

Consultant involvement in commissioning – the implications of the Health and Social Care Bill

Joint CCSC and GPC guidance

March 2011

Introduction

Commissioning is the process by which the NHS assesses needs, decides what services are needed, acquires them and ensures they are provided appropriately. The result can be new services, or the continuation or redesign of existing services. The essential elements of successful commissioning include assessing needs, reviewing service provision, developing ideal service models, listing and assessing service options, deciding priorities and designing services. The ability to identify priorities is a key skill for commissioners.

As part of the Government's White Paper proposals in England, responsibility for commissioning will be devolved to clinically-led commissioning consortia and the NHS Commissioning Board. PCTs and SHAs will be abolished while clinically-led commissioning consortia will be responsible for commissioning the great majority of NHS services for their patients. The NHS Commissioning Board will hold consortia to account for the outcomes they achieve as commissioners, according to standards set by NICE.

As an autonomous body, the Board will have five main functions:

- leadership on commissioning for quality improvement
- promoting and extending public and patient involvement and choice
- ensuring the development of GP commissioning consortia
- commissioning services that cannot solely be commissioned by GP consortia; and
- allocating and accounting for NHS services.¹

Clinically-led commissioning consortia will be encouraged to initiate and maintain dialogue with a variety of groups to ensure that commissioning decisions are not made in isolation either from the patients and public, local authorities or other health and care professionals.

We believe that the BMA can bring doctors from different sectors together to achieve genuine cross-sector collaboration on commissioning.

This paper has been produced to set out the implications of the Health and Social Care Bill published on 19 January 2011 and the two preceding documents: *Equity & Excellence: Liberating the NHS* published in July 2010 and the *Legislative Framework and next steps*² published in December 2010 to highlight the importance of involving secondary and tertiary care clinicians in the commissioning process and to enable consultant involvement. The timetable for the changes to commissioning outlined in the White Paper is given in Appendix 1.

Successful commissioning can only be achieved with GPs, secondary and tertiary care clinicians (senior hospital doctors, medical academic and public health medicine doctors) working together. In this guidance, we give examples of the benefits of collaborative working in commissioning.

The BMA has recently produced a new resource pack to help members understand the implications of the White Paper. The pack includes guidance notes for consultants outlining the key white paper proposals including a specific briefing on the commissioning of NHS services by clinically-led commissioning consortia. This can be accessed at the following link:

http://www.bma.org.uk/healthcare_policy/nhs_white_paper/whitepaperresourcepack.jsp

While the Government will not direct commissioning consortia on their governance arrangements, the Secretary of State has said that 'all clinicians must take on a much greater role. GPs will be expected to work closely with hospital consultants and their colleagues in all parts of the profession'.³

Support for consultant involvement in commissioning

The BMA believes that it is absolutely essential that all expert clinicians play a central role in commissioning decisions and, as such, clinically-led commissioning consortia must design local mechanisms that ensure consultants and other specialists are brought into the decision making process. The most appropriate secondary care doctor may be an associate specialist or specialty doctor where their skills and experience are at an equivalent level of seniority.

General Practitioners Committee (GPC) position

The GPC has highlighted the importance of [this] engagement across the whole profession in determining successful improvements to patient care and NHS services.⁴

This position is also supported by the Royal College of Physicians' and other Royal Colleges. The Royal College of Physicians for example believes that specialists must be fully involved in the planning and commissioning of all services, especially for specialist services and those involving patients with complex and long-term conditions. The College also believes that clinically-led commissioning consortia should use best practice protocols for commissioning services developed by the Royal Colleges, in addition to existing guidance and the proposed NICE quality standards. Furthermore, the College supports clinically-led commissioning consortia having access to networks of specialist physicians to support commissioning of care pathways, alongside bringing in expertise from local authorities or current PCT staff to coordinate with social services.⁵

Talks between the Royal College of General Practitioners (RCGP) and the Royal College of Psychiatrists (RCPsych), the National Mental Health Development Unit (NMH DU) and the NHS Confederation in September 2010 resulted in plans to develop guidance and training packages around mental health for GP commissioners. General agreement was reached between the groups regarding the commissioning of complex co-morbid conditions by psychiatrists. It is clear

that the RCPsych see the new proposals as an opportunity to work constructively with GPs and overcome past difficulties with commissioners which were caused by a lack of understanding of mental health issues. The following work will be undertaken in 2010/2011:

- A joint paper on shared values and principles in mental health commissioning
- A guide on commissioning mental health services (led by NMH DU)
- A 2011 conference on mental health commissioning (further details to follow)

Benefits of consultant involvement with commissioning

The importance of consultant involvement with commissioning was reinforced in *Liberating the NHS: Commissioning for patients* which stated that ‘successful commissioning will clearly [also] be dependent on the wider involvement of other health and care professionals.’⁶

Some localities are already encouraging more effective working between primary and secondary care in preparation for the changes outlined in the White Paper, as outlined in the various examples below:

Example 1

GPs in Tower Hamlets, London, have initiated discussions with their PCT colleagues, resulting in a number of positive developments including working much more closely with consultant colleagues. A primary care urgent care board has been set up specifically to manage urgent care more effectively in walk in centres and Accident & Emergency Departments, ensuring that consultants are able to spend time with major cases. The board contains equal numbers of GPs and consultants, along with managers and nurses.

Clinically-led commissioning consortia will be expected to involve health and social care professionals from all sectors to help design care pathways or care packages that achieve higher quality care, a better patient experience and more efficient use of NHS resources.⁷ Moreover, the Government has acknowledged that the most successful examples of clinical commissioning have been the result of effective engagement between practice-based commissioning groups and other care professionals.⁸ With this in mind, the Government has promised to work with the NHS and professional bodies to promote multi-professional involvement.⁹

Example 2

In Sunderland, collaboration between primary and secondary care has begun with the commissioning of clinical fora, involving representation from primary care and the relevant secondary care department with the objective of addressing service developments constructively.

Example 3

In Coventry, secondary care professionals have provided a useful secondary care perspective to the City Primary Care Trust. Two consultants (1 physician and 1 surgeon) employed by the Acute Trust have enabled increased understanding between the two separate Trusts. By liaising with different departments, holding discussions relating to Key Performance Indicators and reporting back, these specialists have provided a useful knowledge base from which the two Trusts can appreciate each others viewpoint more fully.

Consultants are likely to get involved in different ways at different stages of the commissioning process. The stage at which this is absolutely essential is in the designing and planning of patient pathways, because this is where their clinical knowledge comes into play.

Example 4

In the North West, partnership initiatives have been key to improving breast screening uptakes in minority and deprived communities, providing tangible outcomes which benefit patient care. Several commissioners from the locality participated in a conference on 'Addressing Health Inequalities in Breast Cancer Screening – A Partnership Approach' which was organised by a consultant from a local hospital. There was broad consensus agreement on the importance of improving communication with patients from these communities and engaging health professionals across various disciplines from these communities to improve the overall patient experience.

Consultants are also a valuable source of advice on research evidence, clinical effectiveness and capacity planning. Where there is significant research activity spanning primary and secondary care, it will also be important to seek advice from clinical academics to ensure commissioning plans incorporate appropriate safeguards to protect, and, if possible, enhance, clinical research activity. Whilst the NHS Commissioning Board will hold responsibility for promoting involvement in research and the use of research evidence,¹⁰ consultants have a good grasp of the evidence-base in their fields and can help commissioners to identify published research evidence and gaps

in the evidence base. They can also provide opinions on how to fill those gaps (for example with expert opinion, comparison with other new services or new research).

Referral management is an important component of commissioning, including the design of an evidence-based pathway of care. Secondary care clinicians can and should be involved in referral management – too often they have not been, to the detriment of those systems. There are many ways they can do this. For example, by assisting with clinical referral guidelines, access to consultant telephone advice, rapid referral outpatient clinics, clinical referral guidelines, advice and assistance in urgent care centres. Consultants can also advise on and support the development of care pathways outside secondary care. An example of this is commissioning of imaging services for musculoskeletal conditions, where GPs can access appropriate investigations before referring the patient to an intermediate level service (such as physiotherapy) or to a secondary or tertiary surgical service.

Example 5

At an acute GP service in Plymouth, effective communication between GPs and secondary care colleagues has resulted in better management of pulmonary emboli. In an effort to avoid hospital admission for the treatment of this condition, responsibility for administering anticoagulants has transferred to GPs; this has proved popular with patients who prefer to receive treatment at the GP clinic rather than being admitted to hospital. Similar initiatives have been piloted elsewhere involving training from secondary care warfarin clinics (a type of anticoagulant) and haematology consultants.

Consultants' detailed specialist knowledge allows them to advise commissioners to focus investment in new services on those areas likely to have viable and enduring futures. Consultants may be able to advise on reconfiguration, cessation of older services which may no longer be considered to be best practice or if services are unviable. One such example would be the increasing requirement for bariatric surgery for morbid obesity patients services; expert advice may allow commissioners to concentrate their investment on providers with proven expertise, optimum volume of patients, a bariatric surgery database, patient assessment procedures, selection criteria, MDT and skilled supervision of follow-up. Specialist obesity surgical services could be linked to receive referrals from a specialist medical obesity services led by an endocrinologist, according to an agreed local pathway. It is important that such services have appropriate facilities and 24 hour emergency access arrangements for post-op complications.

This collaborative way of working can benefit commissioners and empower those consultants who wish to be involved in service planning.

Whilst there are significant benefits to consultant involvement in the commissioning process, it is important to note that potential conflicts of interest may arise for those involved in the commissioning and provision of services. The GPC has produced guidance on avoiding conflicts of interest in the dual role of commissioner and provider.¹¹ The guidance provides advice on how to adhere to the DH guidance on 'PBC, Practical implementation', and the GMC guidelines set out in Good Medical Practice. All doctors involved in commissioning should remain aware of the potential for perceived or real conflicts of interest and lack of probity and have a professional duty to avoid these. Any links with the private or commercial sector should be declared.

How consultants can become engaged in the commissioning process

Although the Government has placed the emphasis on clinically-led commissioning consortia to engage with other health professionals, it is equally important for consultants to be proactive. This new approach to commissioning provides an opportunity for genuinely clinically-led local planning of services. Senior hospital doctors interested in engaging with commissioning should discuss issues in the first instance via their medical staff committee, directorate meetings, divisional meetings and local negotiating committees before considering making direct contact with the local medical committee (LMC) structures.

Both the commissioning consultation and the guidance that has been produced by the GPC identify and promote opportunities for consultants to play a key role in helping to design care pathways. The GPC is encouraging clinically-led commissioning consortia to think about how to collaborate with secondary care clinicians, public health clinicians and social workers from an early stage. Although much of the detail surrounding commissioning is yet to be provided, there are some areas which have been identified as clear points of engagement for consultants who wish to influence the delivery of care in their specialist areas, or in the course of their work on behalf of by their Trust:

1. Co-option of secondary care clinicians

The commissioning decisions of clinically-led commissioning consortia should include consultants (e.g. clinical consultants, public health medicine consultants, clinical medical academics). The co-option of secondary care clinicians onto specific subgroups of the consortium should be encouraged, particularly when exploring service redesign.¹² Consultants should also seek out opportunities to engage via their chosen committee. This could involve directly contacting the lead commissioning GP(s) once the consortia are established, or via the LMC.

2. LMCs and RCSCs

As a means of supporting the development of clinically-led commissioning consortia, the GPC is encouraging LMCs to build wider relationships with a number of organisations including local hospitals, mental health trusts and community services. In turn, RCSCs should be encouraged to initiate contact with their equivalent structures in primary care to ensure an effective two-way dialogue takes place.

In order to be as effective as possible, consultants are advised to engage in these wider relationships through their existing committee channels rather than making contact on an individual basis. Where there is more than one hospital provider in the area, discussions at directorate level would need to take place to enable changes and new pathways to be implemented easily. Once there is some agreement on the Trust structure for engaging with commissioning then someone, possibly the chairman of LNC, could be delegated to initiate talks with the LMC and report back.

3. Regional Councils – dialogue with LMCs

Regional Councils are the BMA bodies that bring together branches of practice into one setting. Again, LMCs have been encouraged to build relationships with these BMA structures, particularly with consultants and public health doctors in mind.¹³ This is a clear and definable route for consultant engagement. Information on Regional Councils can be found at the following webpage:

http://www.bma.org.uk/representation/local_representation/regional_councils/index.jsp

4. Local authorities

Under the proposals set out in the consultation document *Local democratic legitimacy in health*, Local Government will have an enhanced responsibility for promoting partnership working and integrated delivery of public services across the NHS, social care, public health and other services.

RCSCs should make contact with their Local Authorities or Health and Wellbeing Boards to initiate engagement and seek to influence decision making.

5. Local Directors of Public Health

Under the new commissioning arrangements, responsibility and funding for public health will be allocated to local Directors of Public Health (LDPH) who will be tasked with improving the health of local communities, through areas such as reducing the incidence of smoking and alcohol misuse and promoting physical activity.¹⁴ LDPH, referred to as Directors of Public Health (DsPH) in the recently released Public Health White Paper *Healthy lives, healthy people: Our strategy for public health in England*, will be transferred from the NHS into Local Government. The paper makes clear that DsPH will offer support to GP-led consortia helping to identify, prevent and manage a range of conditions but they will also need to have input into commissioning services for people with established diseases and long-term conditions. In addition, the Department of Public Health (DPH) intends to engage in a range of regular informal and formal mechanisms for public health experts to advise other NHS colleagues. Whilst the nature of this engagement is yet to be defined, consultants are encouraged to seek engagement via existing committee channels.

6. NHS Commissioning Board

Overall leadership on commissioning will be provided by the NHS Commissioning Board. As part of this role, it will be responsible for providing national leadership on commissioning for quality improvement, promoting and extending public and patient choice, ensuring the development of clinically-led commissioning consortia including holding them to account and commissioning a range of services including national and regional specialised services. Whilst it is currently unclear what mechanisms the organisation will utilise to measure this, consultants could play a key role in providing results.

7. Monitor

Working in conjunction with the NHS Commissioning Board, Monitor will ensure that commissioning decisions are fair and transparent; whilst it is currently unclear what mechanisms the organisation will utilise to measure this, consultants could play a key role in providing results.

Conclusion

Whilst GP-led consortia will need to actively engage with secondary care, consultants should be proactive and seek out appropriate opportunities arising from the White Paper and associated documents. Consultants are ideally placed to advise clinically-led commissioning consortia on secondary care pathways and planning strategy of secondary care. In some cases, the most appropriate secondary care doctor may be an associate specialist or specialist doctor where their skills and experience match the level of seniority. Both the BMA and the Medical Royal Colleges support consultant involvement in commissioning and our examples demonstrate some of the positive outcomes that can be achieved by such a collaborative approach.

Appendix 1

Implementation Timetable

2010/11

- Clinically-led commissioning consortia to begin to form on a shadow basis (building on practice-based commissioning consortia, where they wish) and, where they are ready to do so, begin to take on some responsibilities from PCTs, supported by indicative budgets

2011/12

- a comprehensive system of shadow clinically-led commissioning consortia in place, taking on increased responsibility from PCTs, including increased responsibility for the leadership of the existing Quality, Innovation, Productivity and Prevention (QIPP) initiative
- the NHS Commissioning Board to be established in shadow form as a Special Health Authority from April 2011 and to have a role in supporting the development of clinically-led commissioning consortia
- Strategic Health Authorities to be abolished by April 2012

2012/13

- formal establishment of clinically-led commissioning consortia, together with indicative allocations
- the NHS Commissioning Board to be established as an independent statutory body
- the NHS Commissioning Board to announce (in the third quarter of 2012/13) the allocations that will be made directly to consortia for 2013/14
- Clinically-led commissioning consortia to be fully operational, with real budgets and holding contracts with providers
- Primary Care Trusts to be abolished by April 2013

References

- 1 Equity and Excellence: Liberating the NHS 2010, pg 32
- 2 http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624
- 3 http://www.bma.org.uk/whats_on/annual_representative_meeting/chairmens_speeches/lansleyarmspeech.jsp
- 4 The Form and Structure of GP-led Commissioning consortia, November 2010, pg 7
- 5 Response of the Royal College of Physicians to Equity and excellence: Liberating the NHS, pg 2
- 6 Liberating the NHS: Commissioning for patients, para 6.13
- 7 Liberating the NHS: Commissioning for patients, para 6.11
- 8 Ibid para 6.12
- 9 Ibid para 6.13
- 10 Equity and Excellence: Liberating the NHS pg 31
- 11 British Medical Association (2008), *The dual role of practice based commissioner and GP provider: avoiding conflicts of interest and ensuring probity*
- 12 GP Consortia Commissioning: initial observations pg 12
- 13 GPC guide to the NHS White Paper: The role of Local Medical Committees in supporting the development of GP consortia, pg 5
- 14 Liberating the NHS: Commissioning for patients para 6.7