Royal College of General Practitioners - Update on Commissioning Activity

13th September 2010
RCGP Principles Underpinning Commissioning

- Patients will have good access to safe effective care that is person centred and evidence based, based on need and not based on their ability to pay. ¹
- Primary care services will be developed in an equitable and efficient manner to support the needs of the local community, groups of patients and individual patients and to promote equalities.
- Patients will continue to receive high quality general practice care, delivered by doctors trained in general practice, from community setting within a multidisciplinary context.
- Training and education should be protected
- Doctors involved in commissioning must have access to training and support.
- General practitioners must work in partnership with other specialties to effectively commission.
- All general practitioners must have access to timely and easy to use information systems.
- GPs will continue to act as advocates for their patients in all circumstances
- Transaction costs must be reduced and kept at an absolute minimum
- A system of trust between provider and commissioner should be instituted with a minimum amount of onerous reporting, and accounting required. Instead a system based on trust, but with total transparency if required should be promoted (so complete access to all relevant transactional data).

¹ The White Paper and associated documents make it clear that existing NHS Trusts will be compelled to become FTs and FTs will in turn be removed from the NHS balance sheet. The removal of FTs from the NHS will have consequences for staff, which would no longer be NHS employees and new members of staff who would be outside NHS pay scales and review bodies, pensions and their important terms and conditions.
## INTRODUCTION

<table>
<thead>
<tr>
<th>White Paper Equity and Excellence</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief headlines on the plans contained in the White Paper</td>
<td>5</td>
</tr>
</tbody>
</table>

## Emerging Issues, Risks and Benefits on the White Paper with Respect to GPS and the RCGP

<table>
<thead>
<tr>
<th>Clinical Engagement and Leadership</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioner Capability, Conflict, Capacity and Competence</td>
<td>6</td>
</tr>
<tr>
<td>GP Federations and Relationship to Consortia</td>
<td>7</td>
</tr>
<tr>
<td>Risks to the NHS</td>
<td>8</td>
</tr>
<tr>
<td>Risks to GPs</td>
<td>8</td>
</tr>
<tr>
<td>Outsourcing Commissioning Functions</td>
<td>8</td>
</tr>
<tr>
<td>Organisation and Configuration of Consortia</td>
<td>10</td>
</tr>
<tr>
<td>Engagement with Specialist Colleagues</td>
<td>11</td>
</tr>
<tr>
<td>Governance Arrangements</td>
<td>11</td>
</tr>
<tr>
<td>Timescales</td>
<td>11</td>
</tr>
</tbody>
</table>

## The College’s Involvement in Commissioning Pre White Paper

| Appointment of Commissioning Lead | 12 |

## The Challenges for the College

| Determining the Principles underpinning Commissioning | 13 |

## What Should the College be Doing to Support its Members?

| Consultation | 14 |
| Supporting Commissioning | 15 |
| At National and Strategic Level | 15 |
| For Consortia | 16 |
| For Practitioners | 16 |
| For the Public and Patients | 17 |
| Alignment with Key Partners and Government Bodies | 17 |
| Private/Independent Sector Organisations | 17 |
| Primary Care Organisations | 17 |
| Sister Colleges and Others | 18 |

## Other Key Issues

| Other Key Issues | 18 |

## Next Steps and Decision Areas for Commissioning for Quality

| Next Steps and Decision Areas for Commissioning for Quality | 19 |

## References

| References | 21 |

## Annexes

| Annexes | 22 |
Introduction

1. This paper focuses on the College’s current and future engagement with commissioning, and suggests potential ways to support our members in the delivery of the reforms suggested in the White Paper. It is not a comprehensive review of the White Paper and does not in any way pre-empt the results of the RCGP consultation process on the White paper.

2. This paper relates to the following RCGP Priority Goals:\(^2\):

- **Priority Goal 1**: Deliver excellent patient care by supporting General Practitioners and members of the primary health team through the provision of high quality services and valued member benefits.
- **Priority Goal 2**: Continue to develop our role as a leading global organisation for general practice/ family medicine through international partnerships and by influencing health policy towards our goals.
- **Priority Goal 3**: Provide leadership at all levels in healthcare by supporting the professional development of General Practitioners to maintain standards of excellence and promote patient safety and quality in general practice.
- **Priority Goal 5**: Ensure continuous improvement in the calibre of clinical care provided by General Practice by setting quality standards for education, Continuing Professional Development (CPD), revalidation and the whole practice environment, by improving and extending training for GPs, and by implementing quality development in initiatives.

3. Though the White Paper is applicable to England only, the implications of such a reforming agenda will have significant impact on the other countries, and their different choices on health service development will inform RCGP approaches.

White Paper Equity and Excellence

4. The issues facing the profession cannot be underestimated. Guidance from central Government on implementation is likely to be relatively limited and it will be left to professional leaders to determine the impacts of reforms on patient care. Though general practitioners have traditionally over-achieved against expectations, it is likely that only a small percentage of GPs across the country currently have the skills, experience and competence to take forward the requirements contained in the White Paper. It is vital therefore that, assuming that the core approach to commissioning in the White Paper is carried forward, the RCGP provides guidance on principles and good practice on commissioning for its members.

5. The White Paper and a suite of additional papers were published for consultation in July 2010. It is expected that consortia will commission the great majority of NHS services, including elective hospital care and rehabilitative care, urgent and emergency care

\(^2\) Priority Goals to be finalised following Council discussion on 10 September 2010.
(including OOH), most community health services, and mental and learning disability services. General medical services will not be included.

6. Commissioning has many definitions\(^3\) and is not a single process or entity. Put simply it is a process involving professional dialogue to bring together all the elements that allow for the provision of safe, effective, accessible and cost-effective patient care, which is important for the whole of the UK.

7. In the paper “Liberating the NHS: Commissioning for patients”\(^4\), the central theme of commissioning in England is described as: “…understanding the health needs of a local population or a group of patients and of individual patients; working with patients and the full range of health and care professionals involved to decide what services will best meet those needs and to design these services; creating a clinical service specification that forms the basis for contracts with providers; establishing and holding a range of contracts that offer choice for patients wherever practicable; and monitoring to ensure that services are delivered to the right standards of quality.” (Para. 1.7).

**Brief headlines on the plans contained in the White Paper**

8. The new White Paper *Equity and Excellence: Liberating the NHS* provides the long-term vision for the NHS, with the aim to give the NHS a coherent, stable and enduring framework for quality and service improvement.

9. The key principles embraced within the White Paper are on the creation of a competitive market, in which the power is in the hands of commissioners (GPs) and providers are obliged to compete against each other.

10. General practitioners are therefore expected to have a key leadership role within the new agenda, and should have a genuine opportunity to shape how the NHS is run and be in a position to improve the care that their patients receive. General practitioners will be leading commissioning groups and will define the extent and nature of services required for their population.

11. Providers of services will be under clear contractual obligations, with sanctions, in relation to accuracy and timelessness of data they provide to the commissioning groups. The White Paper states that GP consortia will have the freedom to decide what commissioning activity they undertake for themselves and what activities (such as demographic analysis, contract negotiation, performance monitoring and aspects of financial management) they want to subcontract from external organisations, such as local authorities, private and voluntary sector bodies or from ex PCT managers/staff.

\(^3\) The Department of Health defines commissioning as the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers. Commissioning essentially involves planning what is needed, allocating resources and measuring the outcome of this expenditure. Commissioning takes place at various levels and by different bodies, including very large scale (for specialist services) and also at community level, where detailed knowledge of smaller areas is needed, and at individual patient level.

brought in to support consortia functions.

12. Another of the White Paper supporting documents: “Local democratic legitimacy in health” involves local authorities playing a key role through leading the statutory joint strategic needs assessment which will inform commissioning of health and care services. It also wants to strengthen the collective voice of patients and the public and includes a new consumer champion, Health Watch, to be located in the Care Quality Commission and at local level. Consortia will need to engage with patients and the public on an on-going basis and will have a duty of public and patient involvement.

13. Though the profession has been engaged with commissioning before, the White Paper represents a radical change and the challenges being afforded to GPs cannot be underestimated. It offers a major opportunity for doctors to prove that they can make the decisions and implement these decisions that are required to organise and design care for patients in an effective and efficient manner.

**Emerging issues, risks and benefits on the White Paper with respect to GPs and the RCGP**

14. This section provides a number of emerging issues relevant to the development of the infrastructure of commissioning and consortia. The key issues, risks and benefits have been identified following discussion with key players and in no way pre-empt the discussion about the White Paper that is taking place amongst our Members, Council and wider patient groups.

**Clinical Engagement and Leadership**

15. Clinical engagement is critical to the success of commissioning both to improve quality of care and to make savings which can fund innovation. For this to happen it is vital that all GPs (and in fact all clinicians) are aware of their individual and collective responsibility for resource allocation and demand management. This is an area where expertise needs to be developed and where the College can play a leading role in both ethical and clinical debate. A small percentage of GPs will be required to take direct leadership roles in commissioning. This is a new demand for all, while at the same time undertaking existing roles, including training, clinical work, running practices and so on.

**General practitioner capability, conflict, capacity and competence**

16. The NHS is a complex organisational system that discharges many functions along side delivering clinical services. GPs are used to running small businesses rather than conglomerates handling billion of pounds. To help motivate practitioners it is being proposed that a new GP contract includes a payment for providing primary care contingent on performance in commissioning consortia. This raises the risk that GPs will be influenced by money (or be perceived as being influenced) for their referral decisions.

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5 Liberating the NHS: Increasing Democratic Legitimacy in Health (Department of Health, October 2010)
17. There are concerns about GP capability and competence to commission, which are partly answerable by education and skill development. Other concerns are about accurate information availability and analysis, plus whether information systems are robust enough to allow for effective commissioning; and whether the management costs being proposed are sufficient. The ability for emerging GP consortia to enter into complicated negotiations with hospitals is doubtful in the short term and poses the risk that consortia could fail, almost from the outset, in managing their budgets.

18. Time and discussion will tease out the body of knowledge that GPs will require to take forward the vision of the White Paper. However, it would be expected that all general practitioners will need to be equipped with a set of generic skills and knowledge around commissioning, for example:

- What is it?
- What is my role?
- What does it mean if things go wrong?
- What is demand management?

19. As well as understanding their responsibilities in the NHS system, a smaller number of GPs will have to develop additional skills in leadership, complexities of commissioning and general risk management systems.

20. Effective commissioning will require commissioning groups to understand and manage clinical variability and poor commissioning performance. This is, as yet, an area that is underdeveloped and will require different methods of data gathering, incentives and support in primary care development. The NHS Commissioning Board will have the powers to intervene in the event that a consortium is unable to fulfill its duties effectively, or where there is a significant risk of failure.

21. Currently GPs enjoy high levels of trust\(^6\) from the public, this could be undermined due to sustained lobbying and media campaigns at local, regional and national level to challenge unpopular GP consortia decisions. Consortia may not have resources to handle sustained negative coverage, local inter-professional relationships may suffer, and the reputation of the profession as a whole could be damaged.

**GP Federations and relationship to consortia**

22. Under the new arrangements GP practices will continue to be providers of primary care as Independent contractors. The RCGP has been promoting the creation of Federations of practices since the publication of the RCGP’s Roadmap document in 2007.\(^7\) Federated practices can work together, and in partnership with other providers (including local specialists, third sector organisations or private providers) to provide health

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\(^6\) Ipsos MORI research published Oct 09 “Over the last quarter century, doctors have been named as the profession most trusted by the British public... more that 9 out of 10 adults in Britain trust doctors to tell them the truth.”

services commissioned by the GP consortia. These Federations could also have a vital role in supporting GPs in the new world of health care provision.

23. In addition, Federations can serve as a multi-professional vehicle for delivery of patient care across a number of chronic disease pathways.

**Risks to the NHS**

24. There are a number of commentators who fear that the reforms contained within the White paper represent further privatisation of the NHS, citing two main ways that this can occur. The first is that new primary care providers (for example, private providers) will be able to join consortia which opens the door to non-NHS bodies to have direct commissioning decisions using NHS money. The second is that the outsourcing of management support for commissioning functions to private bodies (see below) represents the dismantling or de-nationalisation of the management functions of NHS. A more general risk is the lack of funds for commissioning.

**Risks to GPs**

25. Many commentators fear that far from being empowered to improve services for patients as they wish, the White Paper will mean that GPs take the brunt for spending cuts and public responsibly for closing services and hospitals and for resource allocation in a climate of reducing funds.

**Outsourcing Commissioning Functions**

26. PCTs in England spent an estimated £300 million pounds on external organisations 2009 – 2010 to help with the many functions that are required from a PCT. It is likely that more money will be spent on these external organisations, both during transition stage of consortia configuration but also when consortia are at steady state. The reasons for this assumption are explained below. GPs will also be held responsible for job losses, including those of local consultant and medical colleagues.

27. To enable GP commissioning consortia to work effectively they will require high-level, general and specialist management support and it is probable that most of this support will be secured (outsourced) from the private or independent sector.

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8 It is expected that consortia will be able to commission services directly that fall within the “primary care” remit, for example GPwSI services.

9 NHS Support Federation 2010. NHS Unlimited - Who runs our GP Services?

10 Potential commissioning functions that might be outsourced are:

- Transaction/contract management
- Performance management
- Demand and risk management (including market management)
- Change management
- Internal and external communications, public consultations and stakeholder relations
- Back office management (accounting, HR, legal)
- IT/analytics
- Data collation and analysis (particularly in the light of the new Government’s focus on publishing outcomes and making patient choice effective by arming them with meaningful information)
- Public health
- Strategy guidance
Commissioning Models

28. It is anticipated that at least four separate models of commissioning support will emerge:

Model 1: Once disbanded, PCTs re-form as service provider organisations for GPs and will reconstruct themselves to provide functions/support to emerging GP consortia. The Department of Health is encouraging PCT staff to establish themselves into social enterprises in order to undertake this role, under the Right-to-Request scheme.

Model 2: GP consortia employ selected ex-PCT commissioners directly. This model, while providing control to the GP consortium, will be unlikely to achieve scale to attract talent or investment. Consortia will be on average one fifth the size of PCTs. Efficiency and value for money in functions such as transaction management, risk management, IT functions and back office tasks are all derived from scale.

Model 3: Large out-sourcing companies develop ‘one-stop shop’ solutions.

Model 4: Consortia of various organisations who have a track record of delivering "best in class" solutions on the requisite functions of a commissioning organisation are created. If co-ordination between various members of the consortium works well, this would provide the best solution in terms of quality and value for money.

There may also be hybrid models – i.e. very selected ex PCT staff used to implement model 4 type companies.

29. Because the third and fourth models as described above have the benefit of scale, it is possible that they will be able to attract investment that the first and second model cannot. As such, one would expect the market to consolidate, and the type of organisations outlined in options three and four to eventually become dominant providers of services to GP consortia.

30. In addition, the timeline of developing the new organisations is important, with the immediate requirement of having to appoint/elect GP members to lead the consortia. These GPs and others will need to form a group, formulate policy and gel quickly. Once this small group is in place it will need to produce a staff structure and appoint staff with job descriptions. If work is contracted out the leaders will require specifications and tender processes. Unless newly formed consortia use existing PCTs for management support, they will have to outsource many of the PCT functions. GPs require the skills to start an organisation from scratch - they will need outside help.

Organisation and configuration of consortia

31. Consultation around the White Paper continues. Debates will be required around the size/configuration/location of commissioning consortia as well as the roles of the various providers outside general practice. The changes themselves will have a two year timescale to implementation, but will be influenced by choices made now – hence the need to understand the options early.

32. GP Consortia must be of a scale to justify appropriate infrastructure support and this will be a challenge in the current environment of reducing management overheads. More
specifically, organisations will need:

- sophisticated management and IT infrastructure,
- the capacity to negotiate and manage contracts with providers,
- resources to analyse data and use this for population,
- health planning,
- access to capital and other funding to expand the organisation and its services or withstand potential losses.

Being of sufficient scale to access capital is also critical as GP commissioning groups will need funding to develop facilities and services that will enable new services outside hospitals and for wider infrastructure development.

33. Experience from the past has illustrated that in order to pool risk and to create economies of scale as well as being able to communicate on an equal level with large Trusts and external bodies, that consortia will need to be of sufficient size. Though this size will be determined by local need, including local geography and existing care pathways, we anticipate that each consortium should cover at least 500,000 of the population rather than the 100,000 suggested in the White paper.

**Engagement with specialist colleagues**

34. The White Paper states that there must be a clear separation between the commissioner and the provider. This means, in essence, that though local specialist colleagues might be involved in service redesign, that the service would the need to be tendered out under the “any willing provider” rule. This might have the effect of pitting the GPs against their local consultant colleagues.

**Governance Arrangements**

35. Together GP consortia will hold between £70 to £80 billion of public money and will be Statutory Bodies. This means that they will have mandatory legal powers and duties dictating how they have to discharge their duties. The consortia will have to have an official accounting officer and must have accounts that are audited and made public. The White Paper is very short on detail with regard to governance arrangements and it has been suggested that there will not be significant guidance emerging from the Department of Health.

**Timescales**

36. Timescales are short and GPs will be required to continue the existing responsibilities whilst establishing GP consortia, and employ or contract out management support within two years (possibly even less) across the whole of England. The indicative timescales are:

- 2010/11: GP consortia to begin to form on a shadow basis (building on practice-based commissioning where they wish)
- 2011/12: Comprehensive system of shadow GP consortia will be in place the NHS Commissioning Board will be established in shadow form from April 2011
2012/13: Formal establishment of GP consortia. NHS Commissioning Board established as an independent statutory body Board to announce allocations to be made to consortia for 2013/14

2013/14: GP consortia to be fully operational.

The College’s involvement in Commissioning Pre White Paper

Before discussing the role that the College might have in taking forward the White Paper, it is important to review our role in commissioning to date.

37. Over the last 12 months the College has been actively engaged with the commissioning agenda, largely through its association with the external organisations, Aetna and Price Waterhouse Coopers (PWC).

38. In 2009 the RCGP, in partnership with Price Waterhouse Coopers (PWC) and Aetna won a Department of Health tender to become a preferred provider for taking forward World Class Commissioning (under the Framework for Procuring External Support for Commissioners (FESC) procurement framework). Winning this tender meant that RCGP/Aetna/PWC would be one of a number of organisations that PCTs could draw on to provide development support. This would necessitate the members of the partnership bidding (either alone or together) for work as it became available from PCTs.

39. The work included providing a range of functions, such as:

   a. Diagnostic work on PBC / PCT relationships
   b. Organisational development of PBC commissioners
   c. Helping establish PCT vision for commissioning
   d. Project work on specific local challenges
   e. Drawing inferences and learning from the projects

40. We believe that the partnership brought together the strengths from the three individual organisations, namely: Information systems and data analysis from Aetna, organisational development from PWC and vision, clinical engagement and improving clinical skills from RCGP.

11 http://www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/FESC/DH_083553 “FESC is designed to complement existing frameworks used by the NHS to procure services. The majority of these will provide consultancy charged on a day-rate basis. FESC, on the other hand, provides the opportunity for PCTs to partner with independent providers who can undertake aspects of the commissioning function with the PCT - whilst remaining accountable to the PCT board throughout. Contractual arrangements are more robust and payment models are designed to incentivize suppliers to deliver the required value. As a result, knowledge and skills are transferred to NHS staff and the PCT gets greater value for money”. 

12
Appointment of Commissioning Lead

41. In 2009 the College appointed a Commissioning lead, Dr Andrew Spooner who has been providing support to the individual projects and the local clinical leads (see Annex 2, RCGP Commissioning in General Practice in the North West region).

The Challenges for the College

42. The White Paper represents a potential opportunity for front line clinicians to exert much greater influence on the mechanisms to improve quality of care for patients. General practitioners have been lobbying for years to get greater involvement and influence on the commissioning of services for their patients. We need to agree the principles of our involvement in the commissioning agenda and we must also determine how we can best:

- use the resources and expertise within the College
- obtain maximum return for our efforts
- produce a revenue stream for the College to support the new agenda
- position ourselves to be able to influence the agenda such that patients continue to be able to receive high quality general practice care
- ensure our members who wish to take on leadership roles are equipped with the skills, knowledge and experience to commission services
- use the opportunity to produce a step change in care and quality in general practice
- support the new cohort of doctors (First5 and AITs) to play leadership roles in the future consortia.
- learn from previous experience in commissioning.
Determining the Principles underpinning commissioning

43. The General Principles that underpin the College’s view on commissioning will need to be fleshed out during the consultation process. The BMA has already published a set of Principles\(^\text{12}\) and the College will do so following consultation with members.

44. Principles could include:

- Patients will have good access to safe effective care that is person centred and evidence based, based on need and not based on their ability to pay.\(^\text{13}\)
- Primary care services will be developed in an equitable and efficient manner to support the needs of the local community, groups of patients and individual patients and to promote equalities.
- Patients will continue to receive high quality general practice care, delivered by doctors trained in general practice, from community setting within a multidisciplinary context.
- Training and education should be protected
- Doctors involved in commissioning must have access to training and support.
- General practitioners must work in partnership with other specialties to effectively commission.
- All general practitioners must have access to timely and easy to use information systems.
- GPs will continue to act as advocates for their patients in all circumstances
- Transaction costs must be reduced and kept at an absolute minimum
- A system of trust between provider and commissioner should be instituted with a minimum amount of onerous reporting, and accounting required. Instead a system based on trust, but with total transparency if required should be promoted (so complete access to all relevant transactional data).

What should the College be doing to support its Members?

45. The College understands that it has a responsibility to its members and also to the profession. It must make sure that, whatever emerges from the consultation and subsequent legislation, the fundamental principles of the NHS are protected, and that patients are able to continue to receive high quality general practice care. This care must be delivered by doctors trained in general practice, from a community setting within a multidisciplinary context. In addition GPs must to continue to be able to act as advocates of their patients rather than being constrained to do so by conflicts of interest.


\(^{13}\) The White Paper and associated documents make it clear that existing NHS Trusts will be compelled to become FTs and FTs will in turn be removed from the NHS balance sheet. The removal of FTs from the NHS will have consequences for staff, which would no longer be NHS employees and new members of staff who would be outside NHS pay scales and review bodies, pensions and their important terms and conditions.
Since the publication of the White Paper the College has addressed its responsibilities to its members as follows:

**Consultation**

47. The College has already commenced an internal and external consultation process led by the Honorary Secretary.

- Consulting with its members on a number of key questions about the White Paper (in progress) and its suite of supporting documents
- Form an internal expert group chaired by Dr Claire Gerada (completed)
- Identified internal staff to lead on issues relating to the White Paper (completed)
- Formed a Google Group (completed)
- Set up specific site on [www.doctorsnet.uk](http://www.doctorsnet.uk) with both open access and members only site (in progress)
- Hold internal consultation with staff, senior officers, trusted colleagues (in progress)
- Hold consultations with key external bodies (in progress)
- Engage with the public and patients through the College Public and Patient Group and through other forms of engagement (ongoing)
- Gather intelligence (in progress)
- High level debates with large number of organisations (in progress)
- Attend at key conferences and workshops (in progress)
- Attend at high-level confidential professional meetings (ongoing)

**Supporting commissioning**

48. The College is best placed to lead on clinical pathways, development of education and training for commissioning, helping emerging consortia deal with variation in practice, and supporting work on quality and standards in emerging Federations.

49. We should offer:

- Clinical leadership through our members and faculties:
- A trusted brand for care-pathway guidelines, quality assurance standards and so forth
- Education and Training events
- A support network for Commissioning leads and Responsible Officers
- Development of peer assessment and management tools for Federations
- Engagement with sister colleges and primary care partners
- Updates RCGP curriculum that include commissioning

50. What we hope to provide

**At National and Strategic Level**

51. Areas where the College has a role are as follows

- Influencing policy: ensuring that we have a presence at the highest decision making level in order to shape the decision-making processes. (in progress)
- Creating commissioning networks: (to be commenced)
• Creating strategic links with key influencers and between primary care organisations.
• Collecting evidence for effective commissioning models and services (to be commenced and a role for RCGP/CIRC in partnership with college commissioning leads)
• Working with sister colleges to create leadership forum/faculty: This is in train with co-chair of a Royal College of Physicians (RCP) and RCGP and under auspices of Academy of Medical Royal Colleges to create a Faculty of Medical Leadership and Management (in train)
• Leading a network of clinical expertise to develop and influence high quality commissioning in relevant specialist areas. This role could be undertaken in full by CIRC and discussions are required to determine how the clinical champions can support commissioning, for example to develop safe practice and quality indicators (with NICE) with respect to emerging new providers, e.g. referral management centres and develop best practice care-pathways (to be commenced)
• Creating links with the third sector (commenced) and learn best ways of disseminating information and best practice in relation to third sector organisations.

For Consortia

52. For example

• Describing existing policy and disseminate in multiple formats (lecture, web, e-learning etc) (work commencing)
• Work with commissioning groups to understand how policy affects service delivery (to be put in place)
• Creating a clinical network of expertise (to be commenced)
• Creating a leadership forum (commenced as current Medical Directors Fora)
• Providing opportunities for consortia to share and learn together (to be commenced but can be through the Yahoo group)
• Developing education and training packages (in progress with a number of workshops and e-learning modules being developed).
• Developing a Tool-Kit for Federations (launch in October)
• Provide information as to how best to create links to the third sector and local authorities.

For Practitioners

53. For example

• Providing generic information and advice on commissioning – including publications, events and education packages
• Liaising with patient and voluntary organisations
• Debating with the profession and patients
• Identifying the changes required for practices to move to customer care
• Enabling consortia to conduct local consultations on plans and to liaise with local authorities and Health Watch
• Empowering GPs and referrers to make decisions with patients
• Peer and patient review of clinical decision making through quality standards
• Providing information as to how to link to the third sector
For the Public and Patients

54. For example

- Producing guides as to what patients and local communities can expect from a good practice (leaflet currently being drafted)
- Supporting consortia in developing effective patient and public involvement
- Inclusion of views in core debates
- Defending poorly argued media campaigns criticising GP consortia decisions to ensure the public are informed

Alignment with key partners and Government bodies

Private/Independent Sector Organisations

55. As discussed earlier in this paper, it is likely that the commissioning landscape in the next few years will involve a small number of external organisations supporting large numbers of GP commissioning groups. The market place for external organisations wanting to provide support to emerging GP commissioning groups is already very cluttered and will be likely to get even more so as others see opportunities for income generation by getting involved. Many of these organisations are courting the RCGP as co-working with the College would provide clinical credibility and by implication, substantial opportunities for income. The College will need to decide whether any such relationships are exclusive.

56. Our experience over the last 12 months working with Aetna and PwC has given us considerable and valuable experience and our expertise and confidence has grown considerably. We are now in a better position to understand how to use the private sector to best to achieve our ends. It has also taught us the advantages of working with the commercial/private sector (as well as many of the problems).

Primary Care Organisations

57. Senior officers are currently debating whether and which primary care organisations we should be aligning ourselves to. This is a sensitive area, as with the demise of PCTs a number of existing influential organisations will need to form new partnerships with GP consortia.

58. College Officers have been in discussion with a number of primary care organisations, such as NHS Alliance, National Association of Primary Care and National Health Service Confederation.
Sister Colleges and others

59. Commissioning can only be undertaken in collaboration with our specialist consultants, colleagues and public health. As with Commissioning Groups, the College acknowledges and welcomes the opportunity of working with our Sister Colleges and specialist groups to develop an extended range of care in community settings.

60. The College has been working with the Royal College of Physicians (RCP) for three years helping to redefine care pathways. Together we have produced the document, Teams without Walls\(^\text{14}\), which sets out the vision for patient centred care pathways. We would continue to work with RCP and others such that our clinical dialogues can produce services that meet the needs of patients with complex and long-term health needs.

61. In July 2010, the British Association of Medical Management (BAMM) went into receivership. Since July 2010, Dr Clare Gerada has been co-chairing an RCP, RCGP group (and from October, also Royal College of Psychiatrists and Royal College of Public Health) exploring the possibility of establishing an Academy Faculty of Medical Leadership. This will form the “home” for all medical leaders and managers and would in time develop a programme of support and education.

62. The Royal College of General Practitioners and the Royal College of Psychiatrists are working together to meet the challenge of the White Paper and make the most of the opportunities presented therein, building on the history of co-operation between the two Colleges and their excellent relationships with partner organisations. GPs and psychiatrists will work together to develop an agreed vision of care, commissioned by structures and processes that are financially efficient, make the best use of all provider organisations and have inbuilt explicit quality assurance frameworks, delivered by a workforce that is committed to operating across traditional boundaries, and works in partnership with patients and the community. The Primary Care Mental Health Forum will be active over the next few months attempting to influence decision-making and direction of travel. Members of the Forum are working within a group set up by RCPsych on Commissioning (the Primary Care sub-group is being led by a Psychiatrist, and Carolyn Chew-Graham from RCGP. The group is writing a document on Mental Health Services and Primary Care Commissioning, in collaboration with the NHS Confederation. This document will form a key part of RCPsych (and ideally) the RCGP response to the White Paper.

Other Key Issues

63. Consideration must be given to how commissioning performance is measured/assessed and by whom and how to address practitioners/practices where there is poor commissioning performance. This could be an important role of the College.

64. Another key issue will be the value of maintaining a separation between the provider and

\(^{14}\) Teams without Walls: The value of medical leadership and innovation (RCP, RCGP & RCPCH, , 2008: http://www.rcplondon.ac.uk/professional-Issues/Documents/teams-without-walls.pdf )
commissioning functions (except in primary care).

65. Under the proposals (Equity and Excellence Para 4.33) the Department of Health will have a progressively reducing role in oversight of training and education, and responsibility for its funding will pass to healthcare providers. Healthcare providers’ plans for funding and providing education and training will be overseen by the NHS Commissioning Board nationally and by the GP consortia at a local level – a further substantial additional responsibility for the consortia. This devolution of responsibility for funding of training would appear to effectively abolish the ring fencing of training spends represented by the national Multi-Professional Education and Training Levy. These changes, introduced at a time of overall funding shortage, pose very real threats and uncertainties to the quality of workforce training on which the future quality of the service so vitally depends. It would be important that the College had a high profile in protecting education and training.

**Next Steps and Decision Areas for Commissioning For Quality**

66. Over the next few months the College must agree a way forward. Senior College officers suggest that the College should:

- Engage in a constructive dialogue with the Government around the White Paper and the following legislation:
  - to get more clarity
  - to understand the desired structures and mechanics
  - to understand the exact timeframes
- Continue to be actively involved at all levels with the Commissioning Agenda, including at local consortia level
- Continue to develop a package of generic commissioning support material and training to Members
- Continue to engage in partnership working with a range of providers on a non-exclusive basis. This should include the possibility of tendering for partners who offer us the best opportunities to fulfill the relevant College priority areas.
- Continue to develop strong relationships with other primary care organisations, including the GPC, NHS Confederation.
- Collaborate with other Royal Colleges to establish a culture of co-commissioning
- Establish an RCGP Commissioning Support Unit, augmented by additional expertise, to help develop, collect, disseminate good practice around clinical pathways and in time provide practical support to emerging Consortia through our faculty network. This unit could be used as a vehicle to develop other
services into GP Consortia (e.g. organisational development and change management, programme management, commercial advice), delivered by external organisations with members of the College trained to deliver such functions. Maintain relationships with third party suppliers.
References


Framework for procuring External Support for Commissioners (FESC) (Department of Health: http://www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/FESC/DH_083553)

Liberating the NHS: Increasing Democratic Legitimacy in Health (Department of Health, October 2010)

Teams without Walls: The value of medical leadership and innovation (RCP, RCGP & RCPCH, 2008: http://www.rcplondon.ac.uk/professional-Issues/Documents/teams-without-walls.pdf)


Annexes

Annex 1: Giving GPs budget for commissioning: what needs to be done? A briefing paper developed by the Nuffield Trust in association with the King’s Fund, the NHS Confederation, the NHS Alliance, the National Association of Primary Care and the RCGP.

Annex 2: RCGP Commissioning in General Practice – programme of work for the North West region

Annex 3: An open letter to Dr Hamish Meldrum from Dr John Lister of the London Health Emergency organisation on the subject of the BMA’s response to the White Paper