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FLOCK TOGETHER

WILL COMMISSIONING REFORM BREAK DOWN BARRIERS TO INTEGRATION?

MANAGING THE TRANSITION IN HEALTHCARE COMMISSIONING

The development of Clinical Commissioning Groups, provides both an opportunity and a challenge to GPs. The opportunities include:

- *To control the majority of NHS resources and thereby to extend their responsibility for the care of their patients;*
- *The movement of the commissioning of healthcare from a general management exercise in financial assurance to a health assurance tool driven by clinical need;*
- *The ability to show that, as generalist clinicians, they understand the needs of their patients and can commission care to meet their needs more efficiently than PCTs, can make better decisions and can manage the local healthcare system more effectively.*

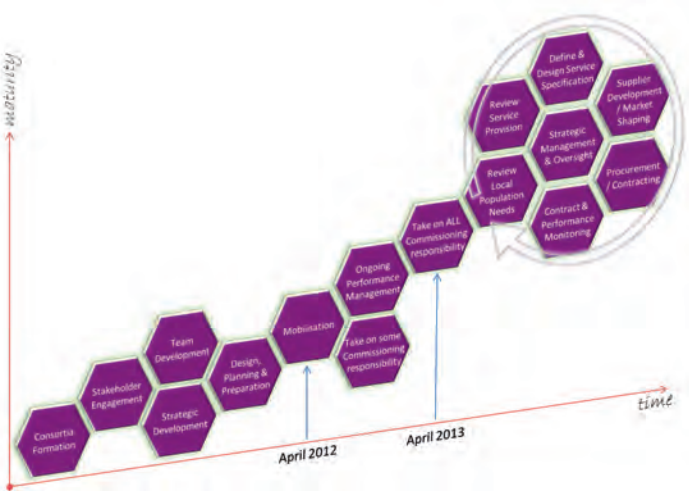
These opportunities cannot be ignored and we believe that, if it can be done safely, they should be grabbed.

The transition from a general management-led system to a clinically-led one, to improve clinical efficiency and through that to improve quality and outcomes for patients and value for the taxpayer, is not going to be easy, however.

New leadership and operational skills are going to have to be developed, new organisational models will need to be explored, and new partnerships will be required throughout the local health economy – and all this needs to be done quickly and in such a way that ensures sustainability beyond the authorisation process, timetabled between April 2012 and 2013.

One way to plan and deliver such a transformation is to map a programme of activities onto a 'maturity model' such as The Thinking People's CCG Commissioning Capability Maturity Model (depicted below).

Such models should incorporate existing national and regional leadership & development programmes with local diagnostics and transition plans, and all these should feed into a programme of work that is designed and delivered, with 'help' as required, by local clinically and operationally-experienced leaders, subject matter experts and facilitators: at the end of the day they must own this programme, transformation is only successful if it is not done to you but by you.



In addition to leadership development, specific strategic, managerial and operational models will need to be explored in depth; tools and techniques will need to be embedded and deployed, and specific outputs (such as constitutions, policies, procedures, stakeholder management & communication plans, clinical pathway designs, financial management dashboards, etc) will need to be developed and delivered, integrally to each respective module, as part of a tailored programme for each CCG according to their current level of 'maturity'.

The desired outcome of such programmes is to have authorised CCGs by April 2012 (without conditions) equipped with the skills and stakeholder networks necessary to begin to work 'in shadow' whilst building organisations capable of taking on fully authorised commissioning responsibility by April 2013.

Boards, leaders, and individuals should be supported by a combination of knowledge transfer, coaching, mentoring, guidance and support available when they need it, framed in a language that they understand, and relevant to their stage of development.

The support available from The Thinking People Group, which blends clinical with academic and experienced programme management and business change expertise, is designed by experienced healthcare professionals and supports a clinically-directed programme to help CCGs deliver their vision – to meet the challenge, grasp the opportunity and demonstrate that they deserve the confidence of every citizen.

If you feel you can benefit from a no-obligation, no-nonsense, discussion with one of the Thinking People's Team, please contact the Group Managing Director, Martin Roots via email at **martin@thethinkingpeople.com**

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Supplement editor
Alison Moore

KPMG

FOREWORD

GPs GET POSITIVE ABOUT THE FUTURE

In 18 months clinical commissioning groups will be responsible for commissioning up to £60bn of healthcare. In that time GPs and other clinicians need to change from the equivalent of running a cornershop to managing a superstore. New roles, new risks and the blistering timetable clearly make implementation an enormous challenge.

But as this deadline looms closer I have noticed a step change in both enthusiasm and commitment from the clinicians with whom I come into contact. This is consistent with the results of our recent KPMG/Ipsos MORI survey which found that significant numbers of GPs were now actively involved in commissioning decisions (see page 29).

Why might we be seeing an upturn in positive attitude? One reason could be that this health reform is simply closer to the hearts of most clinicians than past initiatives – the health of local people. Then there is a growing belief that clinicians will genuinely be central to decisions on a large scale and that a change across the whole system is the best, or perhaps the only, way to improve outcomes. The incentives to participate are also stronger. The quality and outcomes framework domain changes are part of this, plus there seems to

'The attitude of clinicians is a strong indicator of progress'

be a sense of collective spirit evoked by ensuring all practices engage within the CCG. Although there have been some negative responses, the majority of CCGs I meet take it as a challenge to actively involve colleagues to improve care.

The attitude of clinicians is a strong indicator of progress. If ever there was a sector where the involvement of the front line was instrumental to change, then healthcare must be it. If clinicians can see how commissioning could work and are willing to engage in practical solutions, regardless of outstanding high level policy issues, then there is hope that it will make a real difference to the health of their local populations.

So what will the next 18 months bring for CCGs? The first steps in learning how to be a great commissioner come with the delegated budgets that many CCGs are now taking on, and the impending 2012-13 contract negotiations. Learning how to manage such significant sums while in the safe "shadow" environment is an opportunity that should not be missed. Not only does it provide a training ground for commissioners and a test environment for policy makers, but the practical involvement of many different parties is crucial to keep building the shared enthusiasm needed to deliver the results that really matter. ●

Gary Belfield is an associate partner at KPMG.

GETTY

INTEGRATED CARE

WE WANT TO BE TOGETHER

Breaking down barriers between sectors has become an important part of the health reforms, but changing entrenched culture will be a formidable challenge. Emma Dent reports

While the NHS may notionally be a national health service, in reality it is made up of individual sectors – primary, secondary, community care – that over time have developed their own, often protectionist, agendas and ways of working.

Breaking down those cultural and contractual barriers is key if the service is to provide patients with integrated care. Although muted in the original Health and Social Care Bill, government enthusiasm for integrated care became noticeably more prominent in its response to the NHS Future Forum. It said the NHS Commissioning Board should promote integrated care through moves such as developing tariffs for integrated pathways of care and exploring single budgets for health and social care.

Grand plans which many may see as overdue: but the first challenge is getting a consensus on what integrated care, let alone commissioning for it, actually means.

"It is one of those terms, like 'choice', that means different things to different people and is causing a degree of uncertainty and confusion," says Shane Gordon, co-lead of the NHS Alliance clinical commissioning federation and chief executive of the North East Essex GP

commissioning group. "The real issue is what Monitor thinks it means."

Commentators agree on one thing: "If integrated care is well coordinated it should follow the patient journey," says Primary Care Network director David Stout. "The practical thing has to be to have coordinated care."

However, there is a drawback, says Mr Stout. "There is no sense of what an operational service doing that will look like." However, in the face of reduced budgets, both managerial and operational, in both the health service and social services, continuing to operate the status quo is not an option. The reaction in the face of the overall financial envelope being squeezed can be for services to become more entrenched and inward looking. But that very pressure can lead to some radical responses – organisations cannot trade their way out of the problem."

Aligned incentives

Dr Gordon agrees. "It is pretty obvious that if you do integrate you should be able to drive some efficiencies. What strikes me as contentious is different incentives within the same integrated organisation, such as acute services losing out if more work is carried out in primary care. Incentives have to be aligned."

As such, Dr Gordon believes the biggest challenge towards service integration is the tariff – a concern echoed by other commissioners (see box, right). "It drives behaviours that are not integrated." Long-standing sector protectionism can be overcome, others claim, but relies on strong relationships being formed.

And management cuts are an issue too. "The government has underestimated the impact the reductions will have; we have to find a sensible middle route as there is a danger it will get in the way of delivering the bigger goal," says Mr Stout.

Don Redding, policy director at health and social care charity coalition National Voices, fears much of the work already carried out by local champions is disintegrating in the face of cuts and uncertainty.

"Relationship continuity is key. Middle to senior management level relationships that are built up across services and across traditional sector boundary lines have often been built upon for years, but it is not on everyone's agenda at the moment. I am concerned how they can stand up to the pact of government reform and structural change."

Mr Redding points to the importance of the voluntary sector in ensuring minority, local community voices help co-design well rounded services. "We need to establish the principles," he argues, pointing to encouraging signs that such an approach is being adopted by emerging clinical commissioning groups.

"GPs are used to being gatekeepers to acute care. But, as well as a clinical opinion, many people need help to deal with the emotional or social impact of a condition, which can be provided through local support groups and so on. Yet as GPs can know very little about what is going in their own patch, the burden of finding out what is available locally falls onto the shoulders of people who are already vulnerable."

'What strikes me as contentious is different incentives within the same integrated organisation'

There are also national commissioning concerns. Smaller charities working with relatively small numbers of people are afraid their voice will not be heeded nationally by the NHS Commissioning Board. The same concerns apply to other niche provision areas such as some mental health services.

These concerns lead to the question of who will provide such services if the NHS is not interested, or if, as Dr Gordon points out, Monitor is not satisfied with the quality. "Monitor has the ability to force competition and contestability and could compel providers to become integrated – or for others to come in – if patients will get better quality care as a result," Dr Gordon points out. "The finances are inescapable."

Mr Redding warns against assuming that the voluntary sector will step in to plug gaps in provision. "It is difficult for them to commit to programmes with large fixed costs. A better way of doing things is for statutory services to offer services designed around the patient, with them in partnership." He warns that it could take five years to see real change – a timetable unlikely to satisfy policy makers with a two year churn mentality.

However, Mr Stout believes integrated service provision may not be on a scale to attract newcomers. "The majority of care provision is already there and if things are going to be integrated in a limited way, it could be quite difficult to attract new providers in. They need a whole health economy, but if they are to be given a year-on-year care budget that has to be held to account, to stop majority control of an economy going to one provider," he says. "There is a lot of talk about commissioning being the lever to get value for money and a quality service for patients but it could be difficult to assess if it is delivering either." ●

'A DIFFERENT MINDSET': THE NORTHAMPTONSHIRE EXPERIENCE

"I was recently talking at an event in Finland. They said they had been working on integrated care for 10 years and were still yet to define it," says Julie Passmore, programme director for Nene Commissioning, the lead organisation for the Northamptonshire Integrated Care Partnership and one of the largest clinical commissioning groups in England.

One of the 16 original integrated care pilots, Northamptonshire became the "largest and most complex, in what we were trying to do, in having both vertical and horizontal commissioning, across both services and organisations, across both health and social services", Ms Passmore says.

As an example she cites the Nene elderly care service. "It involves all agencies, delivering across primary care, community care and acute services, with incredible investment from social services. It is not a horizontal or vertical service, it's both."

The service is alerted when elderly, frail patients are in accident and emergency or about to be admitted to acute care. Patients who have been admitted receive a comprehensive geriatric and psychiatric assessment, if appropriate. Step-up and step-down beds are provided in the community by a local care home provider, with trained staff and hospital doctors doing ward rounds, and patients returning home are provided with care from the integrated team and social services.

"It needs a different mindset and way of working. It is complex and can be difficult to visualise. Asking how you put aside organisational protectionism is the $64,000 question. We say it has to be clinically led – we had clinicians who had been wanting to do this for 10 years – and you need management support," says Ms Passmore.

"There is a huge willingness here to do things differently. It's a whole system; you can't do it piecemeal or on a small scale, it is far better to go bigger. You need the whole system to change before you can see outcomes and there are a lot of reasons not to succeed; statutory rules and regulations – and the tariff is a disincentive as it encourages admissions."

The organisation has now set up an end of life care programme and is seeking to integrate numerous local long term condition care pathways, by October.

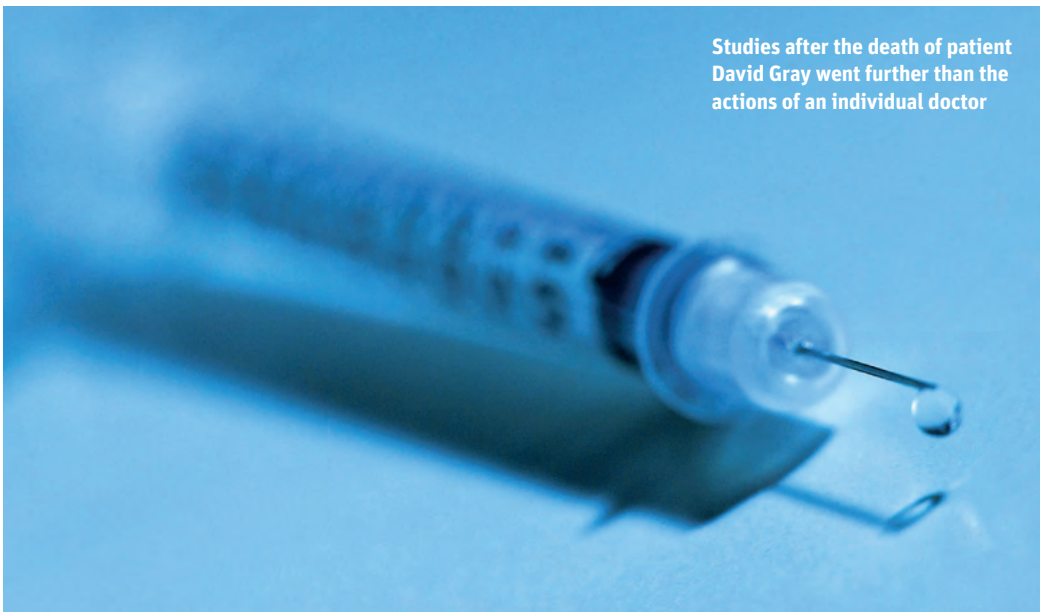
The accidental killing of a patient by an out of hours doctor brought home to commissioners the need for much greater scrutiny of services. Alison Moore looks at some of the changes

A SHOCK TO THE SYSTEM

It is rare that one incident affects how a service is delivered across the whole country, but the death of a patient injected with the wrong dose of morphine by an out of hours doctor is leading to widespread change.

The death of David Gray in 2008 led to investigations by the Care Quality Commission and police. The GP who treated him, Dr Daniel Ubani, was on his first shift after flying in from Germany, admitted he was tired and was later struck off.

But the CQC report highlighted issues that went far further than the actions of an individual doctor. It included the need for primary care trusts to scrutinise out of hours services more closely and ensure adequate staffing by GPs; the need for services to be monitored by senior primary care trust staff who understand the data they are given; the need to investigate serious incidents and learn from them; and the need to ensure GPs are appropriately trained, qualified and experienced, with good English and knowledge of the NHS.



Studies after the death of patient David Gray went further than the actions of an individual doctor

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'As a result of the Ubani case GPs are less willing to work in the out of hours services because it is quite high profile'

Lasting effects

Three years on, the effects of the case are being felt across the NHS. In Cambridgeshire, where David Gray lived, the out of hours provision was re-tendered, using a new specification with input from GPs and patients. As well as making the service more patient centred, it stressed quality and safety procedures.

The new contract was won by a GP-owned not-for-profit company that is being closely monitored with announced and unannounced visits.

NHS East of England, which covers Cambridgeshire, produced a set of standards for out of hours care. These covered a wide range of indicators, such as patient experience, service responsiveness, clinical outcomes and governance.

It also put in place a series of visits to PCTs and out of hours providers, led by a Royal College of GPs doctor and peer-reviewed.

A number of themes have emerged from this work:

- It is important that the care pathway of patients calling the service is well understood by commissioners.
- The best services are the ones where a medical director is accountable for out of hours care.
- Information and learning need to be shared across the wider health system, rather than out of hours being seen as separate.
- Careful attention to medicines management is vital.
- Commissioners need to understand the performance data they receive from providers. In some PCT areas, this needs to be tightened up.
- The postgraduate deanery needs to be involved to offer educational and training opportunities.

The need for proper induction, maximum working hours and matching capacity to demand are all included. But the standards also stipulate that GPs doing out-of-hours shifts should be on a local performers list rather than simply registered with a PCT somewhere in the country.

As a result of this work, PCTs in the strategic health authority area had to produce action plans. "We are confident that services in our area are safer," says deputy director of GP commissioning Ed Garratt. "There is much better working between commissioners and providers."

He adds: "I'm certain that we are ahead of the pack. We are the only region to have produced standards and done a programme of visits."

A review by former RCGP chair Steve Field and former national director for primary care David Colin-Thomé last year backed up many of these points, also calling for more performance management of contracts and highlighting variations in the degree of challenge by PCTs.

Andrew Gardner, chief executive of Harmoni, whose out of hours services cover eight million people, says very few services have been re-tendered over the past year or so, although it has taken on work in some areas where smaller operators have had financial difficulties.

Uncertainty about the future means many contracts are being extended while the position with GP commissioning and the introduction of a 111 urgent care phone number is clarified.

'The first new commissioner who is hit by a scandal will be taken to the cleaners'

But where Harmoni does have contracts it is seeing increased performance management from commissioners, who are demanding more detailed data. This can involve looking at key indicators such as the number of locally registered doctors delivering the service.

The demand for extra information means that Harmoni is having to invest more in business information – but Mr Gardner points out that small operators, which cannot share the costs of this between several contracts, may struggle to produce all the data asked for.

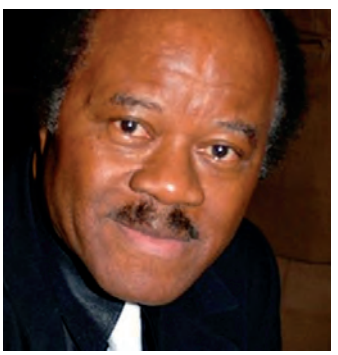
However, there are some potential problems looming. Recruitment has become difficult. "What we can see as a result of the Ubani case is GPs less willing to work in out of hours services because it is quite high profile. It is a challenge for us to get doctors working in the out of hours service," says Mr Gardner.

This has driven up Harmoni's costs, and could drive them up for commissioners in the future.

Shared learning

Immediately after the reports were published on the Ubani case, they found their way onto PCTs' agendas, which examined whether they complied with the findings. But NHS Alliance spokesman Rick Stern is slightly sceptical about whether this amounted to a change in approach. Giving people more rules and guidelines does not necessarily sort things out, he says. Mr Stern advocates more emphasis on shared learning and has been involved in a pilot for 12 out of hours services where they can share experiences anonymously. But organisational culture is important, as is reporting and acting on problems.

This month the fourth round of benchmarking data will be published by the Primary Care Foundation. While in the past this has been anonymised, now it will be clear who is performing well. Mr Stern believes this may drive change. "It will be more obvious and people may feel more need to do something about it," he says. But further progress on the ground may be being stymied by the cuts in management costs. PCT Network director David Stout says: "When you are reducing management costs, the likelihood of increasing administrative processes at the same time is a bit far-fetched."



Dr Daniel Ubani was struck off after giving a patient a lethal overdose

With many PCT staff leaving and with the formation of clusters, expertise in this area of commissioning may be becoming thin on the ground and relationships which have been built up affected.

But there may be some positives from clinical commissioning groups taking on the responsibility for out of hours care, which is something the Department of Health has highlighted. Out of hours services with problems around capacity – which may mean people are facing a long wait to be seen or cannot get to see a doctor locally – are likely to quickly come to the notice of GPs, if only because their Monday morning surgery will be full of disgruntled patients.

There is also an increasing trend to see out of hours care as part of the wider spectrum of urgent care services, whether that means patients seeking same day appointments with their GP or accessing urgent care centres. The RCGP is producing guidance that covers urgent and emergency care commissioning: this sees out of hours services as part of a greater whole with the need for more integration.

While moves to look at whole systems may be welcome, there is also a need to think about the particular issues around out of hours, says Mr Stern. "The danger is if people lose a handle on out of hours in its own right.

"The first new commissioner who is hit by a scandal will be taken to the cleaners. It's an area which you would not want to get wrong – there have been so many documents telling people what to do." ●

YOUR NAME'S NOT DOWN: LOCAL PERFORMANCE LISTS

One of the most dramatic results of the David Gray case is that around a third of PCTs are now thought to insist that doctors working for an out of hours provider are on a local list, rather than simply on any PCT's list.

Before this, it was common for GPs to register on one list and then practise anywhere in the country. PCTs imposed different standards on GPs registering for them – on command of English, for example – so in theory GPs could "cherry pick" where they registered and then move on to work anywhere in England.

Dr Ed Garratt argues that the local list approach gives PCTs greater clinical oversight of who is working in the out of hours service, and is supported by the public and GPs.

But limiting GPs to working in one area can have disadvantages, according to Andrew Gardner, chief executive of Harmoni. It means there is a smaller pool of doctors to recruit from and this may be contributing to recruitment difficulties and could drive up the cost of services. And doctors who may be of a very high standard are no longer able to move around England to work.

YOUR MONEY OR YOUR LIFE?

GPs are being placed in an unprecedented position to profit from private sector links. Alison Moore reports

Concerns over GPs' conflicts of interest date back to the days of fundholding, when savings were widely seen as being used to improve practices – adding to their value when GPs either moved on or retired.

But the arrival of clinical commissioning groups – and growing tie-ups between GPs and private providers – have concentrated these concerns.

What has changed in the past few years is that more GPs have formed links with private companies – a survey in *Pulse* last year found that a quarter of 350 GPs surveyed had an investment in a private provider of NHS services in their local area. Astonishingly, more than 40 per cent said they were aware of a colleague who had made a decision they felt was compromised by financial interests.

GPs will be making these decisions as members of clinical commissioning groups – a closer connection than being members of a professional executive committee or a practice-based consortium with limited power.

In one case, a company that owns two practices has formed a small CCG that has been given control over their budgets for outpatients and prescribing. It also runs some secondary care services in the area.

The challenge now will be how to manage these potential conflicts of interest. The PCT Network and the Royal College of GPs has produced a guide which stresses the need to have a process for dealing with these before they occur and to be proactive, for example through clinical commissioning groups grasping the issues at the induction stage.

'More than 40 per cent were aware of a colleague who had made a decision compromised by financial interests'

"If you go into this with your eyes open, you are less likely to get into a pickle," David Stout, the director of the PCT Network, says. He suggests the "Paxman" test is a useful rule of thumb; how would you feel about defending a decision in front of Jeremy Paxman?

The guidance suggests:

- Policies and processes should be in place to deal with potential conflicts of interest, rather than a system relying on individual judgement.
- There should be a clear statement of the conduct expected of commissioning group members.
- Procedures such as a register of interests, declaration of interests and disclosure at particular meetings, when

ALAMY

relevant, should be in place.

It also defines potential conflicts of interests as extending beyond the immediately financial – there could be personal commitments, a specific interest or even professional loyalties. Such conflicts of interest can never be eliminated entirely and it may not be desirable or practical to do so, it adds.

But it acknowledges there may still be questions to be answered, such as whether GPs should choose between being a commissioner and a provider of extended services.

The BMA has been proactive on potential conflicts of interest, issuing nine pages of guidance covering enhanced schemes and quality premium payments as well as involvement in commissioning decisions. It stresses the importance of transparency and of GPs being seen always to act in the best interests of the patient. GP committee leader Dr Laurence Buckman told the BBC the premiums were "disgracefully unethical" and the BMA has said they should not be paid to individual doctors or practices, but used to pay for CCG activity.

Deputy GP committee leader Richard Vautrey says that transparency will be important. Many decisions may be pushed to the NHS Commissioning Board to avoid conflict of interests. Health and wellbeing boards will also have a role – as will lay members of CCGs, one of whom will have a lead role in ensuring probity.

But one approach could be to ask GPs to make a choice between being a provider of additional services and taking a lead role in commissioning.

"The question remains for GPs whether there is more opportunity for them as enhanced providers of services or as commissioners of services," says David Jenner, a spokesman for the NHS Alliance. "It is difficult to do both."

That's pretty much the approach already in place with Assura Medical, which works with 1,500 GPs through locally led provider companies. Any GP who sits on the board of one of its GP companies cannot also sit on a commissioning board, or a shadow CCG board. It says several members have stepped down from its GP provider company boards over the past three years, because they want to pursue a commissioning role. Although they may remain a member of the provider company, they will need to declare that interest and step down from discussions and decisions which involve Assura.

ALAMY

'The BMA stresses the importance of transparency and of GPs being seen always to act in the best interests of the patient'

When dealing with individual patients, GPs are also advised to offer a choice of provider for any referral and to make it clear if a financial interest is involved. This is in line with GMC guidance. Assura says it will look again at what it does if the guidance from the Department of Health changes.

Nick Goodwin, a senior fellow at the King's Fund, suggests one approach could be to separate the processes of planning and developing improved services from the actual tendering and contracting. GPs could be involved in the first part of this, bringing their local and clinical knowledge. But handling of tenders and the awarding of contracts could be done by other staff – possibly federations of consortia working together to provide a core of staff to deal with this technical end of commissioning.

However, how services are specified could, of course, affect who can tender: is there a risk that GPs could specify services in such a way that they will automatically be strong contenders for the contract? Mr Stout suggests that clinical senates, drawing in other healthcare professionals, could be one way of ensuring this does not happen.

Other guarantees against the unfair exercise of power relate to the environment in which decisions are taken. Openness, transparency and scrutiny are important, as are standards of governance. But commercial confidentiality could limit the openness with which some of these decisions are made.

Declare an interest

GPs and other clinicians should be able to declare an interest and absent themselves from discussions and decisions, and the lay members of CCGs could play an important role in ensuring that decisions are seen to be untainted by personal interests.

This approach should apply not just to tendering and contracting, but also to determining the outcomes of any tender – has it actually delivered what it set out to do, such as reducing costs or improving access? The NHS Commissioning Board and the Care Quality Commission could develop robust outcome indicators that hold commissioners to account, suggests Mr Goodwin.

And the GMC's guidance on the duties of a doctor should mean that they are not referring patients to a service run by themselves without explaining that connection to the patient.

However, too many regulations may hamper the most innovative and flexible clinicians, preventing improvements from being put into place quickly, and may turn off some GPs who have much good to offer.

The Department of Health expects to issue guidance on conflicts of interest in the autumn, after it has been tested with stakeholders. A spokesman said: "All clinical commissioning groups will have a governing body whose role will be to oversee open and transparent decision making and ensure clear public accountability.

"These governing bodies will ensure that decisions are made fairly and transparently, that there is good stewardship of public money, and effective systems for managing any conflicts of interest, and that the organisation is publicly accountable for its actions."

They will also meet in public.

In the end, the government may feel a degree of conflict of interest is worth living with. Nick Goodwin says: "It's part of the logic of the reforms that we are trying to bring providers and commissioners closer together."

The government wants to see more work at a community level, rather than in acute hospitals – provided it is cheaper, of course – and inevitably that means GPs will do some of it. Risk sharing – where an organisation agrees to provide certain services for a defined population for a set price, with an agreement it can keep all or some of any under spends – may also be an attractive proposition.

But what happens if that organisation is owned by GPs and seen as making big profits off the back of the contract? There might be nothing wrong with this – it may have been tendered for in a perfectly ethical way – but the sight of GPs getting richer through treating patients at less cost could be a disturbing one for the public.

GPs are acutely aware that although involvement in commissioning offers them tremendous opportunities to improve care and reshape the health service, the esteem the public holds them in could be at risk if they are seen to be making excessive profits from it. ●

With the 'pause' over and the reform programme back in full stride, Gary Belfield addresses some of the question now occupying GPs

HOW SOON IS NOW?

There are two distinct streams of debate going on around the commissioning reforms. One is in Whitehall and deals with the setup of the NHS Commissioning Board and all the guidance and rules that will emerge. The other is on the front line with clinical commissioning groups and is practical, widespread and increasingly influential. This is where the future is being formed.

These frontline debates are encouraging. Despite uncertainty created by the government's listening exercise, the mood of the clinical community seems positive, and is improving. Now the "pause" is over people really believe the commissioning proposals will take place. I know from working in the NHS for nearly 20 years that clinicians are pragmatic and practical people who will now embrace the reform programme to make it work.

To get a better insight into GPs' attitudes towards the government's plans, in July KPMG commissioned a survey of 100 GPs practising in England.

Until recently clinical engagement in commissioning was random and voluntary. Now most practices are actively involved in their consortium's decisions. A third (34 per cent) of GPs surveyed said that over three quarters of the practices in their consortium are regularly involved in commissioning decisions.

Working with a number of these CCGs I have observed a series of common questions that all are now actively addressing.

Patient involvement will be vital to shifting care out of hospital

How do we balance cost and quality of care?

Our survey discovered that the biggest challenge is finding the right balance between cost and quality of care. Financial expertise (40 per cent) and care pathway redesign (36 per cent) are considered to be the most important areas of expertise for consortia over the next 12 months. The inextricable link between care and money is now clearly felt as the front line takes on delegated budgets.

This is good news. The joint focus on costs and outcomes is being built into the wider drive to "get care right first time". Clinicians see the unwarranted variation in care and additional costs are incurred every day in their practices.

Half of the GPs surveyed have now factored QIPP (quality, innovation, productivity and prevention) into their plans. This suggests substantial progress since last year, when a survey by Doctors.net.uk found less than half of surveyed GPs understood the term and of those who did, 90 per cent did not see it as something that would make a positive impact on care. There is no doubt some way to go but our experience of working with CCGs is that QIPP is fast becoming a high priority.

How do we engage the public in commissioning decisions?

Debates about public engagement are changing in scale and ambition, moving from small local initiatives to wider questions of care pathway design. This is more than the societal trend to be more inclusive in decision making.

CCGs are acting on the clear evidence that active patient engagement tends to reduce the costs of treatment. Wider public engagement will also be vitally important when some of the major shifts of care outside hospital take place in the next few years. A successful CCG will engage with the public for specific issues – such as the redesign of a care pathway or the debate about an A&E service – as well as ongoing discussions within individual practices on their experience of healthcare in the area.

How do we avoid recreating the PCT?

Given the likely running cost allowance there is little danger of replicating PCT staffing numbers but more importantly I detect a desire to create a different cultural model and way of working that is less bureaucratic and more agile. CCGs are discussing what this means in practice – in effect how to turn the current organisation model upside down with PCT clusters transforming themselves into commissioning support organisations serving clinicians as clients.

The desire to avoid PCT pitfalls also brings into focus a crucial element of being a successful commissioner – the need to be an intelligent client. This will not happen overnight for CCGs. Three in 10 of the GPs surveyed (29 per cent) said it is likely their consortium will buy in external support for commissioning. A market of support is steadily growing to step in and I expect this number will increase when the running cost allowance is announced next month.

However, CCGs also realise that it is important not to dilute the potential power of putting clinicians in the driving seat.

From our work with CCGs we can see some common emerging guidelines which are beginning to underpin role and process design:

- Know when you are outside your area of expertise. Find the answers within the CCG or buy in support.
- Decide your priorities and follow them through. Be resilient and resist the temptation to be diverted off course in the face of competing interests.
- Be on top of key data. Create a single dashboard where the areas that need attention are apparent. This doesn't mean wading through 50 pages of spreadsheets as I recently witnessed in one CCG.
- Be prepared to change your priorities if the evidence is compelling.

This is an exciting and daunting time for clinical commissioners. The challenges to acquire new skills and take on significant new responsibilities are immense. But the rewards are worth reaching for and their practical approach gives increasing confidence that they will make it work. ●

Gary Belfield is an associate partner at KPMG.

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