Overview of GP Commissioning and White Paper

A brief guide to 'Liberating the NHS'

'Liberating the NHS' proposes very significant changes to the NHS and to Local Authorities. This chapter offers a very brief summary of the key changes proposed in the White Paper and accompanying documentation of particular relevance to GPs, practice managers and those who will be involved in commissioning in future.



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The areas referred to in this summary and in the overview diagram are explored in a little more detail in the subsequent section.

The Liberated NHS – a short summary

Within the new, liberated NHS, there are a number of key areas of particular importance to general practice:

The NHS Commissioning Board will represent a new relationship between the NHS and government; divorcing political involvement from the day to day running of the service. An NHS Outcomes Framework will set expectations for performance within the resource parameters established by Parliament. The Board will manage general practice contracts and set the practice-level budgets for the new GP Commissioning Consortia. It will monitor and hold GP consortia to account for their commissioning. Strategic Health Authorities will be abolished but there is likely to be regional representation of the NHS Board.

GP Commissioning Consortia will be formed from groups of practices. Budgets will be calculated for the individual practice, but held at consortium level. All practices will have to form or join a consortium and be involved in commissioning to varying degrees. Primary Care Trusts (PCTs) will be abolished from April 2013.

GP practices will continue to serve their patients but will have greater responsibility to link in with colleagues at GP consortium level. The GP contract is likely to be altered to take into account this new responsibility. It is suggested that a proportion of GP remuneration will be given to the consortium for the delivery of commissioning outcomes.

Local Authorities will form a new relationship with the NHS and GP consortia, which will attempt to address the local democratic deficit in the NHS. Local HealthWatch will replace Local Involvement Networks (LINKs) and will have a greater signposting and monitoring role.

HealthWatch will be commissioned by the Local Authority, and will provide feedback to them and to HealthWatch England on the delivery of local services (see Chapter 4 for more). All Local Authorities will have a Health and Wellbeing Board (or similar), which will take over the role of the Oversight and Scrutiny Committee and will reflect the greater role of the Local Authority in joint commissioning needs assessments and integrated commissioning with the NHS.

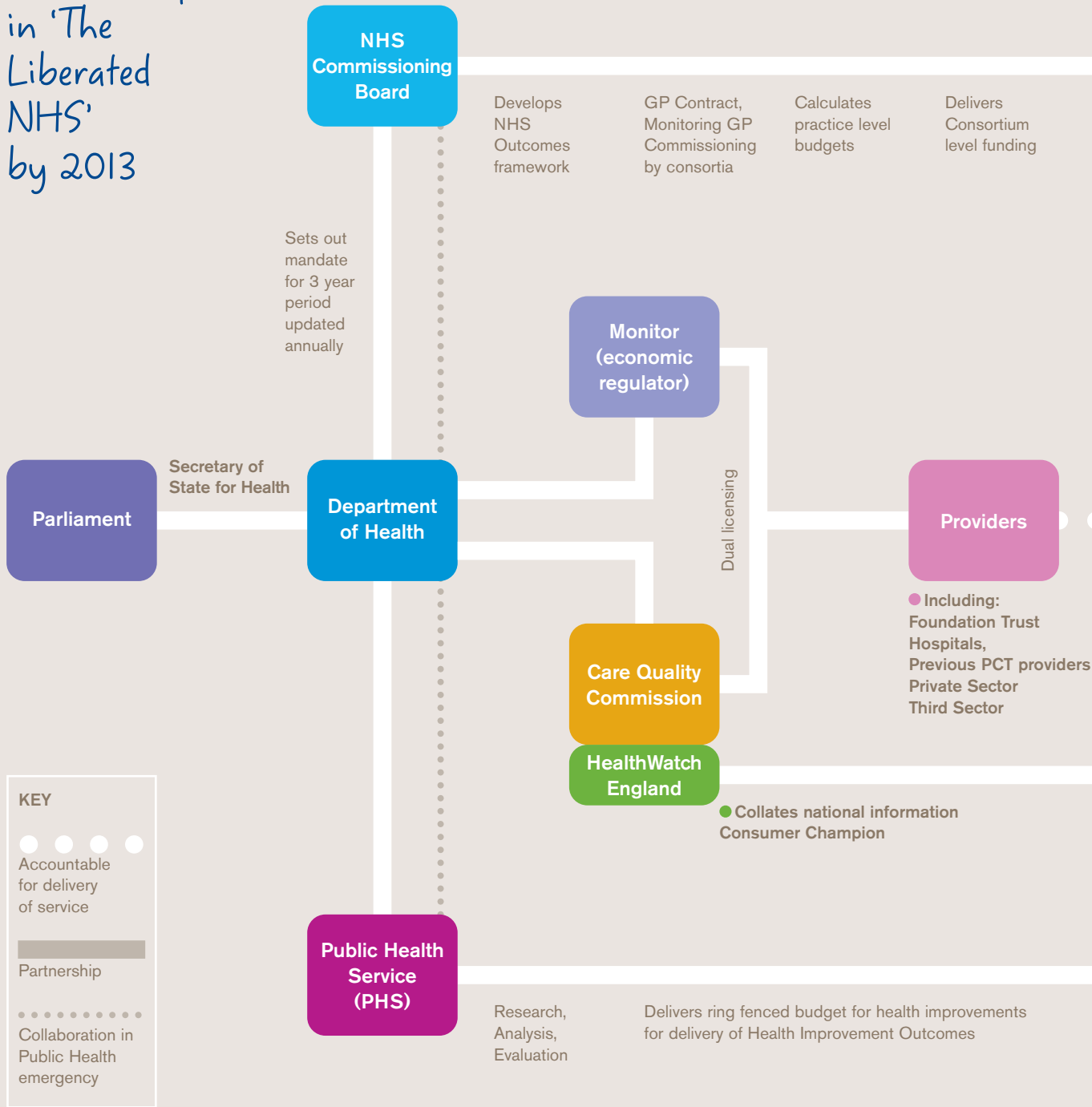
Public Health will be moved to Local Authorities and will be subject to new health improvement agreements, for which it will receive a ring fenced budget. A national Public Health service will be created.

Healthcare providers will be subject to a dual monitoring and licensing system through Monitor (which will become the new economic regulator) and the Care Quality Commission (which will monitor delivery and infrastructure and also receive feedback via HealthWatch England). This is underpinned by the two key principles of:

- **Putting Patients First.** ‘No decision about me, without me’. This principle will be supported by an ‘information revolution’, providing the public and patients with greater information on which to make an extended range of informed choices.
- **Improving healthcare outcomes.** The NHS will be held to account by the NHS Outcomes Framework and Quality Standards. These will be developed in conjunction with the National Institute for Clinical Excellence (NICE) and will replace centrally imposed targets.

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Relationships in 'The Liberated NHS' by 2013



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The Liberated NHS - in detail

NHS Commissioning Board

The NHS Commissioning Board and the Government will agree the standards for performance through the NHS Outcomes Framework and the financial envelope to achieve them. The Secretary of State for Health will report to Parliament on the delivery and standards of this performance.

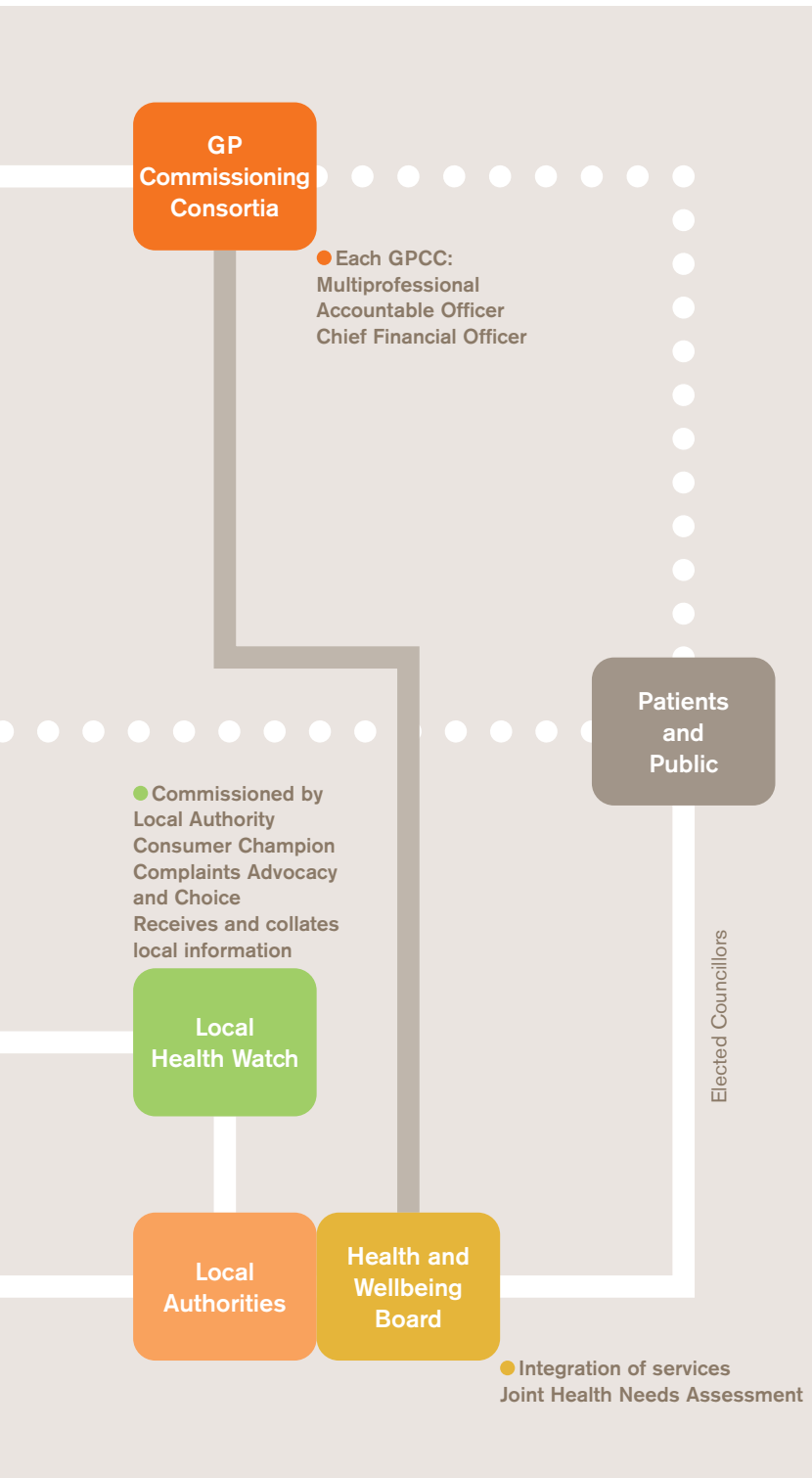
The NHS Commissioning Board will also commission certain services, for example transplantation, primary ophthalmology, community pharmacy, dentistry and maternity services, however these still remain subject to consultation.

Accountability for monitoring commissioning organisations will move from the Care Quality Commission to the NHS Commissioning Board. Therefore, the Board will have responsibility for primary care contracts and commissioning outcomes. The Board may also manage the 'quality premium' (where a proportion of GP remuneration is given to the consortium for the delivery of commissioning outcomes) of the GP contract, an element that may be withheld against delivery of commissioning outcomes and given to the GP consortia for distribution.

The Board will hold the GP Commissioning Consortia to account for delivery of the NHS Outcome Framework.

Public Health

A Public Health White Paper is due in 2011, but proposals suggest that the Public Health function will transfer to Local Authorities and will have a ring fenced budget for the delivery of Health



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Improvement Outcomes. These outcomes will be defined by the new Public Health Service, which will also have a role in public health research, analysis and evaluation.

It remains to be seen how far this will impact the significant role of general practice in public health, particularly in areas such as immunisation. The new national Public Health Service and the NHS will work collaboratively where issues of national emergency arise such as epidemics.

Local Authorities

There will be increased oversight of local health services, through local HealthWatch and Health and Wellbeing Boards. HealthWatch will have broader responsibilities than the Local Involvement Networks (LINKs) that they will replace. They will be commissioned by the Local Authority but will also link in and feedback to a national HealthWatch England.

The Health and Wellbeing Board of the Local Authority may include social care, NHS Commissioners, patient champion(s) and elected local councillors. The elected members of the Local Authority will select the Chair. The local Director of Public Health will also play a key role.

The Boards will partner closely with the NHS, taking the lead on strategic joint commissioning and the Joint Strategic Needs Assessments.

New Monitoring and Accountability Arrangements

Providers to the NHS will require dual licensing – with both the Care Quality Commission and Monitor. Monitor's role will change from dealing with only Foundation Trusts to that of economic regulator for all providers in the NHS. The Care Quality Commission will be responsible for inspection and monitoring of infrastructure and delivery.

Putting Patients First

In order to help patients become more involved in their care, this will be supported by an 'information revolution' offering increased choice. The focus on outcomes will include the NHS Outcome Framework, NHS Quality Standards and HealthWatch; this will ensure services are being delivered appropriately.

GP Commissioning Consortium

Around 500-600 consortia are expected. Although this equates to approximately 100,000 patients per consortium (if divided evenly), the White Paper is not prescriptive about their size or geography. The consortia will be lean organisations. They will need an Accountable Officer, are likely to have a shared Chief Financial Officer and could have shared 'back office' functions.

Practice managers and GPs will need to be aware that although the nuts and bolts of commissioning will be carried out by the GP Commissioning Consortium, their practice will be responsible for the delivery of some of the local commissioning aims. If the 'quality premium' proposal is introduced, practices will have to ensure that their consortium delivers against its given outcomes to maintain practice income.

Whilst some have voiced concerns about the size of the new consortia, all previous evidence indicates that smaller GP groups tend to be able to make changes more quickly than larger groups. In some areas consortia may consist of like-minded practices in subgroups.

What is crucial is that member practices understand the nature of commissioning and its responsibilities, concentrating on developing relationships to make it work, rather than spending time creating structures that may be superseded by statutory requirements.

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Governance

Governance is a mechanism to provide accountability for the way an organisation manages itself. Integrated governance has been described as a collation of systems, processes and behaviours by which healthcare organisations lead, direct and control their functions in order to achieve organisational objectives, safety and quality of services. It directs the way organisations relate to patients and carers, the wider community and partner organisations. Governance is an integral part of how a safe and successful organisation functions. Effective governance is facilitated by good organisational structure, supported with appropriate processes and monitoring. There are key themes that need to be considered within governance, and the structure and processes used need to support these. Within healthcare organisations there are numerous strands to governance, with most of them coming under three overlapping themes; Information Governance, Clinical Governance and Corporate Governance.

Information Governance

It is often considered that a fundamental theme behind information governance is to ensure the security of data and information so that the use of data is facilitated where it is needed for clinical care, whilst at the same time protecting that data from inappropriate use or access. Information governance however is a wider process than this – as it needs to cover not only patient identifiable data, but also ensure that the organisation functions in a robust manner, both now and into the future. Clear agreements about the safe and appropriate use of information will be vital. There are online Information Governance modules¹ that are available and may help in developing a common understanding between all members. The online Information Governance Toolkit may help in developing a common understanding between all members. Speak to your PCT, who will help you log into them.

Clinical Governance

Clinical Governance has been defined as ‘a framework through which NHS organisations are accountable for continuously improving the quality of their services and safe-guarding high standards of care, by creating an environment in which excellence in clinical care will flourish!’² This covers a wide range of functions and is often underestimated by practices. A formal Medical or Clinical Director or a Clinical Governance Director with formal responsibilities should be considered. Responsibility for clinical quality should not be an afterthought; it is fundamental to the delivery of the GP Commissioning Consortia, particularly as they will have to ensure the delivery of quality in primary care and may be held responsible for the quality and outcomes of the services they commission (unlike under fundholding).

Governance provides accountability for the way an organisation manages itself.

Corporate Governance

Some aspects of corporate governance clearly overlap with clinical governance; with corporate governance covering not just the clinical outcomes, but the processes and systems that surround them. Corporate accountability, both financial and functional, is key here. A clear structure of accountability needs to be demonstrated to stakeholders. In this context stakeholders are numerous, from constituent practices, to employees, to providers of care, to tax-payers, to the wider public and of course to patients. Not only will a consortium need to show that it came up with the right decision, but that the process by which it did it was fair and defensible and that the consortium is run in a robust and defensible manner.

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Within these three aspects of governance, and within governance generally, effective outcomes are driven by having the correct foundational structures:

Basic Organisational Structure

GP consortia will be statutory bodies with statutory commissioning rights and responsibilities (currently held by PCTs and SHAs). They will be individually approved by the NHS Commissioning Board. The timetable for development of GP Commissioning Consortia proposes the identification of the first consortia by September 2010, with development of their capabilities by December 2010. These consortia would then start in shadow form at some time in 2011.

It is very clear that this process is intended to be developed from the ground up. Practice Based Commissioning often suffered from top down imposition of bureaucratic systems, rather than organic growth of relationships at practice level. Even though PCTs will continue to have statutory responsibility for commissioning until they are replaced by Commissioning Consortia in 2012/13, they will have to resist the temptation to reorganise themselves around new locality groupings of their own design. PCTs will be abolished 'from 2013'.

Each consortium must have an Accountable Officer who might be shared across more than one consortia. If the notion of a real clinically-led NHS is to become a reality, it would be beneficial if some of these were part time posts held by clinicians.

There is a requirement for each consortium to have a Chief Financial Officer (CFO), essential for any large organisation taking responsibility for public funds. The White Paper refers to the likelihood that these will be shared across GP Commissioning Consortia (GPCC), again prompting the possibility of smaller consortia being covered by shared services and staff.

It is equally clear that the NHS cannot afford a full board and Professional Executive Committee (PEC) inherent in the PCT structure. Whatever model is chosen, there will be a need for a governance process with clear lines of accountability and a light organisational structure that will meet transparent local and national accountability requirements.

Today, consortia could operate within the current statutory framework as sub-committees of PCTs based on a written agreement between practices.

Legal Structure

There has been much speculation about the legal structure of GP Commissioning Consortia but, as they will be statutory bodies, at least some of this is likely yet to be defined. At present, consortia can operate in shadow form as sub-committees of PCTs, with commissioning responsibility and budgets devolved to them before the dissolution of PCTs commences in 2013. However, practices will need to have clear, written agreements about how they relate to one another and to outside bodies.

The key to the success of the new consortia will be the balance between corporacy and subsidiarity. Practices will have responsibility of corporacy that many have never experienced and will have an obligation to take part in commissioning. Corporacy within the GPCC implies shared responsibility for practices to deliver shared commissioning and quality goals even when there may not be unanimous agreement. This will require extra discipline on the part of practices. Subsidiarity implies that the practices still have freedom to deliver agreed services and quality in their own way and to continue to develop their own unique identities. At the very least, practices will need a co-operative agreement, which states a commitment to shared objectives, membership criteria, decision-making processes, information sharing agreements, inter-practice responsibility, management in the case of poor performance, and a dispute resolution process.

The key to the success of the new consortia will be the balance between corporacy and subsidiarity.

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In 2006, the General Practitioners' Committee of the BMA produced an outline agreement for Practice Based Commissioning consortia⁹ some of which is still relevant today. However, statements about what to do in the event of poor commissioning performance or primary care delivery will have to be strengthened, as this could significantly affect colleagues in other practices.

Within each consortium there will need to be representation from individual practices with responsibility for the delivery of the GP Commissioning Consortium's objectives.

Practice and Professional Representation

Within each consortium there will need to be representation from individual practices, who will ultimately be responsible for the delivery of the GP Commissioning Consortium objectives. Member GPs will have an element of their contract based on the delivery of commissioning, along with an interest in the 'quality premium' – the proportion of their contract that is potentially given to the GP consortium for distribution.

Each member practice should have an identified commissioning lead, which may or may not be a GP. A full Board structure as exists within Trusts will not be tenable and could not be afforded by the NHS. However, it will be necessary to form a clinical council or cabinet, to give a voice to local clinical leadership. Transparency will be essential to ensure probity, particularly in the separation of commissioning and providing functions.

Geography

It is tempting to reduce GP Commissioning Consortia catchments to lowest common denominator level and impose co-terminosity. However, it is the list size of the practice that gives it the new combining right and these lists often extend over PCT and Local Authority boundaries. Where it makes sense, there seems to be no reason why the logistics of cross border responsibilities and relationships could not be overcome. Indeed, closer working across Local Authority boundaries might become a particular benefit of these new arrangements. The White Paper also refers to the right of patients to register at a distance from their locality of residence. If this is to be the case, cross border responsibilities and commissioning on behalf of these people will have to be addressed.

It is also entirely possible that like-minded consortia will form alliances or amalgamate across boundaries to share scarce resources.

Key points

- These changes will affect everyone in the NHS.
- Practice Managers and GPs should quickly acquaint themselves with the overview of the proposed changes.
- Practices should begin forming the relationships with practices and other groups that underpin the changes.
- Practices should get involved as quickly as possible in the development of their local GPCC or risk being allocated to one.

Chapter 2

What is NHS Commissioning?

NHS Commissioning may be defined as: *Securing the highest quality healthcare services to meet the identified needs of a population within available resources.*



Chapter 2: What is NHS Commissioning?

Commissioning is often demonstrated as a cycle as shown below. The emphasis on 'stages' has tended to produce a view of commissioning as an annual cycle, but the reality is that it is an ongoing process. The fundamental elements of commissioning have not changed through the White Paper. What has changed is that the new service will be clinically driven by GP Commissioning Consortia, with greater patient and public involvement – Putting Patients First.

This simplified model includes several sub-stages, each of which will require capabilities and expertise. These may be available in-house, shared across consortia or outsourced to an expert provider of commissioning services. The different stages are described in a little more detail below to give a flavour of the sorts of capabilities that will be required.

The Commissioning Cycle



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The Commissioning Cycle in the Liberated NHS

Each of the three major elements has four sub-stages:

1. Planning

Health Needs Assessment

The health needs of the population should be assessed to be able to decide whether appropriate, high quality services are available. This includes needs that are unmet and causing health inequalities. A Joint Strategic Needs Assessment will be driven by the Local Authority and encompass health, community and social services. Risk stratification and a comprehensive understanding of the entire population are important elements of needs assessment. They involve identifying patients with differing levels of service need to target services appropriately and ensure sufficient service capacity is commissioned.

Reviewing Current Provision

Current services (including primary care) require regular review to ensure they are adequate, appropriate and of sufficiently high standard to meet the needs identified in the Health Needs Assessment. Performance management of providers based on accurate data and information is an increasingly important element of the consideration of current service provision. Patient and population feedback and choice will also be important elements to consider.

Identifying Gaps and Priorities

Services need to be examined to identify gaps in overall provision, quality, cost effectiveness and geographical distribution. National and local priorities need to be taken into account when deciding on which services to commission or possibly decommission, for reasons such as duplication or services that do not add value. For instance, local providers may have insufficient capacity to deliver timely angioplasty so services may have to be bought in from further afield, or MRI scans sourced from a mobile provider to improve direct GP access.

Capacity Planning

It is vital that planned services have sufficient capacity to cope with fluctuations in demand, avoid duplication of services and ensure delivery of high quality services. Ongoing planning and monitoring are required, for example to cope with flu outbreaks.

2. Procurement

Service Design/Redesign

Service design or redesign is usually an area of particular interest for clinicians. Services can be clarified or changed, or a new service may be required to meet the identified needs or to drive best evidence based practice and to deliver cost-effective services. Changes will result in a service specification created for the contract.

Defining Contracts

This stage converts the service specification into a draft written contract that takes into account activity and quality requirements.

Procuring Appropriate Services

This could be re-contracting for existing services (renegotiation of contracts where appropriate) or procurement of new contracts. New contracts can be procured through a number of routes, for example 'any willing provider' mechanisms or national tendering. Quality stipulations will need to be considered such as through the Commissioning for Quality and Innovation (CQUIN) payment framework, which sets out a commitment to make a proportion of the provider's income conditional on

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3. Monitoring

quality and innovation. The indications within the new NHS Outcomes Framework will also be a key consideration here.

Managing Demand

Services require checks and balances to ensure they are not overused (resulting in extra costs being incurred) or underused (resulting in wasted resources). Managing demand involves developing approaches to support and incentivise the optimum utilisation of services by patients. Patients will be empowered to take more informed decisions about their treatment course and encouraged to take more responsibility for their care, which will impact on both demand and utilisation.

Patients will be empowered to take more informed decisions about their treatment course.

Monitoring Activity and Quality

Evidence suggests to be effective, practices will have to robustly monitor their activity and budgets. They will require timely information on the volume of services utilised by them, the quality of the services and what resource is being committed through new referrals and therefore what their likely budget outturn will be. They may then need to review providers to ensure that appropriate activity is undertaken to ensure they do not overspend. Through such monitoring, they will know whether a provider is delivering according to its contract and to an acceptable level of agreed quality. Quality markers might include, for example, length of stay in hospitals, re-admissions and patient reported outcome measures (PROMS). In-year emergencies such as a flu outbreak may require short-term agreements to adjust activity from elective to acute care.

Invoicing and Payment

Activity can be paid for only once it has been agreed and validated to confirm it is of sufficient quality and it is within the agreed range of activity. Contract challenges may be necessary if information cannot be validated or if

a provider unilaterally increases or decreases activity thresholds outside agreed tolerances or if quality is questioned, for example, through CQUIN.

User and Local Authority Views

Putting Patients First means that they receive high quality and up to date information on services to assist them in making real and informed choices. The Local Authority and the Health and Wellbeing Boards (or similar) will require information on services, particularly from their local HealthWatch.

Feedback

In order to manage their commissioning budgets, practices will require timely feedback on activity, quality and projected budget outturn. HealthWatch may also require regular feedback. The NHS Commissioning Board will also require data in the form of returns. Whatever feedback is provided it needs to come from a common source and format, so the appropriate comparisons can be made and administration complexities minimised.

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Patient and public engagement

Engagement with patients and public requires an ongoing, two-way dialogue. Feedback must be incorporated within every stage of the commissioning cycle; it is not a stand alone process. Chapter 4 of this guide goes into detail about how to work with local partners, including patients and public. GP Commissioners will need to build on their established engagement mechanisms to ensure that the patient voice impacts on their commissioning decisions.

Engagement with patients and public requires an ongoing, two-way dialogue.

Clinical input into commissioning

Individual GPs will have to be interested in the activity of their own practice, but may be less interested in getting involved in the organisation of the consortium itself. Some may wish to become the Accountable Officer and spend a significant amount of time in new management roles.

All clinicians will need to have knowledge of local services and patient needs that can influence most of the stages outlined in the commissioning cycle. However, they may not wish to be involved in the day to day management of commissioning. For example, whilst most clinicians will be interested in information relating to their population, they may not be interested in the data gathering process.



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Many clinicians will also be interested in service design and redesign, but the contracting process may be carried out by staff or organisations working for or on behalf of the consortium.

Although many of these processes are often referred to as 'back office functions', in practice, commissioning without them will ultimately lead to poor service or service failure.

These are vital components of commissioning, but are generally in short supply. They could be delivered across several consortia using existing staff, new shared services or through outsourcing to other organisations. Areas that might particularly benefit from this approach include:

- Health needs assessment (including geographical mapping of demography and health burden)
- Risk stratification – assessing the potential levels of risk of service needs of particular patients
- Writing contracts
- Contract negotiation (with clinical input)
- Analysing data and turning it into information
- Activity and quality monitoring
- Validation of data
- Financial management

...many of these processes are often referred to as 'back office functions', in practice, commissioning without them will ultimately lead to poor service or service failure.

Key messages

- A basic understanding of the commissioning process will become increasingly important, but no-one will be expected to do it all.
- There are experts who can help if you need it.
- All practices will have a responsibility to be involved in commissioning. There is a minimum level of engagement likely to be required to ensure success.
- Clinical involvement in commissioning may be anything from validating clinical activity information, to assisting in designing new service pathways through to becoming the Accountable Officer.
- Many clinicians have found involvement in service design exciting and rewarding.
- Practice Managers and the wider clinical team, including practice nurses and secondary care colleagues, should also consider how they might be involved in these processes.

Chapter 3

The essential building blocks of GP Commissioning

The previous two chapters have reviewed the background and some of the detail within the White Paper. This chapter explores a number of essential building blocks that will underpin effective GP Commissioning. It will give you an overview of these principles and suggest a number of areas for you to explore further in order to prepare you for what you need to achieve.



Chapter 3: The essential building blocks of GP Commissioning

Consortia should have a clear idea of their intended destination and a shared vision of what their success will look like.

Creating the vision

Consortia should have a clear idea of their intended destination and a shared vision of what their success will look like. It is worth spending time and effort in ensuring this vision is fully articulated and agreed upon by constituent practices with appropriate engagement from the wider group of stakeholders – there is often a paucity of detail describing the area between the vision and the detailed day to day service provision. Within this chapter we look at some of the building blocks to deliver the vision. At a high level the vision might say that the consortium wishes to improve outcomes, whilst operating within budget in a sustainable manner. But what would this look like on the ground? Ultimately it comes down to the relationship you have with your patients and your potential patients. By understanding the needs of your population, combined with the power of a clinically led commissioning process, there is the potential for the NHS to capture the best parts of its rich history, and deliver a future NHS that substantially exceeds the current service.

Effective GP Commissioning will be able to:

- Deliver better local services, that are more responsive to local needs.
- Provide services that have been genuinely designed in partnership.
- Use expertise of the public, patients and clinicians.
- Deliver effective planning for health services based on a true understanding of the population and their needs.
- Allow patients and the public to be better informed and more capable of taking ownership of their own health.
- Support clinicians to deliver the highest possible standards of care.

A consortium may wish to include a total population approach to planning where all patients within their catchment area are analysed and data used to model various commissioning scenarios. The commissioner then could choose to commission the scenario with the best outcome. This in turn would lead to the whole commissioning cycle improving in efficiency and outcome. A consortium may also wish to have automated systems in place that ensure they can check the right care was delivered to the right patient at the right time and at the right price.

Consortia may wish to consider how they support their clinicians to deliver better care. For example, by providing a supportive tool that puts context sensitive, evidence based medicine support at their finger-tips, enabling richer clinician-patient discussions and better outcomes. They would have access to locally designed services responsive to the needs of their patients that they have helped optimise, monitored to ensure their quality. A clinician would then be able to understand his performance and demonstrate his ability to deliver high quality outcomes at the press of a button, enabling outcome driven rather than process driven support and development, reducing stress and again driving improved results.

To deliver this, the right building blocks need to be in place. For example, strong leaders in high quality teams that communicate well with all stakeholders. Additionally, a health economy that has the right tools and capabilities to enable them to deliver for the populations they serve.

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Representation of practices

To understand the importance of representation within consortia it is important to understand some of the roles that the consortia may need to deliver as this is likely to shape the final model of representation. The key roles the GP consortia are likely to be required to deliver are shown opposite. Some of these functions are currently delivered by PCTs and will in future be delivered by the GP consortium. However, this does not mean that individual practices will have to deliver these functions.

To deliver the power of GP Commissioning, consortia will need to use the strength of clinical engagement. GP consortia will make decisions based on the needs and values of patients and local communities. You will be expected to work closely with secondary care, other health care professionals, and with communities to design services that meet the needs and expectations of local people.

Every GP practice, in order to hold a list of registered patients, will be required to be a member of a consortium. Whilst practices will have the freedom to form consortia as they see fit, they will need to have sufficient geographical focus to be able to agree and monitor contracts for locality-based services (such as urgent care), to have responsibility for commissioning services for people who are not registered with a practice, to commission services jointly with Local Authorities, and to fulfill effectively their duties in areas such as safeguarding. They will need to have boundaries that interlock so that they cover the entire country.

GP Consortia will be required to:

- Commission NHS services, including elective hospital and rehabilitative care; urgent and emergency care; most community health services; mental health and learning disability services;
- Determine health care needs;
- Determine service requirements to meet needs;
- Enter into and manage contracts with providers;
- Monitor and improve the quality of healthcare;
- Provide oversight of provider training and education;
- Manage budgets and establish priorities on meeting healthcare needs of the population;
- Meet all necessary reporting and audit responsibilities;
- Promote equalities and work with local authorities;
- Engage patients and the public.

GP Consortia will not be responsible for:

- Commissioning primary medical care;
- Commissioning of other family health services, such as primary dental services, community pharmacy and primary ophthalmic services;
- National and regional specialised commissioning.

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The NHS Commissioning Board will have the ability to assign practices to your consortium, if you do not voluntarily join one. There is no suggestion in the consultation documents or the White Paper that consortia will have the option to exclude practices that do not meet their participation criteria.

Whilst it is not critical that you are involved in every aspect of GP Commissioning, it is vital that you play an active part. If you are responsible for a patient list it is essential that you join your consortium. Do not wait for this to happen *to* you instead of *with* you. If you are not already part of a group – start to form these relationships now as they will have a huge impact on the future of your practice.

Each consortium will be a statutory body, with defined powers and authority. Within the organisational structure, there is likely to be a variety of alternatives for voting representation – ranging from votes based on registered population to one vote per practice to all varieties of weightings in-between. It will be up to your consortium to decide the organisational form that best meets its requirements as long as it is fit for purpose and ensures genuine representation.

Another issue will be the method for risk sharing among practices. It is clear that budgets will be developed by the NHS Commissioning Board at the practice level and that these practice-level budgets will be aggregated to establish your consortium budget. It appears that the consortium is the risk-bearing entity for variations from the overall practice budget. Each consortium will need to carefully consider its risk sharing agreements among practices to assure they offer incentives to improving quality and managing efficiency.

Whilst it is not critical that you are involved in every aspect of GP Commissioning, it is vital that you play an active part.

Key messages

- You will need to form or join a consortium, or the NHS Commissioning Board will assign you to a group.
- Consortia will be statutory bodies – you will need to decide what organisational structure and voting representation your consortium will take.
- Pay attention to how risk sharing is allocated amongst your practices and make sure it will deliver the outcomes needed for both practices and consortia by having the right incentives in place.

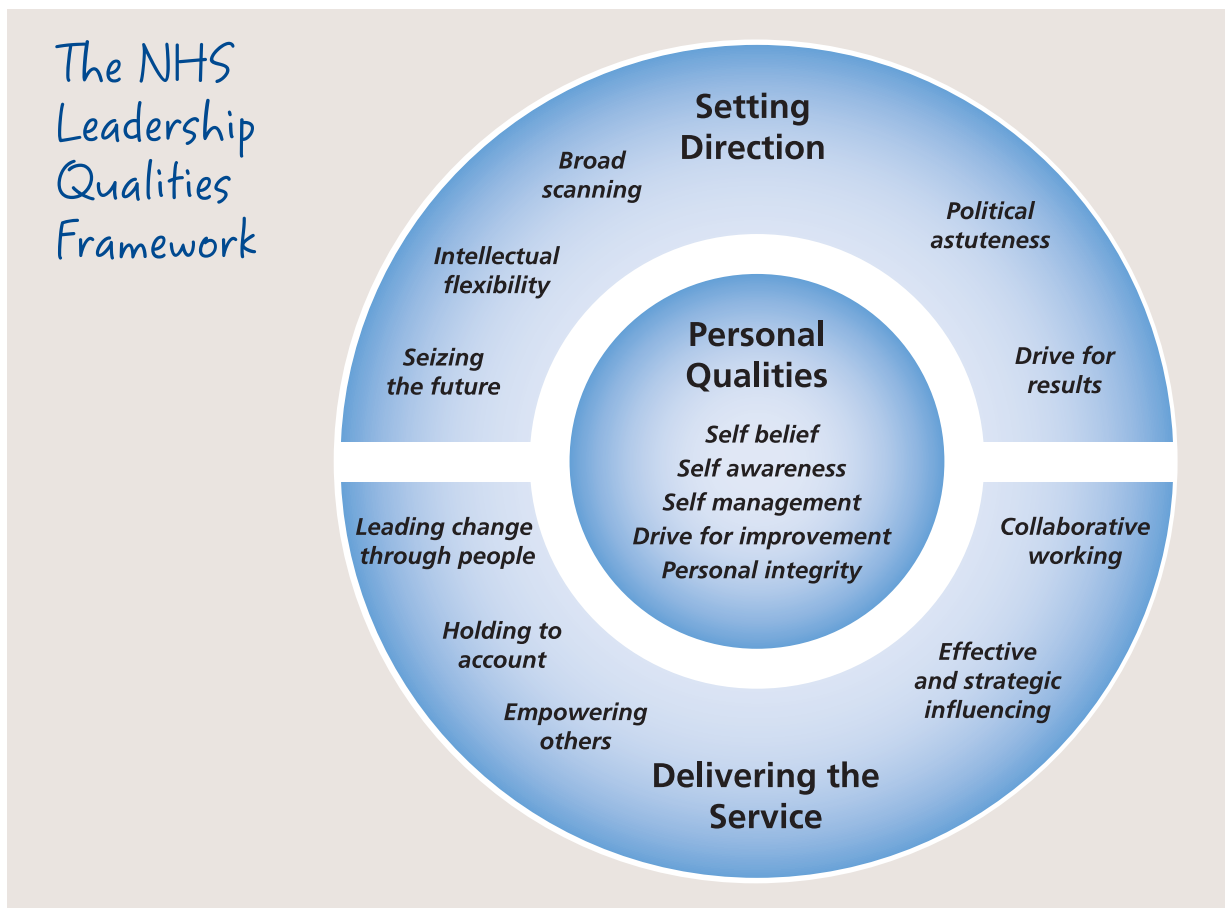
Chapter 3: The essential building blocks of GP Commissioning

Clinical leadership

Strong clinical leadership is a vital component of successful commissioning. The government's health reform agenda places responsibility for commissioning squarely in the hands of GPs, working together in consortia. This means that each consortium, alone and working with others, will be responsible for delivering:

- Improved health outcomes;
- Patient choice of treatment and provider;
- Reduction in health inequalities; and
- Achievement of financial balance.

Clinical leadership will be required at all levels of the NHS in order to deliver excellent patient outcomes, innovation, and value for money. Clinical leadership starts at a grass-roots level with leadership behaviours. This behaviour then permeates throughout the entire organisation. It is essential that there are suitable role models at all levels of the organisation. However, there will be unique requirements within each commissioning consortium. This is because the consortium will be responsible, not only for designing and delivering care, but also for



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working together with local partners in balancing conflicting priorities within finite resources.

In order to be successful, consortia will need to provide leadership, whilst at the same time engaging and encouraging leadership amongst colleagues in primary care, secondary care, community services and social care.

Commissioning consortia will require leaders who have skills, interest and commitment to both clinical service design and to delivering overall health improvement through well-executed contracts.

Leadership Frameworks

The NHS has published two frameworks for leadership: The NHS Leadership Qualities Framework and a Medical Leadership Competency Framework. The Medical Leadership Competency Framework is focused on clinical involvement in service design and delivery, whilst the NHS Leadership Qualities Framework involves broader capabilities. You may wish to explore these publications further to get a better understanding of the skills and expertise required.

The Medical Leadership Competency Framework



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The key hallmarks of successful leadership

A broad range of GPs who act as clinical leaders – with formal and informal responsibilities.

The range of requirements is large and challenging – from strategic planning in support of the Joint Strategic Needs Assessment, to assessing performance of acute trusts and holding them to account for achieving agreed objectives. In addition, GP leaders will be required to improve the performance of GPs as custodians of NHS resources, and to drive improvement to outcomes for patients.

A commitment to lead, challenge and drive performance in those around you.

A number of GPs have demonstrated very effective leadership in PCTs and/or in PBC organisations. There are a number of examples of GP leaders bringing together colleagues from all parts of the health economy in delivering improved outcomes and value for money. The trusted relationship between you and your patients results in an element of advocacy for meeting patient requirements, whilst understanding the need to manage the wider priorities that can serve the needs of whole populations.

A shared vision of the future health and social care economy.

This vision should be developed in conjunction with your patients, their carers, Local Authorities, consultant colleagues, other clinicians and local people. Each consortium will need sound strategies for delivering its shared vision and agreement on approaches for establishing priorities. Consortia will also need to lead the hard strategic implementation work and hold the entire health economy to account for delivery.

Understanding of the significance of your role.

By taking advantage of the skills, experience and interests of clinical leaders, the NHS improves its opportunity to work collaboratively with patients and local people to improve outcomes to match the best in the world. It is important that these clinical leaders have the appropriate skills and training to enable them to meet the challenges of the role. They will need to critically appraise their capabilities and seek to improve on gaps.

GP leaders will be required to drive improvement to outcomes for patients.

Key messages

- You will need to provide strong clinical leadership and encourage leadership amongst colleagues in primary care, secondary care, community services and social care.
- Explore publications such as the NHS Leadership Qualities Framework and Medical Leadership Competency Framework to get a better understanding of the skills and expertise required.

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Understanding budgets, data and risk

If you understand your budget in detail you will be able to maximise the opportunity for your patients, engage with your patients and drive a high quality and efficient service. Therefore it is essential that all those involved have a basic understanding of budgets, data and risk.

There are several types of risk that are inherent in health care. The Department of Health consultation document, 'Commissioning for Patients', describes two types: insurance risk and service risk.

Insurance risk

Insurance risk is described as “unavoidable and natural fluctuations in the healthcare needs of a population.”⁴ This means normal statistical variation across time and populations, as well as outbreaks of diseases, such as the recent experience with Swine Flu. The risk for normal statistical variation is generally managed by ensuring that the population size is large enough to reduce the impact of statistical variability. As the size of the population increases, the degree of normal variation around the mean decreases.

Research has indicated that the mean cost for a practice with 1,500 randomly selected patients could range from 85% of the expected cost to 125% of the expected cost based on random variability only. Whereas a practice of 5,000 patients would have substantially less variation, with the most expensive 10% of practices having mean cost of approximately 105% of expected, and the least expensive approximately 95% of expected cost. Obviously risk reduces the larger the population size, if all other factors remain

If you understand your budget in detail you will be able to maximise the opportunity for your patients and drive a high quality and efficient service.

unchanged. At an individual practice level random variation can still be exhibited outside of these ranges but the chances of this happening are reduced with larger population numbers.

There are many things that can have a serious impact on the need for health care. For example, environmental variability describes events that are unusual or unpredicted, such as an intense influenza season or serious weather event e.g. one that affects COPD. These types of risks can be mitigated through a variety of means such as top-slicing budgets to create an insurance pool or through stop-loss insurance.

Service risk

Service risk is described in the consultation document as controllable and attributable to poor prescribing or referral practices. Whilst poor practices certainly are a component of service risk, there are additional elements, such as:

- Consumer demand
- Local demographic changes
- Changes in unit price (tariffs)
- Lifestyle changes
- Changes in provider behaviours
- Cost pressures (e.g. new drugs/technologies approved by NICE)

These risks can be mitigated through high quality primary care; close collaboration among all care commissioners and providers (including social care); careful review of utilisation against budget; and innovative patient management approaches (such as telephonic care management).

As provider choice expands, patients and the public may make choices that ultimately affect the risk profiles of practices and consortia. It will be important for your consortium to hold to account GP referral behaviour, prescribing practices, and consultant behaviour in order to mitigate risk.

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Budgets

With the principle of 'no decision about me, without me' being key, the White Paper proposed that both the budget and risk are devolved as close to the patient as possible, placing it in the hands of the commissioners. This creates a situation where you can bring about real change coupled with taking full responsibility for the budget allocation and associated risk.

What is in...?

The NHS Commissioning Board will calculate practice-level budgets for registered and unregistered populations that will be allocated to consortia. It is unclear how the allocation formula will be crafted, but it is likely that the majority of commissioned services will be incorporated – for example A&E attendance, the majority of prescribing budgets, the majority of outpatient attendance, elective interventions, and acute admissions.

And what is out...?

Consortia will only be allocated elements of the budget that the GP commissioners can commission. This means it will exclude current GMS/PMS budgets. The White Paper states that this will be dealt with separately by the Department of Health who will overtime develop a new contractual and funding model. This model is likely to promote quality improvement, deliver fairness for all practices, support free patient choice and remove unnecessary barriers to new provision.

Other exclusions from the budget include public health funds, which will be ring fenced and transferred to Local Authorities. Other services will be centrally commissioned and funded: transplantation, primary ophthalmology, community pharmacy, dentistry and maternity services as examples.

How does risk relate to GP Commissioners?

At its simplest, the budget should be set to cover the health care needs of the population in question devised through a combination of patient demographics, disease burden and the costs of delivering healthcare for that population.

The challenge is to supply improved outcomes for that population within the allocated budget.

You will need to understand how you can safely manage the budget (and therefore the risks associated with that budget) to ensure that you can deliver sustainable commissioning. There are many ways of managing the budget and its associated risks. From a GP Commissioning point of view, it may be useful to consider two concepts:

1. The ability to influence the risk.

This is best described by an example. For COPD, over a twelve month period you will have a series of factors that will influence the rate of exacerbations for your population, such as the number of COPD patients and the weather. These will either be impossible to control (the weather) or relatively difficult to influence over a 12 month period (the number of patients with COPD, given the pathogenesis of the disease).

However, there are also a series of factors that you may have greater control over, such as how those exacerbations are dealt with, or preventative interventions to reduce exacerbations within your population. The biggest determinant of your ability to manage that risk will be your response to the demand. By understanding end to end pathways (and their outcomes) in detail, you will be able to highlight pathways of care that are either expensive; with little or no additional clinical benefit; or less effective than an alternative pathway costing the same.

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To be able to understand your population's need, design and utilise highly efficient pathways; you will need detailed data. You will also need the ability to share this data to influence and support other clinicians.

2. The predictability of risk.

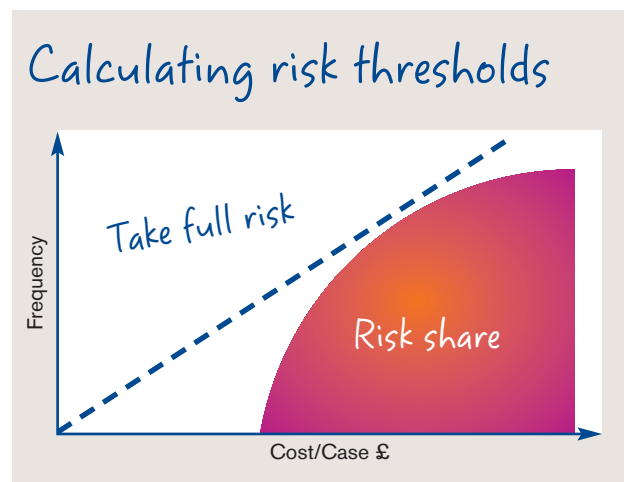
The predictability of health needs is complex. However, there are a number of sophisticated systems that can predict both an individual and a population risk of requiring a health intervention in the future.

These can be used to contribute to a picture of anticipated baseline healthcare spend. This baseline can be remodelled for new interventions and processes by commissioners.

GP Commissioners may wish to consider how they approach the risks of their populations, through effective risk stratification of their populations. This approach enables commissioners to ensure the delivery of services to keep their healthy populations health, supports those with illness to get healthier and for those with chronic disease; minimise the deterioration and manage the illness effectively. Various risk stratification models exist; GP commissioners need to ensure that the system they choose is capable of delivering accurate support, and developing with the commissioner as they take on greater responsibility.

When looking at the various systems available there are some questions you may wish to consider:

- **Value**
 - Does it tell you what is driving the risk?
 - Do you understand the future costs associated with the risk?
- **Technology**
 - Are the data input sources comprehensive enough to model effectively?
 - Is the system flexible enough to input various data sources as needed?
 - Does the system check and validate before modelling the associated risks?
 - Can the system input primary care data?
 - How far ahead does the predictive modelling work?
 - Has the system been calibrated for UK patients and with the ability to recalibrate based on additional data sources?
- **Usability**
 - How easy is the system to implement?
 - Is the system easily accessible to all those who may wish to use it with appropriate privacy and security safeguards?
 - Is the user interface intuitive but with the ability to drill down as needed?



The accuracy of risk prediction decreases the smaller the population and it is important that you understand the process in detail to enable risk sharing and pooling. An event that is common and low cost has a high degree of predictability around its budget and the risk can be safely devolved. An event that is rare and high cost has a higher degree of risk and is harder to devolve. This can be represented graphically, with the curved line, as above, representing a particular consortium's threshold for risk sharing.

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Simple statistics will determine the probability of any one event occurring, with suitable confidence intervals, but this needs to be amassed for every potential event so you can understand the risk and the opportunities for planning and prioritisation.

To ensure that a consortium is capable of safely carrying a budgetary risk, it must share risk with other consortia or organisations on what it cannot safely cover with its own reserves. The exact level of this is dependent on the degree of risk – most commonly a factor of consortium size.

Within a consortium it will be important to incorporate risk sharing amongst constituent practices. This will ensure that they feel ownership over budgets that they can influence, without being penalised for spend outside their control. To set these thresholds, consortia will need to have a detailed understanding of the data, and develop robust risk adjustment mechanisms which promote holding GPs accountable for the costs within their control. It is important to recognise that the success of the consortium will rest on the ability of the constituent practices to effectively manage the care of their patients. There will inevitably be differences amongst the practices (and individual GPs) in their ability and skills to do so. Therefore, consortia will need to have strong monitoring, mentoring, and governance structures to address such differences.

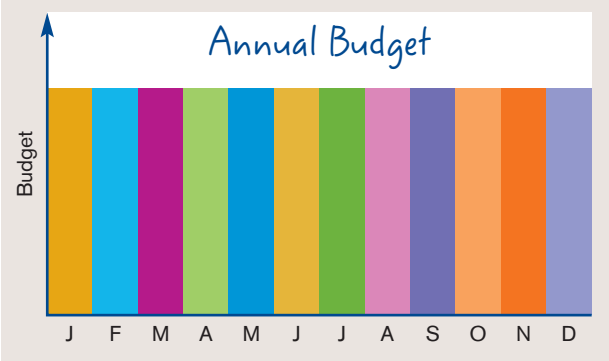
Key messages

- It is possible to accurately assess a population risk and control and manage this risk.
- You need to understand the risk as it will prioritise your efforts.
- An understanding of risk is a key tool in determining your key commissioning decisions.

Financial control

Budgets will undoubtedly be at the forefront of your mind, with a very clear need to maximise the health outcomes but also keep within budget. Financial control is about a lot more than pure budget control. True financial control capabilities will not only allow you to manage your budget, but will allow you to employ sophisticated health planning.

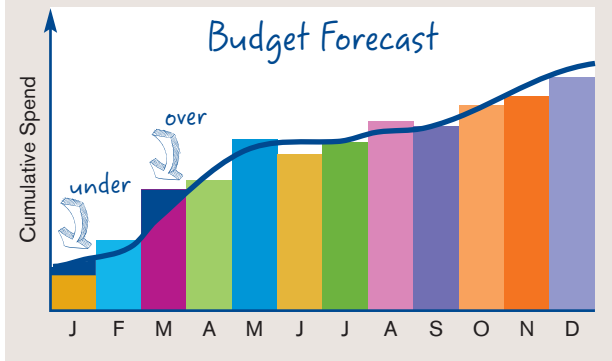
A simple view of monthly budgeting



At a high level, you need to understand what budget you have to spend and how you are performing against budget. You will also need the ability to budget forecast accurately and adjust spend to keep within budget. In order to achieve this, it is important to allocate the annual budget to take into consideration events such as seasonal peaks in certain diseases.

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Real activity varies throughout the year



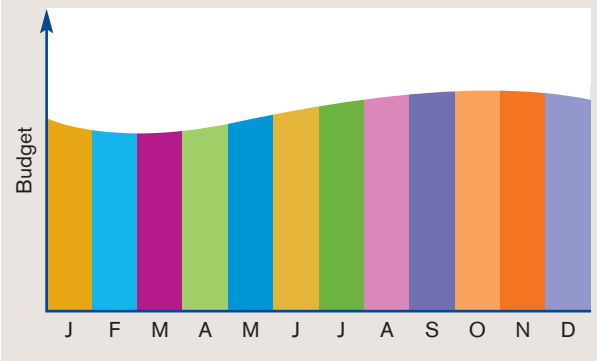
As consortia build up increasingly sophisticated mapping of both total budget and sub-divisions within that budget, they will improve the ability to track budgeted costs to actual expenditures. The ability to drill down either at a specialty level or at a programme budget level (for example, looking at the whole of cardiovascular disease as a programme budget) is critical for both financial control and for healthcare planning. This creates a more elaborate picture that enables you to make the best decisions for your population. A full understanding of the budget is also critical to effectively engaging with patients.

Once a baseline budget has been determined, you will need to understand how actual spend is tracked and how budget forecasting can be developed and monitored. It will be important to perform this function allocation at both the consortium and the practice level.

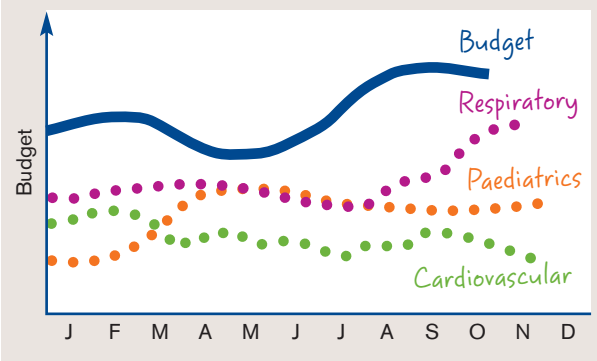
It is at this point that risk-sharing arrangements should be agreed. In general, the risk sharing may be at the individual patient level and/or at a population level. Taking both historical spend and an actuarial approach here is essential, along with incorporation of your predictive risk modelling. For example, practices could agree that any patient who incurs costs greater than

£20,000 in a twelve month period would have all costs in excess of the £20,000 paid from a shared pool of funds set aside for this purpose.

Budget variance by month



Detail budget analysis by month



To ensure that you can keep within budget, you will need to have the capabilities to track spend and to ensure that you are paying providers appropriately through some form of acute invoice validation and checking. You may wish to look at how some of this function can be automated, to ensure the greatest value from clinician input.

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As you develop, you may wish to look at systems that ensure that you only pay for what the provider delivered, as well as the appropriateness of that intervention. In essence, you want to move to a system of ensuring that your patient gets the right care from the right person in the right place and at the right time. This may be through clinician support systems that help clinical teams follow local and national evidence based guidance and commissioning decisions.

Budget forecasting can be a key driver in supporting clinicians and commissioners, and clearly the more timely the data the more useful it is. Hospital data and invoicing can be up to three months delayed from the timing of the episode, resulting in a greater disconnect for the clinician and a substantial lag time in budget forecasting.

You might wish to consider systems for tracking referrals, admissions and provider attendances in near real time to build up a picture in advance of receiving an invoice. This process would also tie in with clinical intervention systems that allow a far more proactive management of patients. This also provides you with information that is closer in time to the clinical decision, enabling better feedback and understanding.

Financial control has to work at all levels of the budget. You need to ensure that all components are working within budget and that early warning signs can be spotted, allowing you to make adjustments. For this to function effectively, it is essential that you have the ability to not only view budgets and spend by speciality and by programme budget, but also by constituent practice. This would ensure that underspend in one area does not mask significant overspend in other areas. This will ensure commissioners are able to respond to budgetary pressures in a timely manner, preventing further slippage.

Financial control is intrinsically linked with clinical behaviour as the data that supports good outcomes is the same, i.e. healthcare activity. Providing better data can assist

clinicians to make better clinical decisions, can help reduce inappropriate clinical variation and this in turn can deliver better financial control. This can be illustrated by an example: you are informed that your patient has attended out of hours once and A&E twice in the last 3 days. You proactively review that patient to understand what is going wrong, potentially preventing an acute admission to hospital. This not only results in better care for your patient, but it also has a significant cost saving for the health economy.

Finally for the data and information to be of value to both commissioners and clinicians on a day to day basis, it is crucial that the systems are accessible. The NHS has to drive considerable healthcare efficiencies over the next few years; therefore all staff must have the ability to be engaged with the process. Ownership and understanding of the budget will drive innovation and highlight the fact that maximising the care given within the allocated budget is the responsibility of all.

Don't be put off by the apparent complexity of these tasks. Your consortium should deliver these services for you, so get involved early to make sure they do.

It is essential that you have the ability to not only view budgets and spend by speciality and by programme budget, but also by constituent practice.

Key messages

- Understanding budgets is critical to both financial control and healthcare planning.
- Accurate timely data and information is key to providing you with clinical support as well as financial control.
- By using data and budget information it is possible to engage a wider team into the process.

Chapter 3: The essential building blocks of GP Commissioning

Help with commissioning functions

Commissioning covers a broad range of functions, as outlined in chapter two. You are going to have to deliver high quality commissioning capabilities to ensure that you effectively serve your patients and public.

You will have to make choices on commissioning support based on a multitude of factors. Getting this part of the decision-making right will be key to your success. The first thing to recognise is that this is not a one size fits all scenario – each consortium will need to go through a process themselves – and whilst there will clearly be core functions and capabilities, the relative priorities applied to these will vary. You may wish to get support to guide you with the decision-making process.

The White Paper indicates that whilst clinicians will be leading the consortia, you will not have to deliver all of the functions yourselves. The expectation is that you will lead a team to deliver commissioning and the White Paper gives you a wide range of options for sourcing support. You could deliver functions yourselves, or with employed staff, or get support from “external organisations, including Local Authorities, private and voluntary sector bodies”.²

A recent King’s Fund Report concluded that “if used appropriately, external support can play a role in raising the standard of commissioning in the NHS, and in doing so help the system to achieve the improvements in quality and productivity needed over the coming years.” They recommended that external support was best used to proactively help commissioners develop their strategic vision and bring new skills, tools, processes or support transformational change.

As a first step when looking at commissioning functions, GP consortia will need to understand and articulate their functions. They may wish to prioritise them as core, shared and optional or lower priority functions. For each consortium, the pressures and capabilities will vary to some degree and, dependent on their local needs, they may wish to assign a greater urgency or investment in some areas over others. It is also important to recognise that the functions and their priorities may well change over time as a consortium develops and more functions are taken on.

The next step will be for consortia to assess their in-house capabilities and whether they are fit for purpose.

“if used appropriately, external support can play a role in raising the standard of commissioning in the NHS, and in doing so help the system to achieve the improvements in quality and productivity needed over the coming years.”

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Three areas that your consortium may wish to look at are:

1. Is the capability in-house able to deliver to the requirements of the consortium?

Is your in-house system capable of delivering the service in a way that allows you to function to a high standard, in a timely manner, or the converse, will it be a weak link that could undermine commissioning function?

If the in-house service is fit for purpose, you will need to satisfy yourself that it is the most efficient way of delivering that service within what is likely to be a restricted service. To a certain degree, you will also need to decide how much staff risk and overhead you wish to carry – with associated human resources, payroll, sickness absence, etc and be aware that where resource is a TUPE transfer from the existing NHS bodies, these contract terms and conditions are protected.

2. Are there support services that we need to procure or develop?

Having decided what in-house capabilities you currently have, you will need to decide what services, if any, you wish to buy in (either short or long-term) and what services you wish to develop in-house (again both short and long-term). An efficient commissioner may wish to not only look at the headline costs, but also at the wider picture. A highly effective service may cost more, but may in turn save more. Clearly when looking at these complex returns on investment, the degree of

risk share and contractual arrangements may well be critical in determining the right choices for your consortium.

3. What support can my stakeholders provide? (And can I provide to them?)

In addition to direct commissioning support, you may wish to consider how to build and develop relationships with other stakeholders within the system. Relationships with Local Authorities and, through them, Public Health Services are going to be key, as are relationships with providers. There may be opportunities for collaborative working, both with stakeholders, but also with their support services – for example co-ordination of legal support on shared projects, where appropriate.

The White Paper opens up the opportunity for you to get the best possible support for commissioning and many sectors will wish to assist with this. Some of the market may wish to engage innovatively with you to develop long-term relationships that move towards sharing risks, developing new solutions and driving innovation and service improvement. It is likely that there will be a wide range of models of support available and you will need to choose relationships and systems that suit you and your patients. It may be that for some products or support services, simple contractual or in-house arrangements work well. Other systems may require longer term arrangements based on solid relationships, understanding and risk share. Whatever methods you choose to adopt, it is clear that there is considerable expertise from a wide range of sources.

Key messages

- Understand what you can and cannot do – get help finding this out if you don't know.
- Plan and prioritise what you need to do now and what capabilities can be developed in future.
- Seek help from your colleagues, partner organisations or external agencies to supplement your expertise where necessary.
- Explore the various options and solutions available to you to ensure that you get the support you need to deliver results.

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There are a wide range of options and models of delivery available to you that will help to ensure your success.

What does this mean?

- You need to develop and grow strong clinical leadership within your own practice and amongst your partners.
- You need to understand your own capabilities and requirements in detail.
- Assess your requirements and look at the most efficient way of effectively delivering those services.
- There are a wide range of options and models of delivery available to you that will help to ensure your success.

Identify key GP leaders who are interested and willing to devote time to this endeavour.



What should you do now?

- Meet with practices in your area to talk about opportunities for forming a consortium, including issues and risks.
- In conjunction with other practices, meet with PCT leaders to discuss planning to transition commissioning responsibilities to GP consortia.
- Identify key GP leaders who are interested and willing to devote time to this endeavour.
- Review existing data to understand current population cost and utilisation characteristics and understand gaps in existing data sources.

Chapter 4

Working together

GP Commissioning Consortia will need to work with colleagues in the wider NHS and social care to deliver a better patient experience, higher quality care and more efficient use of NHS resources. Your consortium will be required to work in partnership with Local Authorities and you will need to engage with your patients and local communities.



Chapter 4: Working together

This chapter describes the key partnerships needed to be created to ensure the success of GP Commissioning.

It sets out how through effective engagement of stakeholders, you can achieve real change and improvement across the health care system, whilst working together in a consortium or forming relationships across a wider geographical location. Building these relationships will be fundamental to the success of your consortium.

The chapter gives some examples for how such relationships can be developed and effective partnerships built.

It also describes the role of the Accountable Officer, his responsibilities and prime objectives, and how this role should be discharged in a spirit of partnership with people working within the health service, Local Authorities, community and voluntary groups, patients and the public, and their leadership role in relation to the Commissioning Board.

...through effective engagement of stakeholders, you can achieve real change and improvement across the health care system, whilst working together in a consortium or forming relationships across a wider geographical location.

Inclusive commissioning

GP Commissioning provides an exciting opportunity to secure a health service, which is based on population need and designed around patients, maximising health and wellbeing. However, in order to deliver this service, it is essential to build and nurture strong partnerships across the health and social care system, as well as with patients and the public.

Commissioning will need to be inclusive at all levels and throughout the commissioning cycle. This will require robust involvement of patients, the public, Local Authorities, community and voluntary groups, as well as clinicians from across the system – for example District Nurses, Health Visitors, Therapists, Community Pharmacists, Secondary Care Consultants and other specialists.

This partnership begins at practice level, with the need for a well functioning primary healthcare team. Team members from across traditional primary and community health services should be involved in developing an understanding of patient needs and how these needs should be met.

You can develop this understanding through analysis of your practice clinical information systems, which are a rich source of data. Community health services clinicians will also have a wealth of knowledge about practice patients. Practices may already have patient groups with whom to test ideas and gain insight into how services can be improved. You could consider drawing on these sources of knowledge together with intelligence from local community and voluntary groups to gain a more accurate view of patient experience, which in turn will lead to better commissioning decisions.



Chapter 4: Working together

For smaller practices, partnership may involve working across local practices where teams of community health staff are shared. This could lead to a 'neighbourhood' approach, developing greater knowledge of local services to support patients' wellbeing.

Formal patient involvement in decision-making will be essential. Whilst the relationship with HealthWatch will be key (see later in the chapter), each consortium will also need to have structures in place for on-going dialogue with patients to ensure effective needs assessment, that services are designed around patients and that they actually deliver what is intended.

In order to have access to this broader expertise, consortia may wish to develop relationships with specialist and other health care providers, working with them to design services. Given the requirement for competition, it will not be in order to give exclusivity to any one provider, rather to ensure that the necessary knowledge is built into pathway design from the outset.

Consortia should give consideration to developing their service models, for example Service Improvement Partnerships, with both existing and potential future providers. This will help generate dialogue between GPs, community and secondary care colleagues to design care pathways, which will maximise return on both health and resources. By creating clinically-led redesign services you will produce a system that enables patients to make effective health choices. This will lead to improved outcomes and a sustainable system.

Securing 'choice' of provider for patients will be a key part of consortia. However, this does not prevent consortia working with providers to develop new services.

Key to effective partnership will be relationships across the health system. These relationships take time to build, nurture and manage.

However, there will already be strong foundations in many areas, with GPs and other clinicians already in place. In other words, commissioning should be multi-professional, with the appropriate skills and expertise drawn in throughout the commissioning cycle. These relationships will be critical for the success of GP Commissioning.

Key messages

- GP Commissioning will need to be inclusive commissioning, working in partnership with patients, the public, Local Authorities and across the health system.
- Start with strong foundations – review partnership working within your own practice and strengthen or develop relationships across the primary health care team, where necessary.
- Develop a 'neighbourhood approach' – draw on the expertise and knowledge of your local partners and share your information with them for a holistic approach to care.
- Consider structures for on-going dialogue with patients – these could build on existing practice patient groups, or require their establishment.
- Consider establishing Service Improvement Partnerships with secondary care and other health care providers, to develop care pathways and engineer service developments.
- You may already cultivate excellent relationships with your local partners – if not, find out who they are and start this as early as possible to give you the best possible start to building or developing your consortium.
- Relationship building will take time – but will be worth the investment.

Accountable Officer

Each consortia will be required to have an Accountable Officer, who may be a GP. The Accountable Officer will be pivotal to developing relationships both within the consortium, and between the consortium and key partners. This will include the building of relationships with:

- The NHS Commissioning Board
- The Local Authority Health and Wellbeing Board
- Providers of Health Care
- Patients and the Public

The role of the Accountable Officer is likely to include:

- Providing organisational oversight;
- Working with the NHS Commissioning Board including to review healthcare providers' training and education plans;
- Ensuring that expenditure does not exceed its allocated resources;
- Ensuring value for money is achieved from the resources available;
- Ensuring adherence to requirements in relation to reporting, audit and accounts;
- Other statutory duties in relation to equality, human rights, data protection and freedom of information.

Your Accountable Officer will need to ensure that your consortium has effective management systems in place that safeguard public funds, assist in the implementation of corporate governance, and enable statutory duties to be fulfilled. Many of these functions could be provided by external organisations – including social enterprise or private-sector organisations. (The range of options on this is covered in Chapter 6.)

Your Accountable Officer will need to ensure that your consortium has effective management systems in place that safeguard public funds, assist in the implementation of corporate governance, and enable statutory duties to be fulfilled.

Key messages

- Your Accountable Officer will help cultivate the local and national relationships you will require for effective commissioning.
- The Accountable Officer will have responsibility for important oversight and scrutiny roles.
- The Accountable Officer will need to have an eye for detail and specific capabilities to deliver this role effectively. These may need to be developed.

Chapter 4: Working together



HealthWatch and LINKs: Strengthening Public and Patient Involvement

Comprehensive local engagement is critical to ensuring that services are designed and developed around patient need. In *'Liberating the NHS'* the government is planning for people to have a greater say in decisions affecting their health and social care and in influencing service design. Working in partnership to deliver real health improvements by strengthening patient and public involvement through improved choice, control and better information is central to many of the proposals contained within the various consultation documents.

Relating to locality and your public

Designing services around the needs of individual patients provides the foundation of much of the government's health reform. The *'Local Democratic Legitimacy in Health'* consultation proposes a structure to begin building this foundation. The purpose of the new structure is to strengthen the voice of patients and create a stronger role for locally elected officials in commissioning health services for their populations. The government lays out three broad goals for local reform:

1. Strengthening public and patient involvement;
2. Improving integrated working; and
3. Enhancing Local Authority leadership for health improvement.

Building on current statutory arrangements the government intends to develop a more powerful and local infrastructure in the form of Local HealthWatch organisations, supported by HealthWatch England, which will strengthen the collective voices of patients and the public in being able to ask, challenge and intervene. This will be achieved by transforming Local Involvement Networks into Local HealthWatch organisations and ensuring there is one in every area across the country.

Local Involvement Networks (LINK) began in April 2008 and are networks of local people and

Proposed HealthWatch functions

Ensure that views and feedback from patients and carers are an integral part of commissioning across health and social care and act as local community champions.

Chapter 4: Working together

groups helping to make a difference by giving people an opportunity to have a say on how health and social care services are planned, delivered and reviewed. They will also be able to hold their local health and social care services to account. Existing LINks will evolve into the new Local HealthWatch organisations and will act as local consumer champions across health and social care. This expanded role will give them greater influence and give health and social care consumers an even stronger voice.

HealthWatch England will be set up as an arm of the Care Quality Commission to represent people at a national level using health and social care. It will provide national leadership and support to Local HealthWatch organisations. Additionally, HealthWatch England will identify concerns, make recommendations and ensure action is taken.

You will have a duty to public and patient involvement and will need to establish relationships with your Local HealthWatch organisations to ensure they are engaged in all stages of commissioning. Local HealthWatch will in turn provide you with evidence about local communities and their needs and aspirations in order to design and develop services. You will not be able to do this alone and it is essential to start developing or strengthening your relationships with your local LINks as soon as possible.

When will this happen?

- Local HealthWatch and HealthWatch England will be in shadow form by Autumn 2011 to support LINks to become HealthWatch organisations.
- Local HealthWatch and HealthWatch England will be up and running by 2012.

...deliver real health improvements by strengthening patient and public involvement through improved choice, control and better information...

Ability to report concerns about the quality of local health and social care services to both their Local Authority and to HealthWatch England.

Commissioned and accountable to the Local Authority – Local Authorities will be responsible for holding Local HealthWatch accountable for delivering services that are effective and value for money.

The responsibility for complaints advocacy services will be devolved to Local Authorities to commission through Local or National HealthWatch to provide advocacy and support for people who want to make a complaint.

HealthWatch England, the national body, will provide advice, support and leadership to the Local HealthWatch organisations and will be located within the Care Quality Commission.

HealthWatch England will provide advice to the NHS Commissioning Board, Care Quality Commission and regulators.

Chapter 4: Working together

Local Government Structures: Improving integrated working

By proposing a new role for local government in health system design, the government attempts to integrate care by 'building services around people instead of institutions'.⁵ In order to cement the power of the Local Authority, the government will encourage local communities to create statutory 'Health and Wellbeing Boards' – either within Local Authorities or existing strategic partnerships.

These boards will forge strong links with NHS Commissioners and jointly influence and shape strategies for local health improvement, social care and the provision of NHS services. Their membership would be determined by local elected officials. GP Commissioning Consortia will have a duty to work in partnership with Local Authorities – in particular regarding health and adult social care, early years services, public health, safeguarding, services for carers (and to cooperate with Local Authorities and other agencies in relation to criminal justice).

Specifically, boards will work with local GP commissioners to:

- Perform the statutory joint strategic needs assessment;
- Promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care, and public health;
- To support joint commissioning and pooled budget arrangements, where all parties agree this makes sense; and
- To undertake a scrutiny role in relation to major service redesign.⁶

The Government will simplify current joint working arrangements to enable effective partnership-working. Organisations will be expected to draw upon the experience and expertise of all public health partners; voluntary sector organisations, charities, academic and commercial partners.

The focus will be to create strong, multi-disciplinary teams with a detailed knowledge and understanding of the needs and requirements of their local individuals, families and communities. This is absolutely critical to the success of the new consortia.

Health and Wellbeing Boards or their local equivalent will be key to your ability to understand the health characteristics – and risks – of the population.

Health and Wellbeing Boards or their local equivalent will be key to your ability to understand the health characteristics – and risks – of the population. Whilst you may commission services to just a subset of this wider population, you will need to understand the context to make accurate and effective commissioning decisions. This will be especially important as patients will have an increased ability to change practices. Similarly, external organisations will be dependent upon your commissioning decisions in order to achieve many of the larger health improvement goals that they hold for the wider population.

You should therefore consider the most effective mechanism to participate fully in this area of work. Where more than one consortium covers a Local Authority area, you may wish to consider collaborating with local consortia to ensure maximum effect.

In order for you and your local partners to be ready to meet your new responsibilities, organisations and individuals need to have the right tools, techniques, knowledge and expertise. This will mean investing in new technologies and tools; developing or sourcing strong contract negotiation and management skills; understanding social psychology and behavioural economics; and forming or strengthening long-term partnerships with local stakeholders in public health.

Chapter 4: Working together

Public Health: Enhancing Local Authority leadership for health improvement

The government has declared that to 'have a fighting chance of meeting new demand in the years ahead, we have to get to grips with the real drivers of demand on our NHS now'.⁷ This means a shift from the current paradigm which focuses on treatment of ill-health to one which encompasses an emphasis on health promotion measures.

A new National Public Health Service will be created to streamline existing health improvement and protection bodies and to protect and improve the health and wellbeing of the population. The Public Health Service will deliver a national strategy for health improvement, ensuring a unified approach to public health and maintaining responsibility for public health emergencies.

Whilst the Public Health Service will provide national leadership, the government recognises that there are wider determinants of ill-health; such as poor housing, poor education, unemployment and family circumstance. Local Authorities will therefore become responsible for local health improvement, with the aim of providing a cohesive, holistic approach to public health. Services will be integrated with areas already managed by Local Authorities such as adult social care, children's services (including education); disability services, housing, crime and disorder. Responsibilities will also include leading on the Joint Strategic Needs Assessments across health and local government services.

Local Authorities will be allocated a ring-fenced public health budget to deliver these objectives and a Director of Public Health will be appointed by each Local Authority, with statutory duties to the Public Health Service. Driven by an in-depth understanding of their local community, the Director of Public Health will deliver on local health improvement requirements, as well as localising and implementing national campaigns set by the Public Health Service. New measures will be created that are based on improvement of outcomes and reduction in health inequalities, rather than volume-based targets.

...a shift from focusing on the treatment of ill-health to an emphasis on health promotion measures.

Key messages

- Local LINKs networks will become HealthWatch – a valuable partner to help you strengthen patient and public involvement in commissioning.
- Local government structures will be redesigned to facilitate improved partnership working. Without these relationships you will not be able to commission the right quality care for your patients.
- A new, national Public Health Service will drive improvements in the health and wellbeing of the population. You need to link in with local Health and Wellbeing Boards (or similar) in order to influence and shape this strategy for better health.

Chapter 4: Working together

What does this mean?

- Each GP Commissioning Consortium will need to develop relationships and build effective partnerships.
 - Each GP Commissioning Consortium will need to ensure that their commissioning is inclusive, drawing on the skills and knowledge of patients, clinicians from across the system, and others.
 - Each GP Commissioning Consortium will be required to have an Accountable Officer. The Accountable Officer will be responsible for ensuring that the consortium fulfils its statutory duties.
 - Locally elected officials will establish and appoint members to statutory Health and Wellbeing Boards (or some alternative partnership structure).
- Boards will be responsible for the joint strategic needs assessment and will facilitate joint commissioning between GP consortia and social services. They will also perform a scrutiny role over local services.
 - Local Authorities will appoint a Public Health Director jointly with the new Public Health Service. Directors will be accountable both to the Local Authority and the Secretary of State for Health.
 - GP commissioners will need to develop strong relationships with Health and Wellbeing Boards to accurately understand the health characteristics and risks of the population for which they purchase care.

When will this happen?

- New Local Authority, Health and Wellbeing Boards and HealthWatch in place by April 2012.
- Public Health Service with ring-fenced budgets and local Directors of Public Health in place by April 2012.

New Local Authority, Health and Wellbeing Boards and HealthWatch in place by April 2012.

Consider the skills and tools that will be necessary to help you gather accurate and timely information about the health of the patients you serve.

What should you do now?



- Find out what the current structures are for partnership working across the health system.
- Understand the current arrangements for involving patients in commissioning and service redesign – at practice, PBC Group and PCT levels.
- Find out what local organisations exist in your area (LINKs, Patient & Carer Groups, Local Authorities, Representative Groups) and how they are responding to the consultation and proposed changes.
- Engage with your local LINKs group during the consultation process and provide support during the transition process. Where possible, use existing patient groups within your practice to feed into LINKs. Continue to engage the public through HealthWatch.
- Engage with your Local Authority to develop an 'ideal' Health and Wellbeing Board.
- Work with GP and specialist colleagues to establish a way to interact with the Board to get the information you need to commission care for your current and future patients.
- Consider the skills and tools that will be necessary to help you gather accurate and timely information about the health of the patients you serve.

Timeline



Chapter 5: Timeline

Commitment	Date
Health Bill introduced in Parliament	Autumn 2010
Further publications on: <ul style="list-style-type: none"> • vision for adult social care • information strategy • patient choice • provider-led education and training • review of data returns 	By end 2010
Separation of SHAs' commissioning and provider oversight functions	
Public Health White Paper	Late 2010
Choice for: <ul style="list-style-type: none"> • care for long-term conditions • diagnostic testing, and post-diagnosis 	From 2011
White Paper on social care reform	2011
Patient choice of consultant-led team	By April 2011
Shadow NHS Commissioning Board established as a special health authority	April 2011
Arrangements to support shadow health and wellbeing partnerships begin to be put in place	
Quality accounts expanded to all providers of NHS care	
Interim arrangements for Cancer Drug Fund established	
Choice of treatment and provider in some mental health services	From April 2011
Improved outcomes from NHS Outcomes Framework	
Expand validity, collection and use of PROMs	
Develop pathway tariffs for use by commissioners	

Chapter 5: Timeline

Commitment

Date

Quality accounts: nationally comparable information published	June 2011
Report on the funding of long-term care and support	By July 2011
Hospitals required to be open about mistakes	Summer 2011
GP consortia must be established in shadow form	2011/12
<p>Tariffs:</p> <ul style="list-style-type: none"> • Adult mental health currencies developed • National currencies introduced for critical care • Further incentives to reduce avoidable readmissions • Best-practice tariffs introduced for interventional radiology, day-case surgery for breast surgery, hernia repairs, and some orthopaedic surgery 	2011/12
NHS Outcomes Framework fully implemented	By April 2012
<p>Majority of reforms come into effect:</p> <ul style="list-style-type: none"> • NHS Commissioning Board fully established • New Local Authority Health and Wellbeing Boards in place • Limits on the ability of the Secretary of State to micromanage and intervene • Public record of all meetings between the Board and the Secretary of State • Public Health Service in place, with ring-fenced budget and local health improvement led by Directors of Public Health in Local Authorities • NICE put on a firmer statutory footing • HealthWatch established • Monitor established as economic regulator 	April 2012

Chapter 5: Timeline

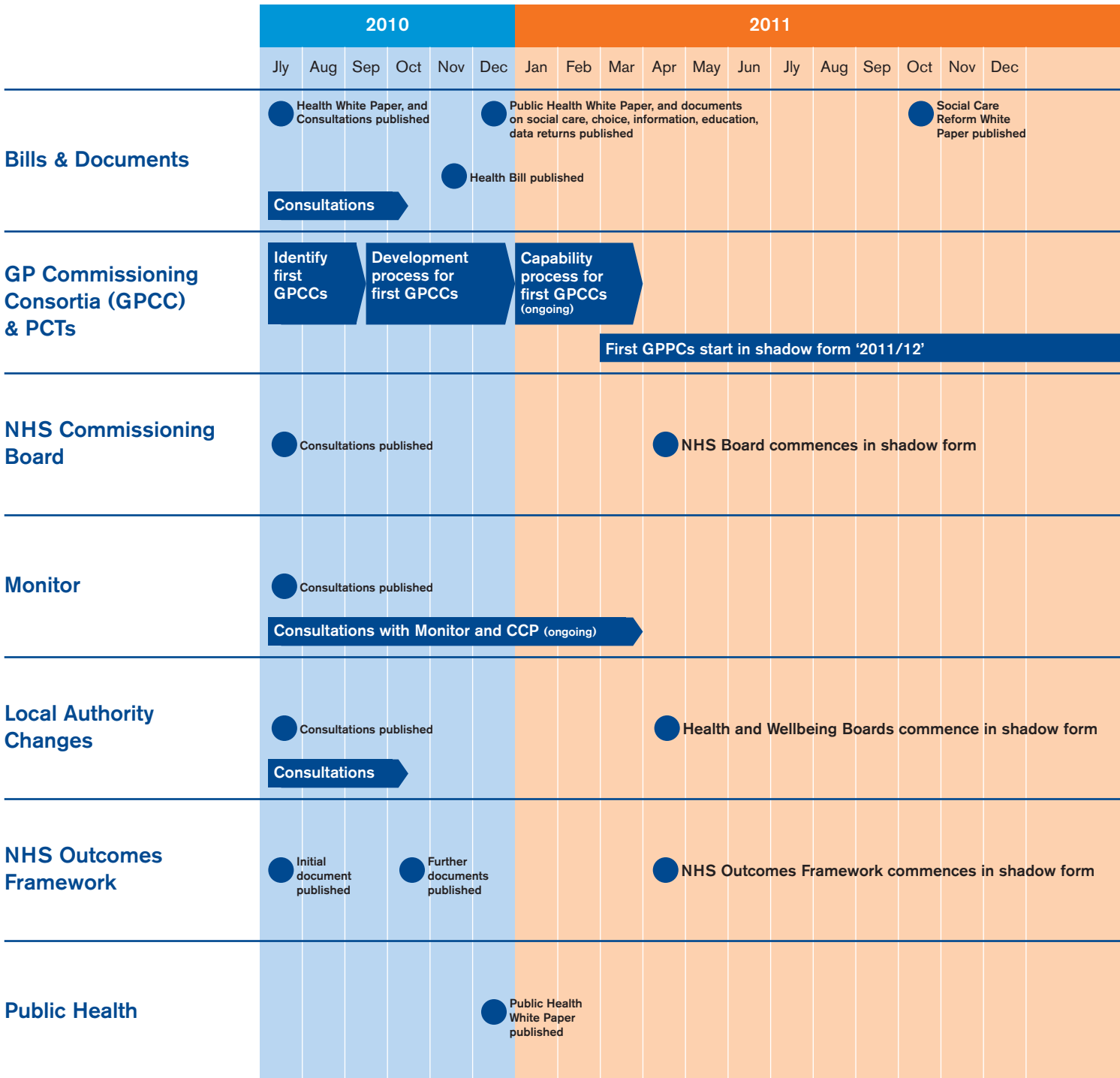
Commitment

Date

International Classification of Disease (ICD) 10 clinical diagnosis coding system introduced	From 2012/13
NHS Commissioning Board makes allocations for 2013/14 direct to GP consortia	Autumn 2012
Free choice of GP practice	2012
Formal establishment of all GP consortia	
SHAs are abolished	2012/13
GP consortia hold contracts with providers	April 2013
PCTs are abolished	From April 2013
All NHS trusts become, or are part of, foundation trusts	2013/14
All providers subject to Monitor regulation	
Choice of treatment and provider for patients in the vast majority of NHS-funded services	By 2013/14
Introduction of value-based approach to the way that drug companies are paid for NHS medicines	
NHS management costs reduced by over 45 percent	By end 2014
NICE expected to produce 150 quality standards	By July 2015

Chapter 5: Timeline

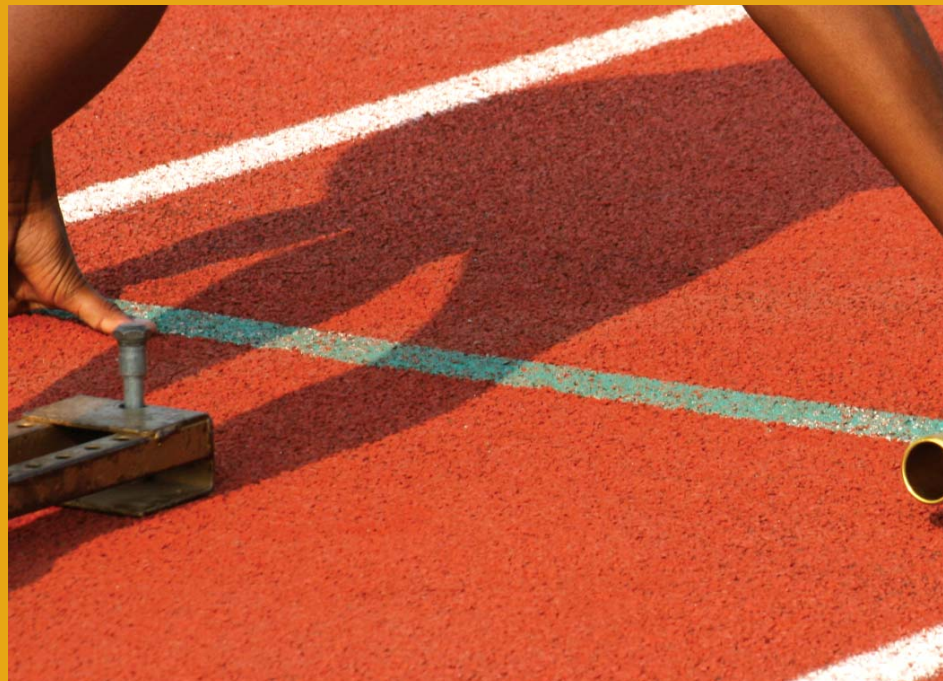
The timeline comes from the White Paper and its supporting consultation documents.



Chapter 6

How can we start now?

There is a requirement for every GP practice to be part of a consortium and to contribute to its goals; it does not mean that all GPs, Practice Nurses and other practice staff have to be actively involved in every aspect of commissioning. Neither does it mean that those who lead the consortia need to carry out all commissioning activities themselves.⁹ However, in order to take this unique opportunity of putting primary care at the heart of NHS reform, action needs to be taken now. It is essential that you make the most of the transition period.



What should you be doing?

The GP press delivers stories of consortia forming throughout the country and tales of PCTs pushing practices together. The White Paper is clear that there will be the 'flexibility to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. The NHS Commissioning Board will have a reserve power for the Board to assign practices to consortia if necessary'.⁹ It is therefore important to prevent this reserve power being exercised, and that you make an informed decision.

It must however be recognised that this is a new regime and is not simply an extension of PBC, nor a reinvention of GP fundholding. This is a much more challenging opportunity with extended responsibility for commissioning and many other functions. The transition period began at the end of July 2010 with the publication of the White Paper and will continue until you have formed your consortium and taken over the reins in your area fully from the PCT. It is anticipated that this will be by April 2013.

Strong, well developed relationships are paramount in making GP Commissioning work, and with the formation of good relationships will come the foundation for your consortium. This is a first important step to make. Everyone has a choice and a decision to take, whether you are presently an active Executive Chair of a group; a practice who previously chose to go it alone; one of the practices, which, under PBC, was happy to take a back seat and let the more active group members take the lead; or someone who has not previously been involved.

The key message now is that you should make an informed decision on which consortium to be part of that gives the best outcome for your patients, the population, the locality and your practice. You then need to agree with others what the functions will be and then what the structure of the consortium might look like.

Consideration needs to be given to the range of functions involved, including but not limited to:

- Contracting and Procurement, including contract management;
- Data, information and performance management;
- Reporting and management of key targets and performance;
- Clinical Governance, Patient Safety and safeguarding;
- Medicines Management including formulary and implementing NICE guidance;
- The role of the Accountable Officer.

Take the time to read the published documents as listed in the references section and speak with colleagues in all positions, including those who have previously undertaken any of the commissioning related roles and those in leading positions, to gather the facts to inform your decision. You will be required to demonstrate that the structure is able to 'deliver the greatest possible benefits from these new commissioning arrangements'.¹⁰



Chapter 6: How can we start now?

Getting together

An early priority will be to draw the component parts together. It is important to generate a shared understanding and recognise strengths and weaknesses and play to these strengths, including developing and nurturing clinical leaders. It is equally important to bring everyone together.

By pooling your understanding and opening discussions as broadly as possible, the group will be able to take full advantage of the wide range of information and local expertise available to them and start to develop the trust relationships on which successful consortia will rely.

You should also consider opening up a dialogue with neighbouring consortia in cross boundary areas, sharing experiences and preventing 'reinvention of the wheel'. Also take the opportunity to speak with national organisations seeking advice, especially those where you are a member or wish to become a member. The National Association of Primary Care (NAPC) is one which is able to offer a wealth of information, guidance and support.

A fully functioning consortium will take time to develop. It is essential that open dialogue takes place between all practices and other stakeholders to develop a shared vision upon which to base further development. Where individuals or others are unclear, or do not understand particular details, they must be given the opportunity to challenge and question. The consortium need to ensure they are representative of their constituents.

These early meetings and discussions are vital. Sharing knowledge and forming the basis for future relationships is essential at this stage. It is important to get this critical development work completed effectively as your responsibilities and roles will increase as you move through the

transition stage. The transition will be smoother, where time has been invested and comprehensive, open, trusted communication channels and relationships have been built upon a shared vision.

It is essential that open dialogue takes place between all practices and other stakeholders to develop a shared vision upon which to base further development.

Key messages

- Agree a shared vision.
- Take the time to equip yourself with the information and support that you will need to make informed decisions.
- Ensure that you consider the patients and the population when looking at function.
- Understand what these decisions will need to be.
- Ensure that you identify the functions of the commissioning group before you form a structure.
- Build relationships with key local partners and organisations that have a wealth of experience for you to draw upon.

Chapter 6: How can we start now?

Looking at structure

(Form following Function)

Given the substantial changes from PBC, present constitution documents or compacts will no longer be fit for purpose, and should be redrawn once the function has been clearly identified and documented. It is important also to recognise that one size does not fit all, both in terms of consortium size but also in the details of a constitution document.

The form of the consortium should take a ground up approach, with GPs taking on their responsibilities as rapidly as possible and early adopters promoting best practice.¹¹ According to the timetable, in 2010/2011 GP consortia should begin to come together in shadow form (building on practice based commissioning consortia, where they wish).¹² As you take up a shadow form, you will begin to identify other requirements that may have not initially come to mind.

There is a natural tendency to consider the structure of the new organisation immediately; this should be resisted. Some key roles need to be defined early on in the development of the consortium through discussion. During the transition process, leaders will emerge and volunteer, as will the identification of existing roles and people you may wish to retain. Whilst these initial skills may prove invaluable in the early days, consortia will need to ensure they review their requirements as more formal structures emerge.

“If your only tool is a hammer, everything looks like a nail.”

Mark Twain

This is important for a number of reasons, not least because resources will undoubtedly remain tight, yet the most important functions and capabilities must be put in place. In developing a suitable structure considerations should include:

- What is the purpose of your consortia?
- What are your local priorities and challenges?
- What are the needs of your local population?
- What are the essential components of successful commissioning?
- What are the strengths and weaknesses of existing arrangements?
- Are there any other relevant factors?

Once function has been established and key relationships are in place, consider what structure would be fit for purpose. Review what skills and capabilities you are going to need and then consider how you are going to fill those roles. You may be able to source skills locally or you may need to explore other potential avenues from which to identify the necessary expertise.

What will you also need to establish?

You could employ staff or buy in support from external organisations,¹³ with freedom to collaborate across consortia not only in your geographical location but across boundaries. There are many options to consider and opportunities to make this happen. These include sharing resources across consortia; you do not have to employ to obtain the necessary skills. For instance, where more than one consortium shares a core secondary care provider, you may wish to share a contract management team. You may also consider buying in specialist help, when required e.g. for procurement purposes. This will require an honest and transparent assessment of your consortium's strengths and weaknesses and how they fit the aims and goals you have identified within your function.

Chapter 6: How can we start now?

Specific roles

There is unlikely to be comprehensive guidance around core roles and structures. However, there are some key roles that are likely to be either statutorily required or essential for effective functioning. You are likely to be statutorily required to have an Accountable Officer. It might be possible to share this post with other consortia. Similarly you will need a Chief Financial Officer which you might wish to share with other consortia.¹⁴

You might wish to consider gathering as much information about internal governance options, in preparation for agreeing arrangements.

As with any new business or enterprise, an ideal model will not be developed immediately. However, it is important to have a core structure identified, which can be built upon or reshaped. Seeking out and utilising appropriate expertise will bear fruit in this area. You may wish to consider using both local expertise and external support. Suitable experts will be able to assist in identifying the functions to be carried out; for example those that will sit within the Local Authority, in the consortium, or shared across a geographical area. It is important to consider how you are going to draw upon and evaluate best practice. Start these discussions now, if you have not already done so.¹⁵

Consortia boundaries must interlock to ensure the population is served by a comprehensive range of services. It will be important to engage with neighbouring PCT(s) and consortia to confirm arrangements, particularly in cases where there are shared arrangements with a Local Authority or a secondary care provider.

Start discussing interim arrangements with host PCTs, as they are to provide many of the transitional functions to support shadow consortia. It is also sensible to engage with other care professionals at an early stage, ensuring that you have an inclusive approach.

For example, you may wish to have dialogue with your local pharmaceutical committee and other representative bodies of local clinicians. This builds upon some of the most successful outcomes of PBC groups that have been dependent on involving other health care professionals.¹⁶

As with any new business or enterprise, an ideal model will not be developed immediately.

Key messages

- Good relationships and partnerships underpin form and function.
- Get everyone together for shared understanding.
- Work with your local PCT to ensure effective interim arrangements.
- Engage with the various representative bodies of local health care clinicians, for example, local medical committee, local pharmaceutical committee and nurse practitioner groups to help you succeed.
- Assess your strengths and weaknesses and consider how you might address those weaknesses and deploy strengths.
- Form follows function; identify aims and objectives.
- Cross boundary links should be considered.
- Identify sources of support, both local and national – use the expertise which is going to enable you to deliver.

Putting Patients First

“No decision about me, without me.”

This ethos drives many of the proposals within the White Paper, and is supported by the many requirements within GMC regulations and guidance in ensuring the best possible care for patients. It is therefore essential that GPs and other professionals firmly place the patient and the population at the centre of the decision-making process.

The driving ambition for change has to be the delivery of high quality care, with better outcomes, more efficiently. You may wish to adopt a set of principles, such as those published recently by the British Medical Association (BMA) and those of the General Medical Council (GMC), that will guide and support your commissioning functions. You also may wish to test these principles with patient groups to ensure that they are fit for purpose.

The White Paper offers considerable opportunities to impact positively on patient outcomes and for GP commissioners to drive towards a better health service. Difficult decisions will have to be made. Both the development of a consortium and the taking of difficult decisions are likely to be made easier if, both patient and clinician have a common understanding of the principles upon which decisions are being taken. It may also increase engagement if changes proposed are discussed openly and honestly.



Key messages

- Review the BMA's White Paper document The principles of GP Commissioning: A GPC statement in the context of *'Liberating the NHS'* and the GMC's comprehensive documents, including "Good Medical Practice" and its associated guidance – they will help you develop your own principles for high quality commissioning.
- Develop a common understanding of the difficult decisions that you will have to make with your patients and public.
- Consider different options for different models of structure that can be implemented.
- 'Putting Patients First' fundamentally underpins the new model of the GP Commissioning.

Chapter 6: How can we start now?

Start to look at practice budgets

Currently, there is significant variation between PBC groups as to what budget information they have been given and how it has been used. This should not prevent you from starting to consider what it means to take responsibility for managing budgets. Previous fair share budget calculations used for PBC can be used as a basis for initial planning, with the proviso that there may be some significant changes when the final budgets are allocated.

All consortia should now aim to work with their PCTs to ensure that they have a current budget from which to start. Once you have this, you and your constituent practices can start to explore the figures in detail and become accustomed to the process. You should endeavour to get the budget in the most accessible form possible, recognising that detailed understanding of Excel is not that widespread. There are various software solutions available that take raw data and allow it to be easily presented and interrogated. This may be something your consortium may wish to consider sourcing to ensure that this function is performed.

All consortia should now aim to work with their PCTs to ensure that they have a current budget from which to start.

Take the time to sit down with the finance team at your PCT, as well as any performance analysts to:

- interrogate how these budgets are made up;
- understand the difference around mandated, non mandated budgets and contracts;
- start to interrogate data to see how the activity transfers into cost and is charged to the budget;
- understand local financial flows and variations that have historically built up and may be at variance with national benchmarks.

There are likely to be some budget modifications when they are announced. However, the current underlying healthcare utilisation data will remain unchanged. If a patient attends A&E he will have still attended A&E, whatever the final allocation. If the attendance was not needed and the patient could have self-cared or have been managed by his GP, this information also remains unchanged. It is possible to concentrate on potential inefficiencies within the system without knowing the final budget. If you start to influence activity and drive forward service redesign, this will be helpful to you in the future.

Understanding current activity and trends will also be of great potential benefit especially if this is performed both at the consortium and practice level. This will allow you to either develop or fine tune data flows, information spread, and understand how intelligence can be used effectively. Consortia can, in effect, fine tune their systems and processes while in shadow form, and work towards taking on a real budget. You may wish to review your current data and informatics systems to see if they are fit for purpose for the new roles they will be expected to undertake.

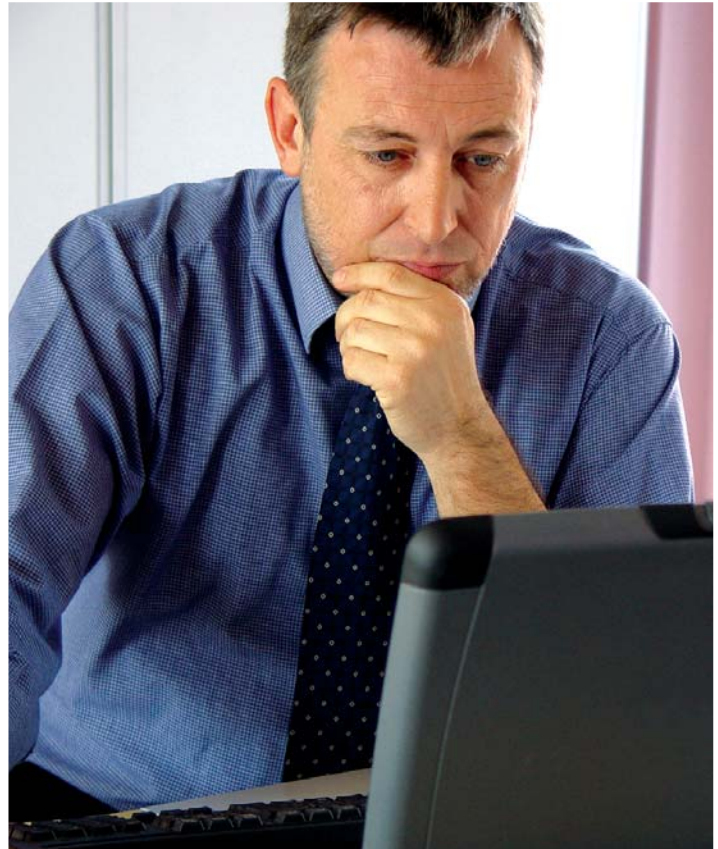
Chapter 6: How can we start now?

Ask yourself a series of questions:

- How is the consortium's budget and activity currently tracked?
- How is information benchmarked and shared with constituent practices and other stakeholders?
- What budget forecasting capability does the consortium currently have?
- What time delays are built into the current systems?
- How is information used by constituent practices?

This should enable you to build up a picture of current capability, as well as understanding how the information is currently being used by all parties. This can then be reviewed to establish the appropriate next steps for your data systems and processes. Take the important step of learning about the practices you are working with:

- Look at the annual expenditure by individual practice.
- Understand the activity and performance levels of each practice and what this means.
- Learn how to measure quality and not just activity.
- Drill down into data, to understand what is referred and what non elective activity takes place.
- Look at the prescribing levels, work with your local medicines management team to understand what is utilised and the costs.
- Read up on Mental Health, this will be devolved to PBR in 2012, understand how this will work.
- Compare data and information to understand the whole picture in the area, tools such as NHS Comparators or Better Care Better Values may help with this.



Key messages

- Work with your PCT and get a current budget from which to start – they will help you understand this budget and how it is set.
- Start to influence activity and drive forward service redesign – this will be helpful to you in the future.
- Understand activity and trends.
- Keep asking questions and make sure you fully understand the answers before you go 'live' with your budget.

Chapter 6: How can we start now?

Understanding commissioning needs

The White Paper makes many proposals around the devolution of commissioning functions to GP commissioners. It is clear that whilst some detail is yet to be decided, the core function of commissioning will be devolved to those GPs. It is important that you understand in as much detail, as early as possible, what functions you will be required to deliver.

You may wish to consider working alongside those who carry out these functions within the PCT. This will enable you to understand some aspects of your future role in detail, as well as ensure that the transfer of function from PCT to GP commissioner can occur in as seamless a manner as possible.

There are GPs with a detailed knowledge of many of the PCT's commissioning functions, but there are likely to be a significant number of areas where additional knowledge and capability will need to be developed or provided. You may wish to consider using external support to develop these, from national organisations such as NAPC or from independent and private sectors. Work through the list of capabilities of a commissioner and complete a skills and capabilities analysis, either independently, or in partnership with a PCT or other supportive body.

It is important to work with your PCT to understand which functions will transfer responsibility to the Local Authority and which will form part of your consortium's responsibilities. For instance, statutory safeguarding duties, patient safety, medicines management and audit – although they are not direct commissioning roles, they may fall into the future remit of GP

consortia. Make sure you work with your PCT to identify and understand the functions required.

Once baseline assessments and understanding of capability have been performed, you may wish to liaise with other consortia to explore the possibility of shared capabilities, and such issues as lead commissioner status for surrounding hospitals etc. To be successful, you will need to have access to the best possible commissioning capability, whether in-house, or in partnership.

Consortia should not underestimate both the time required, but also the value of building solid foundations. Preparation is key, you have a good opportunity to ensure this preparation is undertaken.

Key messages

- Work closely with your PCT to ensure effective transfer of knowledge.
- Complete a skills and capabilities analysis and understand where you need support.
- Understand what functions you are going to be responsible for.
- Use support wisely – it is important to get the right support and this is likely to be a combination of both local expertise and national support.

Even though the Health Bill has not yet been finalised, there is a lot you can start to develop now to get ready for these changes.

What does this mean?

- Even though the Health Bill has not yet been finalised, there is a lot you can start to develop now to get ready for these changes.
- By working closely with key partners, you can be sure that your practice and your consortium are best placed to deliver excellent care for your population.



What should you do now?

- Review this chapter and develop a plan for next steps.
- Implement this plan in partnership with colleagues, your PCT, national organisations or external agencies.

When will this happen?

You should start as soon as possible – preparation is key.

References

Footnotes

- 1 www.igt.connectingforhealth.nhs.uk
- 2 DH: *A First Class Service: Quality in the New NHS*, 1998, Section 3.2
- 3 BMA: *Practice Based Commissioning: Consortium Working, General Practitioners Committee Guidance*, April 2006, Appendix 1
- 4 Department of Health: *Liberating the NHS: Commissioning for patients – a consultation on proposals*, 2010, page 25 para 5.7
- 5 Department of Health: *Liberating the NHS: Local democratic legitimacy in health – a consultation on proposals*, 2010
- 6 Department of Health: *Liberating the NHS: Local democratic legitimacy in health – a consultation on proposals*, 2010
- 7 Andrew Lansley Speech 07 July 2010. Available at: www.dh.gov.uk/en/MediaCentre/Speeches/DH_117280 [online] Accessed on 08 August 2010
- 8 *Commissioning for patients*, 1.15 page 4
- 9 *Commissioning for patients*, 2.11 page 8
- 10 *Commissioning for patients*, 1.12 page 3
- 11 *Commissioning for patients*, 1.19 page 5
- 12 *Commissioning for patients*, 2.22 page 10
- 13 *Commissioning for patients*, 1.16 page 4
- 14 *Commissioning for patients*, 4.1 page 21
- 15 *Commissioning for patients*, 5.5 page 24
- 16 *Commissioning for patients*, 6.12 page 33

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*As *Equity and excellence: Liberating the NHS* includes a comprehensive glossary of terms, we have chosen to refer readers to that section rather than to re-create a similar version in this guide. The glossary is available online, and begins on page 54 of the White Paper.





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