



THE £80bn MAN

**GPs GET READY TO
HOLD THE NHS BUDGET**

CONTENTS

Supplement editor
Daloni Carlisle
Production editor
Amit Srivastava
Design
Kevin Pruitt

COMPETITION



Doctors' groups warn of chaos if GP practice boundaries are scrapped, letting patients register wherever they like. Page 3

WORKFORCE



Once an undemanding role often filled by the GP's spouse, the job of practice manager is about to become hugely important. Page 5

SURVEY

An HSJ poll reveals worrying tension between GPs and PCT managers, which may undermine the new commissioning regime. Page 6

Q&A

A concise guide to the key developments in the world of commissioning from the Department of Health. Page 8

EFFICIENCY



Less than half of GPs have even heard of the QIPP programme. Tackling ignorance about it will be vital to cutting costs. Back cover

ACCOUNTABILITY

TOO MUCH TO DO?

Being the 'accountable officer' for one of the new GP consortia looks like a huge and daunting responsibility. Will anyone want the job? Daloni Carlisle reports

Commissioning consortia's accountability is hardly the most exciting sounding aspect of the NHS reforms but the cost of getting it wrong could be very high indeed.

That, at least, is the opinion of Julie Woods, national director for GP commissioning with the NHS Alliance, who says: "The cost of getting it wrong will be poor quality care, outcomes that do not go in the way we want them to, quality of care [that] does not improve and... [a] financial position [that] is not good." Ms Woods, a former primary care trust chief executive, explains: "The [health reform] bill makes it clear that commissioning consortia must appoint an accountable officer and that this does not need to be a GP. As well as financial obligations, the accountable officer is responsible for ensuring and assuring that the consortium operates efficiently, effectively and economically."

In other words, the accounting officer will need not only to break even but also to show improvements in outcomes, that care is effective and safe and that quality is improving in all commissioned services. Yes, Ms Woods agrees, this is a huge job and a huge responsibility.

This raises a number of questions, such as whether GPs within commissioning consortia want GP leadership and, if they do, whether there is a sufficiently experienced and competent cadre of GPs to take on these new roles. The answer to both these question seems to be possibly not.

"There is a real debate among GPs about whether they want to take on these roles and some [are] saying privately they wouldn't touch them with a barge pole," says David Stout, director of the NHS Confederation's primary care network. "I think it will be disappointing if they don't as that would not be in the spirit of the reforms. The question is whether the role needs to be lightened to encourage GPs to put their heads above the parapet. It will be interesting to see how it plays out."

There is doubt too on the competency issue. The accountable officer roles are not too different from the PCT chief executive

jobs – and look at the trouble there was filling some of them.

Dr Shane Gordon, a leader in the North East Essex GP Commissioning Group, says: "I am anxious about the gap between [where] existing GP leaders [are now] and where they need to be," he says. "Even as someone involved in medical management

'The accountable officer is responsible for ensuring that the consortium operates efficiently, effectively and economically'

for nine years, who has led a GPC cluster for four years, I find it a daunting prospect."

He argues that a framework to describe the competencies will emerge, based on existing work around leadership skills and medical management. But he questions what would happen if consortium members elected a leader, only to find that the national commissioning board refused to approve their choice because they "did not make the grade"?

"I suspect there will be very strong pressure from the treasury and the national commissioning board not to see appointments of people who do not have the skills or ability to deliver successful consortia," he says. "How will this be addressed? It is a real dilemma."

Mr Stout points out that the secretary of state approved PCT chief executive appointments and this was achieved by having an SHA representative on the interview panel. He says: "I cannot see there being interview panels for these new roles so how will the NCB assure itself about people going into them?"

It is not the only area where information and detail is lacking. Beyond the need for an accountable officer and a finance director,



the bill sets out very few requirements.

A DH spokesperson spelt it out: "To support public accountability, consortia will be required to make public their remuneration arrangements, to hold an annual general meeting that is open to anyone, to make their commissioning plans available to the public and to publish an annual report. And, as part of their application to the NHS commissioning board for establishment, consortia will have to submit a proposed constitution, which will be publicly available."

On the one hand this lack of detail might be a good thing and go along with the philosophy of giving power back to the frontline; on the other it could leave GPs somewhat floundering.

Dr Michael Dixon, chair of the NHS Alliance says: "We were all handcuffed in the past and it is right that there is not too much prescription now," he says. The problem, though, is that consortia "do not know where to start".

Ken Aswani, a GP in Waltham Forest working with three local commissioning consortia, plans to start from where he is now. "Governance principles are fairly generic – for example transparency, scrutiny and so on. These are the principles that will apply," he says.

"I am not saying that they will be exactly the same, people will certainly want to minimise bureaucracy for example, but PCTs are still in place and this will be worked through gradually."

One change might be in the governing boards. The bill does not require consortia to have one, although Dr Dixon says: "Any self respecting consortium will want to have a board with non executive directors, the issue

'The public really would have a right to ask why we needed a major reform if all we achieve is boards that look like the old PCTs'

will be about wanting to share accountability among local clinicians and local people."

Well yes and no, says James Kingsland, president of the National Association of Primary Care and now involved in Wirral NHS Health Alliance pathfinder consortium.

Yes, in that his main concern is about how to involve and engage "your average GP" in governance and accountability but very much no on the need for a board. "Our consortium is considering not having a formal board but a collective process and non-hierarchical outlook that links all practices," he says.

If that smacks of woolly thinking, Dr Kingsland is unapologetic. "What do we want," he asks. "More of the same? Creating carbon copies of the old PCTs would be far more dangerous. The public really would have a right to ask why we needed a major health reform if all we achieve is boards that look like the old PCTs and do the same job."

He argues that there is a need for consortia to be inclusive and to have a strong patient voice, to have the involvement of clinicians who are not GPs and to have all practices represented.

"You won't get that by having an elected patient on a board or by having an allied

health professional who is somehow supposed to be the voice of all non-GPs," he says. "Maybe we need to think creatively about a collective approach that is still accountable for the public funds but has a much more inclusive approach than the old, formal PCTs."

Yes, but how? Dr Kingsland is not sure exactly but the current approach in the health care reform bill will allow him to try.

That's not really enough though, say a range of patient groups. Eight leading patient-representative organisations wrote to *The Times* in February 2011 to express their concerns about "weak" accountability in the bill and calling for elected patient representatives who could scrutinise decisions and budget management at local level.

Dr Brian Fisher, who leads for the NHS Alliance on patient and public involvement, is also concerned. Commissioning consortia will have a relationship with local authorities and their health and wellbeing boards, and with the HealthWatch bodies that are set to represent patients and the public. But it is a duty to listen – not to respond, he says.

"In... [the] initial design of the bill [the public] will not exert much leverage," says Dr Fisher. "Commissioning plans are pretty much unfettered by anyone. It's irritating because the rhetoric was strong but the reality it weak. We need to make it clear to the coalition that they need to stick to their rhetoric."

A DH spokesperson spelt out the current position, saying: "Our objective is to ensure that there are clear and transparent arrangements for governance, while at the same time recognising that a flexible approach is needed so that consortia can decide for themselves what structures and processes best enable them to deliver high-quality outcomes, manage resources effectively and ensure appropriate public and professional involvement."

Perhaps true patient and public involvement will be delivered in consortia's constitutions, some of which are now being written. Dr Gordon sees four components, starting with some formal articles of association and governance rules, a shared set of values and a vision and finally means of holding individual practices to account for their behaviour and performance.

He sums up: "The biggest challenge is for general practice to move from being a group of independent businesses to acting corporately towards a shared vision."

Mr Stout suspects that the proof of the pudding may well be in the eating. The bill, he says, is based on the rhetoric of non-interference and autonomy but leaves scope for regulations to flesh out the details.

"I think the government wants to stick to the rhetoric but history shows us that when things go wrong, it becomes hard for the secretary of state to resist taking action. And the more you go down that route, the less successful will be the whole thrust that the reforms are based on.

"It's a fine line to strike between strong and effective accountability and overbearing, top down interference." ●

PRACTICE MANAGERS' BIG MOMENT

A potentially pivotal role in the new NHS awaits many practice managers. Are they ready? By Alison Moore



A once undemanding job, often filled by a GP's spouse, has changed beyond recognition

The days when practice management was a job for the GP's spouse or senior receptionist are long gone: many practice managers are working within small businesses with a £2m turnover, have masters level qualifications and have become partners in the business.

But the growth of GP commissioning consortia is likely to transform the working lives of practice managers, offer them new career opportunities and demand additional skills from them.

Alison Rounce, who is a managing partner at a Nottingham practice, says they will need to look outwards rather than inwards. While previously they might have been concerned about the smooth running of the practice, there will be new concerns such as referral rates and emergency admissions. "We will need to look at where our patients go and why," she says. "It's about mitigating the risk."

Caroline Kerby, joint chair of the NHS Alliance's practice managers network, says: "It will be a different job to the one that it has been. Any practice manager who thinks this will bypass them without affecting them

'Managers may need to have delicate conversations with GPs about their referral patterns'

or their practice needs to start talking to people. It will be quite fundamental."

Ms Kerby – a managing partner in a London practice – is one of a new breed of practice managers who have been closely involved with practice based commissioning and who are likely to play a significant part in consortia.

No one can say for sure exactly what role practice managers will have in the new consortia – and there may be considerable variation between consortia. But data handling, budgeting and negotiating skills, contracting, procurement, performance management and patient engagement skills are all likely to be needed. And they may

need to have delicate conversations with GPs about their referral patterns. Practices may also look to share skills and back office functions, such as pay.

Michael Orozco, Ms Kerby's co-chair, points out that many practice managers won't have seen a secondary care contract with a hospital before now – but will need to know about such things in the future. He urges his fellow practice managers to get involved and engaged with the changes.

Steve Williams, an independent consultant and council member of the Association of Medical Secretaries, Practice Managers, Administrators and Receptionists (AMSPAR), points out that, in the days of fundholding, practice managers became skilled commissioners and many will already have the skills to become effective commissioners within consortia. These include service planning, design, procurement and an understanding of governance and financial accountability.

"We are going to have to be a lot more strategic," says Ms Rounce. "Historically practice managers are very operational – we get stuck into the problems and try to fix them. We will still have to do that but we're really going to have to sharpen up our influencing skills both internally and externally."

The opportunities for them to take on added responsibility will vary; some consortia may buy in as much commissioning support as they can while others could look to the skills available among their members – as well as in PCTs.

Ms Kerby suggests practice managers may have an advantage over PCT managers, who won't have the frontline experience. "It would be a great shame not to utilise that resource and bring in more expensive consultants," she says. "I think it's a matter of blending the skills."

Some former PCT staff are already applying for practice manager vacancies and there could be movement in the other direction – some practice managers may want to move on to become chief executives of commissioning consortia. Some practice managers already sit on shadow consortium executive boards.

But those who remain in practice management may feel they need a new skill set or qualification to meet the challenges. The Institute of Healthcare Management has piloted an accredited managers programme and AMSPAR has already starting to reflect the new direction of travel in its level five qualification in primary care and health management.

As well as the advent of commissioning consortia, general practice will have to deal with GPs' revalidation and Care Quality Commission registration in the near future, adding considerably to administrative burdens.

But Mr Williams says: "Practice managers are best placed to be involved in the future. What they need to do is be proactive and make change happen rather than... wait for others to tell them what to do." ●

ARE YOU LOOKING AT MY PATIENTS?

The public likes the idea of scrapping practice boundaries so they can register anywhere – but critics warn of GPs ‘at war’ and chaotic care. By Kaye McIntosh

The BMA is opposed. The Royal College of GPs is opposed. Even some patient groups aren't keen. To the man or woman in the street, it probably sounds like a sensible idea. But plans to sweep away the geographical boundaries that have been the basis of general practice for more than 60 years have proved controversial inside the NHS.

The aim is “to give patients more control of their own healthcare.” As a Department of Health spokesperson told *HSJ*: “Patients should be able to seek to get the service they want from any practice willing to register them.” The DH is in discussions with the BMA, including on any necessary changes to the GP contract, she added, and plans to have the changes in place this spring, possibly as early as April.

But BMA GPs committee chair Dr Laurence Buckman is not convinced: “The logical result is that you end up with one practice in Birmingham with a population of 65m,” he insists. How could consortia plan for their communities if registered patients don't live in the area? Who does home visits for people who live out of area? “I am clear that boundary-less practice will not work.”

Surprisingly, some patient advocates are equally unenthusiastic. Malcolm Alexander, chair of the National Association of LINKS Members, says: “Practice boundaries stop GPs going to war with each other. We don't think there is any value in competition between GPs – it won't improve the quality of patient care.”

He points to dentistry. Once surgeries could advertise, they boasted about tooth whitening and beauty treatments rather than the quality of services, he claims.

Dr Clare Gerada, chair of the Royal College of GPs, says while patient choice is important, so is good care. Introducing even more clinical handovers because care of the patient crosses boundaries between their home and wherever they choose to register increases the chances of things going wrong.

At best, the policy “equals fragmentation of care, or poor care, at worst it makes it impossible for GP consortia to plan,” she adds. But King's Fund fellow in health policy Nick Goodwin argues: “Commissioning arrangements for out of area patients could be complicated but it is not beyond the wit of man to do things differently.”



‘The logical result is that you end up with one practice in Birmingham with 65 million people’

And the DH agrees. In its response to last year's consultation, “Your choice of GP practice”, the DH says work is underway to look at the impact on practices and any necessary changes to funding systems to ensure that money follows the patient.

But Dr Gerada says the move could be expensive. Patients who don't live near their GP would be more likely to use A&E and out of hours services, she warns. It could also worsen health inequalities – those most able to exercise choice will be the better off and well educated, not the unemployed, elderly or chronically sick.

The Patients Association largely welcomes the policy but chief executive Katherine Murphy says: “There needs to be clarity from the Department of Health as to how [to] support... patients who want to exercise this choice but do not have the means.”

The likely impact depends on the numbers. More than 75 per cent of public respondents to the DH consultation backed free choice of practice. But a far smaller number might actually move. Around 20 per cent of people would like to join a different local surgery, according to a 2009 survey by Ipsos MORI, while only around 6 per cent want to register near work.

Dr Johnny Marshall, chair of the National Association for Primary Care, says patients who move could exert real influence on commissioners. “If you live somewhere where a treatment such as IVF is not funded you might ask, can I register somewhere else where treatment is funded. That might be one way to overcome the postcode lottery.”

But it all depends how big the consortia are. If there's only one covering all of Cornwall, it doesn't matter whether you register in Penzance or Bodmin Moor. So in the end the choice might only be real for commuters who cross consortia boundaries.

But Mr Goodwin says: “The incentive to improve the quality of care is not patients shopping around; it's the threat of patients shopping around. It will only take two or three families for practices to take note.” ●

GPs 'MUST NOT REBUILD PAST'

Managers at PCTs and SHAs doubt GPs' understanding, while doctors feel controlled, an *HSJ* survey reveals. Can they work together to build the new commissioning regime? By Dave West

However revolutionary the government's overhaul of commissioning, the new structures will be built by existing PCT and SHA managers working with GPs – but a new *HSJ* survey suggests the relationship between GPs and managers is worryingly poor.

Primary care trusts have been instructed by the Department of Health to assign staff to emerging commissioning consortia and develop support units to work closely with them in the new system.

Others from PCTs and strategic health authorities, which will be abolished by April next year, will begin working at the NHS commissioning board – some judging whether consortia should be authorised, others commissioning primary and specialist services alongside them.

Meanwhile *HSJ* research into commissioning developments this month showed dozens of PCTs are showing GPs the ropes, often inviting more GPs onto boards, forming consortia groups as powerful advisory committees, and asking local GP leaders to shadow current commissioning staff. Meanwhile many GPs are being asked to learn by working more with managers.

These moves rely heavily on GPs and managers working together. *HSJ* and Ernst & Young surveyed 678 PCT and SHA staff and 112 GPs to capture an indication of these relationships. The results give cause for some concern.

Asked to pick a word describing the relationship between the local consortia and PCT or cluster of PCTs, nearly half of responses were negative. GPs were more likely than managers to choose "difficult", "controlling" and "distant". The most popular positive word was "developmental"; but "empowering", probably the ideal situation, was least chosen.

Some PCT and SHA staff have a pessimistic view of GPs' ability to grasp commissioning: citing GPs' lack of understanding as a major obstacle to success. Many comments made by respondents reveal bad relationships.

Typical responses from PCT and SHA staff include "confusion, distant, does not feel comfortable", and accusing emerging consortia of a "distinct lack of understanding about commissioning". One says the relationship is "historically poor and now becoming adversarial".

One PCT staff member commented: "GP commissioning has elevated those involved from demigods to gods. [Their] attitude is quite shocking and relationships are deteriorating. They have no concept of commissioning or the statutory responsibilities that go with the function."

Conversely, some GPs feel they are still being controlled. Comments include that the PCT "moves slowly and are keeping a firm overall control". One GP commented: "The PCT still tries to control the emerging

consortia even to the point of developing a structure prior to the consortia knowing the form never mind the function required."

PCT and SHA staff appear mistrusting and resentful of GPs, who in turn often feel controlled by and scared of managers. "Both parties are looking at each other askance," said one manager respondent.

Ernst & Young executive director Derek Felton said: "Some of the difficulties that are emerging are due to different perspectives on the style of commissioning that should be pursued. GP commissioning will look very different to PCT commissioning."

In areas where the situation is bad it is being exacerbated by fears about jobs, as thousands of PCT and SHA staff face redundancy, with their final fate likely to be decided by the GP led consortia.

IT'S NOT JUST ABOUT THE CONTRACTS

The creation of GP-led commissioning consortia provides a real opportunity to rebalance health systems in financial and activity terms and deliver better outcomes by making new care pathways stick operationally. But we do need to play to consortia strengths – and not reinvent their form and function in the style of their predecessors. Their form and function will need to be different because the style of commissioning that they will use and the way that they will intervene in the health system will be profoundly different.

PCTs in the main have had limited change levers available to them and indeed most have placed a lot of emphasis on a single lever – the annual contracting round. While many contracting rounds sought to reduce commissioning expenditure, they did little to take out the costs of healthcare delivery. Consortia will use clinical engagement and clinical performance management to connect directly with provider delivery teams and lever change together.

Consortia need to be empowered to engage rapidly on the key priorities – cost reduction and health system improvement – in major service areas that really make a difference such as unscheduled care and long term conditions

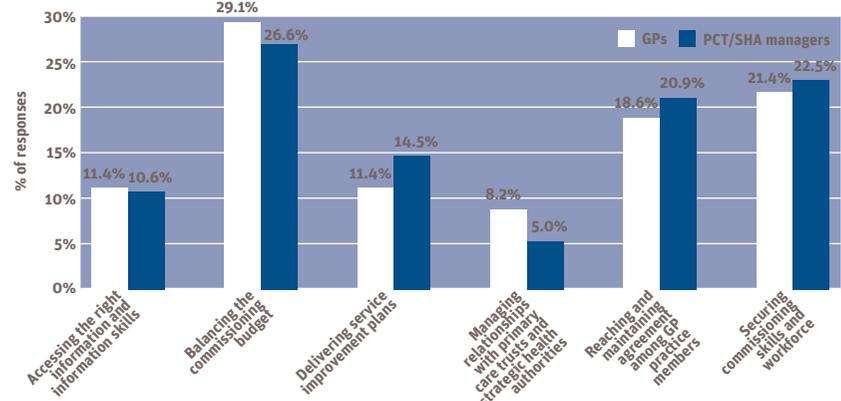
management. These topics don't easily fit into the "plan, procure, monitor" commissioning cycle so wider system performance management skills are needed to make significant impact. If consortia set their sights on these issues, they have a better frame of reference in which to assess the management skills that they need to construct the case for change and then execute delivery.

New consortia need to be structured so they can operate more dynamically than PCTs and be honed to delivery changes to the cost base of healthcare systems. The true tests of good commissioning are all around the change cycle – can they detect that change is needed in health status and healthcare, can they choose the right change lever to use and can they execute the change to deliver the intended outcomes.

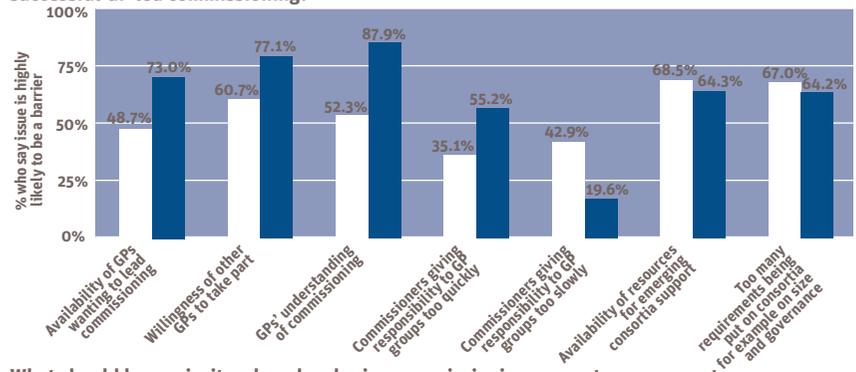
There will be a fascinating array of consortia models that emerge given the different catchment populations, the local PCT inheritance, the provider dynamic and of course, the local health priorities. However, the emerging consortia should take note of the lessons to be learnt from the PCTs, taking care to not rebuild the past and suffocating the opportunities of the future.
Derek Felton, executive director, Ernst & Young

COMMISSIONING SURVEY: THE RESULTS

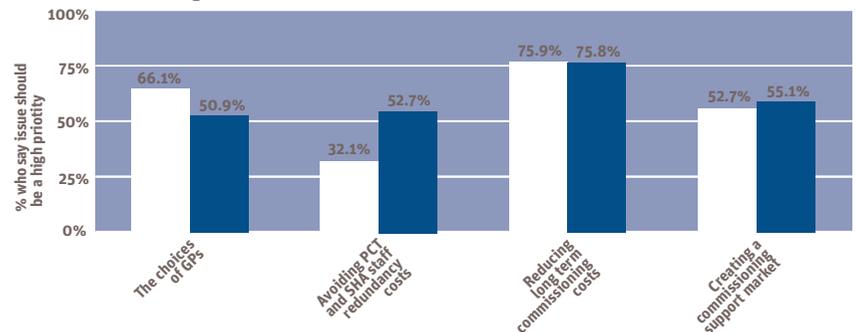
What are the two biggest challenges GP commissioning consortia are likely to face between now and 2013?



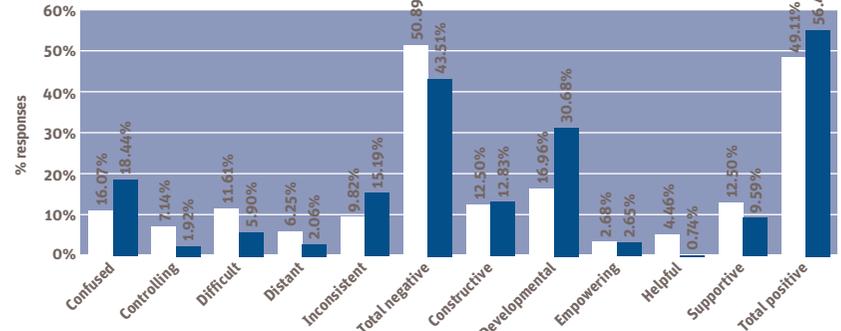
How likely do you think the following issues are to be a barrier to developing successful GP led commissioning?



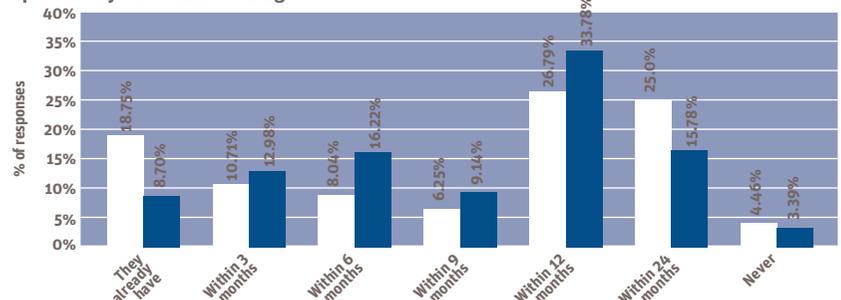
What should be a priority when developing commissioning support arrangements for GP commissioning consortia?



Which word best describes the relationship between your local GP commissioning consortia and their PCT and PCT cluster?



When do you expect GP commissioning consortia in your area to take on material responsibility for commissioning?



Respondents were asked about their priorities in developing commission support structures, in which most non-clinical staff will in future be employed. Both groups recognised the importance of reducing long term costs, but PCT and SHA staff more than GPs said reducing short term redundancies was also important.

One SHA respondent said: "Some consortia appear to think that they can manage without PCTs – but they have no comprehension of the tasks PCTs undertake on their behalf."

Another PCT employee said: "Consortia have been stitched up by the PCT appointing all the old guard establishment staff to run the consortia. The architects and advocates of failed policies play on."

The issue also concerns GP respondents. One said: "The biggest challenge that faces the consortia is that the decent commissioning staff are leaving... [seeking] security of job prospects and we will be left with those unable to find other jobs. I suspect we will be told to find them posts."

But the survey also shows a potential route forward to build better relationships.

Incumbent commissioners appear to think change should happen slowly but they are being forced to make it quickly. Many expect material responsibility will be handed to GPs before April next year – a year ahead of the government's deadline.

At the same time GPs appear fearful PCTs will not hand over responsibility but accept they will not take formal power until later.

Both appear open to GPs confronting major service decisions and roles quickly but for now remaining clearly within the support and accountability of the PCT.

The survey also points to benefits from handing over the reins. Asked which levers are most likely to be used by consortia, GPs more than managers cited closer performance of clinicians, including in primary care. It suggests there is admirable readiness to tackle colleagues' shortcomings.

Asked to rate pathways they think consortia will address first, GPs' highest rated choice was emergency care – a difficult area some managers fear they will avoid.

Mr Felton said GPs and managers must close the "significant" gap in understanding of commissioning. He said: "Managers are worried about giving [up] responsibility but it is imperative that GPs learn and apply new styles of commissioning while PCTs are in place and can be supportive."

Both the NHS Alliance and National Association of Primary Care have argued that emerging consortia should not be rushed into governance and structures or caught up in old ways of thinking. One GP respondent echoed that concern: "Too much energy is being devoted to form and structure and too little in ensuring change – we are fed up with arranging deckchairs." ●

A NEW ERA OF COMMISSIONING SO HOW WILL IT

What are those much discussed pathfinders actually doing? What is the NHS commissioning b

The success of the new commissioning architecture will be key to delivering the government's aims for the NHS, with patients having much greater influence, a clearer focus on evidence based outcomes, and a central role for clinicians in commissioning services to meet their patients' needs.

This architecture will comprise:

- commissioning consortia covering the whole population;
- the NHS commissioning board; and
- a full range of diverse commissioning support functions available to both commissioning consortia and the NHS commissioning board.

The commissioning development directorate, led by Dame Barbara Hakin, a GP for over 20 years, includes experienced senior policy makers, clinical experts and senior NHS managers. Its role is to design and deliver the new commissioning architecture in support of Sir David Nicholson, chief executive designate of the NHS commissioning board. The team includes ten regional directors of commissioning development, working across the country.

DEVELOPING GP CONSORTIA

Supporting and developing GP consortia to maximise the clinical expertise of GPs and build on the role they already play as their patient's advocate is central to the directorate's work. Key developments include the establishment of the GP pathfinder programme. Pathfinders now cover over two thirds of the country and are helping to create the tools they need to aid their development.

Are pathfinders consortia?

Pathfinders are groups of GP practices that are testing new ways of working, helping design the new system and starting to commission services on behalf of PCTs. They do not have the status that consortia will have in future when they are established as statutory bodies.

Can existing companies set up by GPs become consortia?

GP consortia will be both statutory and NHS bodies, so they cannot be a private company of any kind.

Some pathfinders are companies because they have developed from practice-based commissioning groups that used this structure. Pathfinders may want to use these organisational forms for some purposes, but they cannot hold actual commissioning budgets or commission NHS services in their own right.

What about accountable officers?

A consortium cannot have an accountable officer until it is formally established.

Some areas have shadow accountable officers to support leadership development but this is not a formal status.

Can consortia provide services?

Consortia will be commissioning-only organisations and will not be able to provide services. However, GP practices that are members of a consortium can group together in their own right to provide services, provided these arrangements are entirely separate from the commissioning consortium.

How will consortia be authorised?

The authorisation process will be developed in partnership with pathfinders, PCTs and SHAs. It will consider the full range of activities consortia will deliver.

The authorisation process will look at the organisation's ability to make a difference to quality of care while delivering value for money. It will consider internal governance arrangements to deliver its statutory duties. It will also assess how the consortium will involve stakeholders, particularly patients and the public, other clinicians and councils.

Some consortia will develop more quickly than others so we expect a staged approach, but our desire is that all consortia will be authorised by April 2013.

We are exploring how we can make the process as flexible as possible, perhaps authorising consortia to take on the majority, but not all, of their functions in the first instance.

DEVELOPING COMMISSIONING SUPPORT

GP consortia and the NHS commissioning board will be able to buy services to help them carry out their commissioning functions, as PCTs have done for years.

Much commissioning capability in England currently resides in PCT staff. There are also a number of commissioning support organisations which were set up in part to build commissioning skills in the NHS. A number of commercial, local authority, civil society and other organisations provide additional support to PCTs along with some niche services.

We are building on this to create the future environment, seeking to retain and develop the very considerable skills in the NHS while working with external providers to explore how their expertise can be utilised.

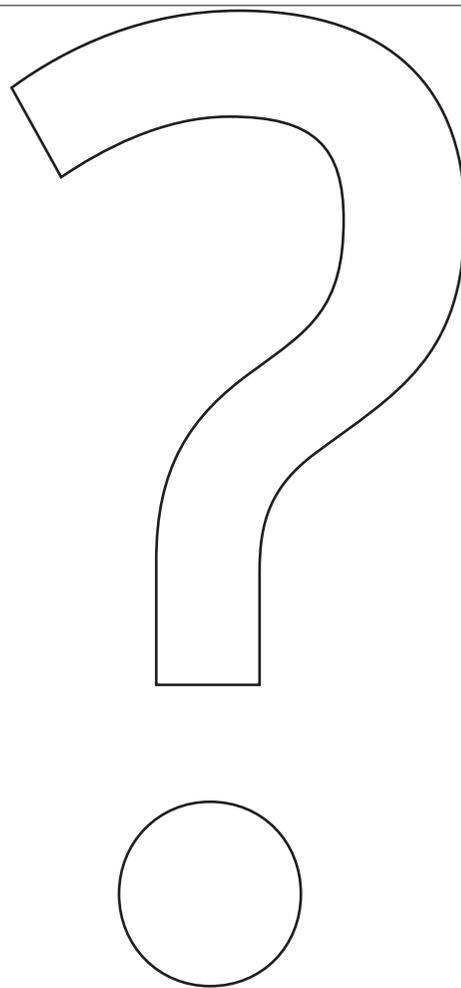
What is the role of clusters in commissioning development?

As well as securing business continuity and delivery during the transition, PCT clusters will have a key role in helping to develop the new commissioning system, including:

- support developing commissioning consortia to take on their new roles;
- be the incubator for a range of commissioning functions which will create the market for commissioning support in the future, either through models such as social enterprises or joint ventures; and
- support the consolidation and development of commissioning functions that will be the responsibility of the NHS commissioning board, such as commissioning of primary care and specialised services.

WORK?

g board? The DH answers your questions about the new regime



ESTABLISHING THE NHS COMMISSIONING BOARD

The NHS commissioning board will lead the commissioning system, ensuring that we see continuously improving services for patients, real value for money and the safeguarding of the core values of the NHS.

The board will account for the overall NHS budget (some £80bn) and directly commission around £20bn of services (primary care, prison healthcare and some specialised services).

The board's success will depend on its ability to support consortia to improve the quality of patient care within their allocation. This will require rigorous, transparent processes for supporting consortia in their initial development, granting authorisation, ensuring ongoing accountability and, where necessary, intervening to support consortia where they face financial or service risks.

The NHS commissioning board will be one body that gives all parts of the system the opportunity to deliver more consistently.

What will be the relationship between the DH, the NHS commissioning board and commissioning consortia?

The secretary of state for health will set a rolling three-year mandate for the board and hold it to account for progress against the NHS Outcomes Framework within the financial allocation. It will be for the board to make consortia allocations and work in partnership with consortia to deliver this mandate. This partnership will be crucial to the delivery of an improved system, with the board and consortia working closely together to maximise their effectiveness.

Working closely with NICE, who will develop a growing body of quality standards, the board will create a commissioning outcomes framework and will hold individual consortia to account

for the quality of the services they commission and their contribution to improving overall health outcomes and reducing health inequalities.

It will create a comprehensive range of commissioning guidance based on evidence-based best practice, standard contracts and pricing structures which will support all consortia in their roles.

It will have a close relationship with consortia both through authorisation and ongoing assurance and through seeking consortium input into the board's work to support commissioning. It will also work closely with consortia in commissioning primary medical care.

SUPPORTING COMPETITION AND ANY WILLING PROVIDER

Competition between providers is an important vehicle, alongside other levers and incentives, to drive up quality, efficiency and effectiveness, and encourage innovation. Commissioners will need to determine which model of competition is most useful for them: competition "in the market" or competition "for the market".

What is "competition in the market"?

Competition in the market, or the "Any Willing Provider" model, is where qualified providers compete for referrals, based on patient choice, against a fixed price, either through tariff or set locally by commissioners. The price is the same for all providers.

To qualify, providers will have to show they can meet the conditions of their licence with CQC or Monitor, if needed, and provide safe quality services to the contractual standards set by the board and consortia. As it is a qualification process, it avoids the need for time-consuming and costly tendering. Any Willing Provider has operated successfully for choice of elective hospital care since 2007.

Providers will be required to work within local referral pathways and thresholds, as part of an integrated health system delivering joined up care. The process and criteria for qualifying will be published this spring.

The choice of Any Willing Provider will apply to most health services by 2013-14. Patients can then choose any provider that meets NHS standards and prices.

What is "competition for the market"?

Competition for the market is where potential providers compete on quality and price for a given service through competitive tendering – this is currently well-established in the NHS. With the introduction of Any Willing Provider the need for tendering should diminish considerably. Tendering will, however, remain an option for commissioners where significant change is required to provider markets to deliver, for example, whole system service transformation. By tendering out longer term contracts for specific patient groups (eg end of life care, or frail older people with multiple complex problems) commissioners may find an effective way of driving transformation and sharing demand risk more effectively with providers.

Does the "Any Willing Provider" policy mean providers will compete on price?

No. Prices are set either under the tariff or through local arrangements. Providers need to meet rigorous national and local contractually enforceable standards to qualify.

IT MEANS NOTHING TO ME...

...but tackling GP ignorance about the quality innovation, productivity and prevention (QIPP) programme will be vital to cutting costs in primary care. By Emma Dent

General practice and primary care leaders are adamant that those working in the sector are well aware of the need for the NHS to make massive savings. However, the message that the quality, innovation, productivity and prevention programme is there to help them is not getting through.

In April last year a survey by online network Doctors.net.uk found that less than half of GPs responding understood the term QIPP. Of those that did, nine out of ten did not see it as something that would make a positive impact on care.

Doctors.net.uk GP and educational lead James Quekett does not believe that if the survey were to be carried out now the result would be much different. Even those GPs that do understand what QIPP is do not see it as relevant, he says.

"We understand what it means but QIPP is not seen as a primary care initiative. We believe the centre sees this very much as for secondary care," explains Dr Quekett.

He is not alone in his beliefs. Again and again, primary care leaders report the sector's indifference. "It is difficult to care about something you know nothing about," says National Association of Primary Care president Dr James Kingsland.



The doctor won't see you yet: how can GPs be more efficient?

"People don't make the link. It is not seen as a bottom up approach. And is certainly seen as national, a missive from David Nicholson's office, not locally relevant. But that needs to change; QIPP is important," says NHS Alliance chair Dr Mike Dixon.

British Medical Association general practice committee deputy chair Dr Richard Vautrey is rather blunter. "QIPP is a bit of a nonsense term," he says. "We need to try and make efficiency savings and don't need politically correct terms; what we need is a greater degree of openness and honesty about what needs to be done. We do not need a politically correct label to tell us that savings need to be made."

WHY £1M IN SAVINGS SPEAKS LOUDER THAN ANY ACRONYM

The North Mersey QIPP programme has identified around £1m in savings through the use of IT – a sum expected to double by 2013.

North Mersey Health Informatics Service is leading the work, which includes shared electronic records, improved communications, remote views of test results and telehealth.

"I had never heard of QIPP until a year ago but the key term is interoperability," says IT clinical lead and practice based commissioning board chair Dr Simon Bowers. "This work is about co-operating across boundaries."

One development is customising patient information so each clinician sees information most relevant to them. And community matrons are benefiting from mobile access to GP records. "Before there were seven or eight log-ins... and bits of paper all over the place."

Although the work has been going on in the region for several years, QIPP has helped to extend it. "GPs may not take much notice of the acronym but that doesn't mean they don't support the principle of what it is intended to do," adds Dr Bowers.

PRACTICE PHARMACISTS HELP TO SLASH PRESCRIPTION COSTS

Employing pharmacists at practice level is helping to improve efficiency in some areas.

In Gateshead, Pharmicus – the medicines management arm of the local provider organisation – works with local GPs on good prescribing habits. "We work with all local practices, going in one or half a day a week. Historically, as it takes several months to get prescribing stats, a lot of the work has been reactive but we are aiming to be more proactive," says lead medicines management pharmacist Catherine Armstrong.

Priorities include pharmacist led medication reviews, reviewing over prescribed products – and reviewing prescription of "specials", such as medications not routinely available in liquid form but that have been prescribed as such. "The anti depressant sertraline is a good example. Rather than having to be especially made up at a premium price, there are other anti depressants available as a liquid. If a GP talks to us before making out the prescription... different medication can be prescribed at a tenth of the price," says Ms Armstrong.

Department of Health national director for improvement and efficiency Jim Easton admits that the level of engagement with primary care does need to improve but stresses the department has no interest in "ownership of the QIPP 'brand'"

He says: "We are not trying to promote a label or a brand. We understand there are real concerns out there that QIPP is seen as a secondary care led programme but the work [that] can be done – in long term conditions, urgent care, medicines management – is all at the forefront of both primary and secondary care."

Dr Kingsland agrees that, as the programme was originally designed to aid redesign of large health systems, primary care clinicians fail to see its relevance. But he believes it could have huge benefits in redesigning services for urgent care and long term conditions.

"At a practice level, colleagues understand it when they see the efficiency gains that can be made at practice level. It can encourage them to ask: could you do something different? The massive amount of work with long term conditions and routine monitoring that takes place in outpatients, for instance – we could do that."

DH primary care development national clinical lead Mo Dewji agrees QIPP opens up exciting possibilities for clinicians. "In terms of efficiency, improving productivity, QIPP can start the debate."

Scepticism remains among many in the sector. Dr Quekett believes GPs "have QIPP inbuilt. We do QIPP all the time; it is built into what we do in general practice".

But Dr Kingsland believes a dedicated programme to publicise the potential of QIPP in primary care – like the one in the acute sector – could be a boon to the programme. "To do it we need behavioural change in every consultation, in every meeting with patients," he says.

Critics say plenty of good work is already going on in the NHS – and while researching this article, it emerged much of what is going on now under the badge of QIPP built on pre-existing programmes.

In response, Mr Easton says that if good work is going on, those doing it should just get on with it. "We will give space and support for people to get on with what they are doing where needed. However I am sceptical that anyone can find all the solutions themselves locally."

The role of commissioning consortia – and pathfinder consortia in particular – will be vital in delivering QIPP in general practice. Some GP leaders are concerned that if commissioning consortia cannot deliver on QIPP, then the programme cannot be delivered at all.

"The QIPP programme needs to talk to pathfinder consortia about how it can translate into practice," says Dr Dixon. "How cost savings can be made while keeping quality and improving care is the big issue for the next few years but this needs to be co-produced rather than sounding like a DH management document." ●