

# PRIMARY CARE

## SPECIAL REPORT

**GP consortia**  
Tackling change

**Self care**  
Patient power

# A CHANGE OF PRACTICE

**GP CONSORTIA** Clinically-led commissioning is on the way but are all involved ready for the challenge? *HSJ* has asked leaders from throughout the primary care sector how to make the changes work

The government's consultation paper, *Commissioning for Patients*, calls for GP consortia to be set up in shadow form for 2010-11 with primary care trusts initially providing support functions such as help with commissioning priorities, national quality standards and tariffs.

Some GPs are champing at the bit and ready to roll and a number of PCTs have already set in train the changes that will help clinically-led commissioning to develop (see case studies).

But polls show that most GPs do not feel equipped to make the changes and that by late summer 2010 only one in four was talking to their PCT about setting up consortia. Certainly GPs are receiving conflicting messages with the BMA telling its members to hold their horses until the negotiators have had a chance to thrash out some of the detail while the NHS Alliance has called for full steam ahead in setting up shadow GP consortia.

Anecdotally, the despair felt by many working in PCTs, who feel they have been discarded and maligned, may make for a

difficult transition. *HSJ* asked some leaders in primary care what PCTs could or should be doing now to make sure practices are well placed for clinically-led commissioning – and that their staff are well placed to continue to provide advice, support and expertise as the market for this opens up.

### Case study 1 Developing the PBC consortium

NHS Salford in the north west of England covers a very diverse area where mortality rates vary by seven years for men and six years for women between the richest and poorest areas.

It would be fair to say that the populations served by the GPs vary about as much as is possible. Yet, over the last two years, all of them – 55 in total – have come together in one practice based commissioning consortium that manages 70 per cent of the PCT's budget and owns the PCT's quality, innovation, productivity and prevention (QIPP) work.

Fiona Moore, head of practice based commissioning, joined the PCT in 2008, by which time the GP practices had organised

into eight clusters, each receiving financial information from the PCT that allowed them to benchmark against each other. This stimulated interest in commissioning, says Ms Moore. "We helped them to work through the commissioning cycle, of demonstrating a need for a service and developing the business case for it."


But as eight clusters, the GPs were not in a position to negotiate with providers, so in 2008 the consortium was developed.

The first step was to establish the governance arrangements, setting out how the PCT related to the PBC and the PBC to its members. "This is the most fundamental thing I think for the consortium to succeed," says Ms Moore. "We also developed a support team of people who would work with the PBC." For the time being they are employed by the PCT but work for the PBC.

Another piece of the jigsaw was a five year road map, setting out how the PBC would gradually move from carrying out the PCT's objectives, to earning more autonomy including delegated decision



A bridge to the future? A five year plan may be essential in building a solid foundation for practice based commissioning



**‘Change does not happen overnight. You need resources and support’**

#### **MICHAEL DIXON, CHAIR, NHS ALLIANCE**

“The role of the PCT now is to enable GP consortia to get going. It will be a different sort of relationship where the consortia are clients and the PCT is seeking to support.

I think the wise PCT will have been working with practice based commissioning consortia already and have a good relationship that will put them in good stead for the forthcoming changes.

Hopefully consortia will see talent at the PCT that can help them with all sorts of things; benchmarking, financial management, contracting and so on. The more support that PCTs can give now, the more likely consortia will be to form an ongoing relationship with them as providers of support services.

The future of individuals who now work in PCTs is entirely dependent on them being able to show now that they can offer



added value. To be part of the future, PCTs and their directors are going to have to sell themselves.

We also need to see how to speed this up. People will walk away and take redundancy payments and be lost to the system if we cannot get this moving forward.

I don't think there is much danger of recreating the past. The new model is entirely different in that it is clinically led.”

making for contracts up to £50,000. Year three (2011 in the original plan) would see staff transferred from the PCT's employment to the PBC's. Year four the introduction of real rather than indicative budgets and by year five the consortium would be carrying out all commissioning.

Alongside this, the PCT and PBC set up strategy groups to help develop clinical commissioning, covering areas such as long term conditions and cardiology that would provide the focus for driving commissioning forward.

“They involve community staff, and acute clinical staff in order to bring in the clinical perspective,” says Ms Moore. “It has taken time to establish them and that's one thing you have to accept in this sort of transformation. Change does

not happen overnight. You need resources and support.”

Everything was on track as the end of year two approached in spring 2010. Consortium members had grasped activity and finance data to the point where practices were challenging providers on their service charges, with an incentive scheme to reward them, and developing new consultant-to-consultant protocols with acute care clinicians.

“It's been absolutely brilliant,” says NHS Salford chief executive Mike Burrows.

“Each practice has to be a member of the consortium and has to sign up to a set of deliverables in this incentive scheme. It has become a competition on who could develop the biggest challenges on the acute contract.”



## 'My fear is that this reform will throw the baby out with the bath water'

GP Hamish Stedman says it has been a steep learning curve. "The thing that came across was that every clinical decision has a financial implication and I do not think GPs really had a grasp of that before. What you do for one patient has a bearing on the entire population."

On the clinical side, the consortium had set up a referral review system that allowed clusters to review not only their own but each other's patterns, reviewing how they work up patients and what services are available and being used. It is the sort of work that will lead to new services being commissioned.

Then came the election and now the white paper. "Now we are getting the consortium members up to speed with the implications of the white paper," says Ms Moore.

Where does the future lie? Dr Burrows feels that Salford's GP consortium is well placed for the changes ahead. "This is a role model," he says.

Dr Stedman, meanwhile, is circumspect. "I never envisaged that the consortium would take over completely from the PCT. My fear is that this reform will throw the baby out with the bath water. There are good calibre financial and business managers in the PCT

### JOHNNY MARSHALL, CHAIR, NATIONAL ASSOCIATION OF PRIMARY CARE

"Any transition is tough and I think it would be fair to say that although some PCTs and GP consortia have good relationships, many do not. When you are going through a transition relationships are important and I think it is really important right now to create a new environment with different behaviours and attitudes on both sides, from GP consortia and PCTs.

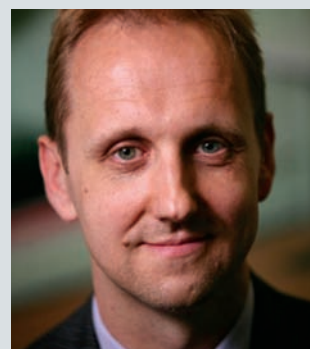
It is important for PCTs not to take a centralised approach. We cannot move overnight but if we are looking for a bottom up approach, PCTs need to work alongside the GP commissioners

in future. GPs need help to understand the functions of PCTs and what is involved in commissioning.

In some areas GPs need help to understand the size of this agenda and what they want to achieve locally. The developmental needs will vary so it is not one size fits all.

So my advice is get alongside the GPs, develop relationships, and start with a blank piece of paper so that you can understand what you want to achieve and construct from the grass roots up.

I am optimistic. If you think about the merger of Kraft and



Cadbury, that took 90 days. The NHS is more complex, but we are looking here at a two year transition. With the right skills in place, we can deliver it."

and we will have to make sure we get the best from them in the future."

### Case study 2 Developing business support in primary care

In 2007, Tameside and Glossop PCT's horizon scanning indicated that a drive towards more contestability in primary care commissioning and provision was likely.

"I could see it coming," says chief executive Tim Riley, although he did not predict quite how far the white paper,

*Equity and Excellence*, would go. The PCT put in train a strategy that would not only support practices in becoming competent at commissioning but also identify what practices needed to be effective provider businesses, for example IT support, clinical governance, clinical safety and pharmacy advice.

"We wanted to understand how we could shape GP support services to enable practices to operate more effectively and to understand if such services could become independently

viable should the need arise," he says. "The question was; if the practices could choose who they would buy these services from, would they still choose the PCT?"

The first step was to identify what practices needed so the PCT offered consultancy support to work with practices on a confidential basis, with each practice receiving tailored business development advice.

Out of 40 practices 21 took up the initial offer. Each practice saw only its own report and the PCT received an anonymised overview. Practices could then

### DAVID STOUT, DIRECTOR, NHS CONFEDERATION PRIMARY CARE NETWORK

"What's clear is that for commissioning to work in the new era it cannot be a replication of how we did it in the past. Financially and practically, that just will not work.

PCTs are not happy about the public criticism of their role – they are not only being abolished but being told that they were useless. It is demoralising given how hard people in PCTs have worked to implement government policies, the failure of which they are now being blamed for.

Among PCTs there are mixed feelings about the new policy.

Some are quite gung ho and want to make this work; some are cautious and some are in denial. It's the same for GPs.

So we need to ask how will commissioning work in the new era and what steps can we take to move towards it? The speed of change will vary from place to place and there are lots of unknowns.

The Department of Health will be looking for early adopters and these will probably be well developed practice based commissioning consortia.

The first thing to do is talk to



GPs. Step two will be quite variable. It might be seeking to transfer responsibilities and delegating to existing PBC structures or just starting to work through how to support that

transfer. PCTs need to consider what GPs want and what services they might offer to consortia.

But to try to sell their wares to GP consortia now is probably trying to run before they can walk.

From a network perspective, we are keen to hear about new ideas and share them. We need to see this developing as a genuinely bottom up process, not see people waiting until the government tells them what to do. Create your own solutions and use the current ambiguity to design your own systems."

## 'We need to be careful not to redesign PCTs or reinvent them'

decide what support they needed and the PCT could see where to develop support services that GPs might use.

Mr Riley says: "We found that most practices were reasonably well developed in their management of patient services, most human resource management and business management, albeit at a small business level."

They were less good at practice development and strategy and at marketing their own wares. "We did not expect that," says Mr Riley.

Since then, the PCT has developed its PBC support and is now developing a practice business support unit.

Primary care IT support is already in place and working well.

Some practices have taken up support from consultants as a result of this work. Alpha Primary Care, an Irish company that specialises in business support in primary care, has worked with several.

In one practice, Alpha Primary Care's diagnostic review found that the principal partner was spending 60 to 80 hours a month on quality and outcomes framework administration. Managing director Jack Nagle says: "We recruited and trained an administrative resource who now does most of this work."

"The GP now spends five hours a month and has been able to put half the time saved back into the practice and half into having a life again."

So will the practices use these services in future? Mr Riley is not sure. Initially the notion was to deliver improvements in general practice; now the strategy has developed to provide a sensible development of functions that have, until now, been available only through PCTs and SHAs.

He says: "I think there are practices that will appreciate they need to be competent in business. What they will not want is us telling them what they need."

### Case study 3

#### What about access?

When the access target in primary care was abolished, many GPs breathed a sigh of relief. But access remains a high priority for patients who regard being able to call a doctor and make an appointment that suits them as fundamental to providing a service. NHS Islington recently embarked on a piece of work that it hopes will stand practices in good stead.

"Patient satisfaction surveys have shown that we score badly on access," says Liam Knight, assistant director for primary and community care commissioning. "So we commissioned a piece of work that would hold a mirror up to the practices, enabling them to see how they perform from a patient perspective."

With a locally enhanced service incentive, practices have been working with a consultancy, Salix, that questions patients and the public, working with practices to develop improvement plans.

Dr Renu Hans single-handedly runs the Dartmouth Park Practice and despite scoring highly for access on her QOF targets, she sees how improvements can be made.

She would like, for example, to turn over a blank outside wall at the practice to the local school's graffiti club to create health messages. "I want to engage with young people and open up the practice in a positive way," says Dr Hans. She also wants to turn a spare room into a mood gym – providing access to internet health advice and computerised cognitive behavioural therapy.

For Mr Knight this dovetails closely with the task for supporting practices for the future. "The access targets have gone," he says. "But if we are to unlock the benefits of the new agenda then GPs need to address and take ownership of this issue. If they are not accessible, they will struggle with the commissioning role." ●

### JAMES QUEKETT, MEDICAL ADVISER, DOCTORS.NET.UK

"The GPs who are being quoted in the media are not typical of the vast majority of working clinicians. When doctors.net.uk polled GPs, 83 per cent said they did not feel equipped to make the changes demanded in the white paper."

GPs are nervous and they have not been highly engaged up to now. That's the flavour I get.

As a GP I will be looking for somebody with a good track record who has shown that they are an effective commissioner and have managed to redesign a service. If I am looking for a PCT manager I want someone who has



involved primary and secondary care clinicians and reconfigured services that have saved cash.

Those managers who have a negative response to GPs are the ones who will be in trouble."

### JAMES KINGSLAND, CLINICAL LEAD FOR PRACTICE BASED COMMISSIONING, DEPARTMENT OF HEALTH

"I think everyone was taken aback by the proposal to abolish PCTs. My concern is that we should not lose the best of NHS management too soon. They are going to be vital for the development of GP commissioning."

We need to be careful not to redesign PCTs or reinvent them but to work with GPs to design commissioning and help consortia function.

Part of what was wrong with commissioning to date was that managers and clinicians meant different things by it. Managers were talking about procurement and contract management; clinicians were talking about referral and spending money through prescribing and urgent care.

It was a partnership that did not flourish. PCTs designed care services on behalf of GPs who then did not refer to them because they were not relevant.

We need a change in focus. Clinicians now need to learn how to do needs assessment and how to provide services against that need. They need expertise to procure against that need and



help to place contracts and manage them. They need support to monitor them.

We don't know how many GP consortia there will be and we don't know what core functions of PCTs they will take over. We actually do not even know clearly what those functions are – when I ask PCTs for a sheet of A4 spelling them out, they don't come back to me.

If I was a PCT chief executive, I would put in some fantastic support and then take a Nanny McPhee approach: 'When you need me but don't want me, then I will stay. When you want me but don't need me, then I have to go.'

The thing I would not do is start with structures, appointing chairs and so on."



# YOU HAVE THE POWER



The idea of getting patients to take responsibility for their own health is gathering pace. But how do you put in place changes that enable engagement and bring clinicians and patients together?

In the early days of the coalition government health secretary Andrew Lansley was drawn into a debate around whether the state should tell people what to eat or whether this was a matter best left to individuals.

The underlying notion – of people taking responsibility for their own health – is one that has been rumbling along for some time and now looks set to get a boost with the launch of a self care campaign by the Department of Health at the NHS Alliance's conference in November.

The drive for improved self-care is both financial (for example, the Proprietary Association of Great Britain suggests that the NHS could save £2bn if people with self-limiting illnesses treated themselves rather than turning to the NHS) and ideological; the notion of “shared decision making” where patients have the right information to make choices for themselves is firmly entrenched in the white paper.

This does not come out of the blue. Organisations like the King's Fund and the Health Foundation have been working on them for years, looking at how patients and the public can be engaged and empowered in



primary care and how patients with long term conditions can become co-producers in their own healthcare. Doing so not only improves outcomes, the evidence suggests, but also saves money and increases job satisfaction.

Health Foundation assistant director Natalie Grazin, responsible for the organisation's co-creating health programme, says: “I do think the white paper is very exciting. It brings together what had previously been lots of different groups of people who had been working on similar areas of interest.

“It talks about transforming the dynamic between patients and clinicians. This is not just something that happens in the world of long term conditions; it is not just about accessing information or clinical records; it is not just about being open with patients when things go wrong; it is the whole array.”

She sees a clear role for managers as this agenda moves forward. Clinicians, she says, will need help to transform the dynamic.

“What we have learned over three years of co-creating health is that this requires a big culture change involving a significant

change in the way that clinicians practice.”

So, for example, a consultation can involve a clinician telling a patient test results – or it can involve a patient who already knows the results sitting down to discuss their implications. The latter requires a mechanism for sending the right results to the right patient at the right time.

Similarly, if patients and clinicians are jointly to set an agenda for their consultation rather than it being dictated by the clinician, then patients need a mechanism to do this. It could be as simple as a form – but they need it at the right time.

Ms Grazin says: “It requires a system change and that involves managers.”

The Health Foundation is about to launch a programme looking at shared decision making that will take the lessons learned from co-creating health to look at how patients make decisions and how they can be supported to make good ones using clinical evidence.

Ms Grazin says: “The key point in shared decision making is that patients do not just need information to make a good decision – they need decision support.”

Dr Michael Dixon could not agree more. He is chair of the NHS Alliance but, as a GP in Devon, has been working on a two year, DH funded project with Peninsula Medical School, the University of Westminster and an inner London practice to explore a similar dynamic.

Initially, the practices were commissioned to produce leaflets on how patients with common conditions such as back pain can treat themselves.

Dr Dixon says: "What we are finding is that just producing material is not what produces results. What does produce results is bringing people together." Bringing people with similar conditions together with a health professional has a profound effect on health behaviour, he says. (See also case study).

So the debate around whether it is up to the state or the individual is, it seems, rather misleading – or at least superficial. It's a cultural shift that is required, with a system that supports clinicians to make the change. And that requires managers. ●



## 'IT SHOWS WHAT CAN HAPPEN WHEN THE COMMUNITY IS ENGAGED'

The GPs at Smethwick Medical Centre in Sandwell don't park their Mercedes on the forecourt. Actually they don't own Mercedes. "They'd have the wheels off round here," laughs Dr Niti Pall. "No, we decided early on that the partners would invest in the practice rather than taking a huge amount for themselves."

Dr Pall and partners are committed to improving the health of the people living in this very deprived area. It has, she says, been an 11 year journey but for the purposes of this case study, we're going to take a short cut to three years ago when Pathfinder Healthcare Developments was set up.

PHD is a social business – a community enterprise company – set up with £200,000 capital from the Big Invest Social Enterprise Fund and with further investment from Sandwell PCT. It is solely owned by Smethwick Medical Centre, chaired by Dr Pall, and exists to allow the doctors to take risks as it reshapes patient services without jeopardising the practice itself.

By reshaping services around the patient, PHD has improved management of patients with long term conditions to the point of preventing 200 emergency admissions to secondary care last

year. The offering is based around a set of well-trying techniques but brought together in a way that engages patients, says PHD business director Dee Kyne.

So risk stratification, case management, sign posting patients to services, workforce development, group consultations (more of which later) and telephone counselling are all built around strong engagement.

This involves regular feedback and satisfaction surveys and also

## 'The more transparent we become with patients the more they engage'

community health champions who go out to pubs, libraries, temples, mosques and other community venues to offer health checks and raise health aspirations.

"The more transparent we become, the more collegiate we are with patients, the more they engage with us," says Ms Kyne.

Underpinning it is a business-like approach to data analysis that has enabled the practice to look at

where the money is really spent and then implement utilisation management. In this, the practice has been supported by FESC approved provider Aetna UK.

"If you had asked us where we spend most of our money, we would have said mental health and diabetes," says Ms Kyne. "We found out that we are spending most on children with asthma and people with two or more long term conditions. That was a real shock to us." It is one that helped them target services better.

One of the approaches working well at Smethwick is group consultations in which a group of patients with the same diagnosis – diabetes, say, or coronary heart disease – gather with a clinician. "This is not just educating patients but deciding together how to manage their health, what goals they want to reach and how they are going to do it.

"They co-teach each other about what works and can get input from the clinician as needed. It is a clinical consultation, not a support group, where people can collectively voice their concerns."

The practice has also developed a service for patients identified as being at high risk of emergency admission to hospital. It's a familiar model in which patients are offered telephone counselling

to help them set goals and learn to manage their own condition.

"Because of all the community engagement, we have a 75 per cent uptake rate of the case and care management programme. This compares to uptake rates of 20 per cent in the US where it was developed," says Ms Kyne. "It just shows what can happen when the community is activated."

The PCT has been so impressed it is about to roll out the approach developed by PHD across Sandwell at a cost of £500,000.

Director of commissioning Andy Williams says: "The agenda we are facing was always going to be about controlling costs and activity in secondary care.

"Moving to a preventive agenda has involved the GPs developing a wide set of skills including organisational development, data handling, risk stratification, case management, utilisation management, gaining familiarity with secondary care data. This is consistent with the white paper."

Will it work? Smethwick's GPs are, perhaps, uniquely committed, Mr Williams admits, and this sort of development takes time and money – neither of which is in huge supply right now.

But, he says: "It is the right thing to do and we need to find a way to do it."