



March 2012
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Commissioning **EXCELLENCE**

Clinicians and finance managers need to work together

If the NHS is to achieve better health outcomes with constrained resources, clinicians and finance managers need to be partners in commissioning.

Finance managers cannot design pathways but they can help clinicians to use the financial resources at their disposal to deliver the best possible care to patients.

NHS Networks plans to bring the two groups together in a new network for GPs and primary care finance managers. The focus on primary care reflects the influence of the sector on public health and its impact on the wider system.

The network will be facilitated by Primary Care Commissioning (PCC) and co-ordinated by Professor Mahmood Adil, national QIPP adviser, clinical and finance engagement, at the DH.

Professor Adil said: "Primary care is the backbone of the NHS. With GPs in key roles in CCGs there is a perfect opportunity to apply whole-system thinking to commissioning. This means clinicians understanding the financial consequences of their plans and finance managers understanding the importance of clinical quality and value in service redesign."

NHS Networks is seeking expressions of interest in the Clinical and Finance Engagement Network. Members will be able to pool expertise, share intelligence, and access useful resources, including a planned series of workshops and results of a survey to identify priorities, barriers and planning tools, which is due to run later this month.

Anyone interested in joining the network should contact maria.axford@networks.nhs.uk

RIGHT CARE is science not magic

David Colin-Thomé believes that if the NHS takes Right Care to heart, "you really could have a sustainable health service with the resources we have today". It's a bold claim, but not rash.

Right Care aims to reduce unnecessary clinical interventions and eliminate needless variation in health investment. Patients and taxpayers will share the benefits, with billions of pounds of recurrent savings.

Right Care will also see more care delivered out of hospital, delivering additional savings.

Colin-Thomé says: "The NHS spends around £6bn on outpatient services. About two thirds of the 60m contacts are follow-up appointments and in a similar proportion of cases the patient is already seeing their GP. How many of these people really need to be seen in hospital?"

No wonder QIPP programme leaders are keen.

Colin-Thomé, a former GP and retired clinical director with the Department of Health, believes that Right Care must be more than the hobbyhorse of a few clinicians. "It needs to be systematic and widespread, part of the day-to-day business of commissioners as well as clinicians," he says. It also needs to be discriminating.

"The QIPP programme really isn't an arbitrary cuts programme.

Continued page 2



RIGHT CARE

Continued from page 1

"The health service isn't strong on discernment but a clinically directed commissioning system should be different. The best possible care for patients is also usually the most cost-effective."

The Right Care team oversees the NHS Atlas of Variation, which maps levels of NHS investment by clinical condition across England. Right Care is not against variation per se, but the needless variation arising from the lack of a coherent strategy and from differences in data quality, analytical skill, commissioning expertise, clinical input, management ability and political will.

The atlas is one of several knowledge management tools for commissioners, but Colin-Thomé does not exaggerate its importance: "It's a good start, not magic. We can provide the information for better management, but responsibility for taking the decisions has to lie with clinicians and managers."

Prescribing is well regulated with NICE guidelines to inform decisions on drugs to be available locally. Elective surgery is the Wild West by comparison: clinical judgement battles with clinical preference and clinical prejudice. The cardiologist Mike Chester has campaigned for more discriminating use of angioplasty and stent. In a paper published last year, he noted that the biggest study to date concluded that "planned angioplasty produced only a relatively small and temporary improvement and was not cost effective". He cites the 50,000 "unnecessary" procedures performed over the past 13 years at a cost of more than £250m.

Similar criticism could apply to procedures such as hysterectomy, gall bladder removal and prostatectomy.

Statistics obtained from patients show around 18% of knee replacement operations produce no clinical benefit. There is a four-fold variation in knee surgery expenditure between PCTs:

if those above the median reduced their spending to average levels £39m would be saved.

Colin-Thomé says: "A procedure is introduced for a good reason, but over time the reasons for using it start to drift, the thresholds for using the procedure are lowered and the inevitable result is that people who may not need it have it anyway."

Unnecessary procedures may adversely affect patients' quality of life and health. Unsurprisingly the elimination of "low value" interventions features prominently in the Right Care programme.

The words matter. Talk of "low value interventions" does little to engage clinicians. Patients and the media will confuse value and cost.

A recent Right Care report recommended "value based" and "effective clinical commissioning" rather than language about "procedures of limited clinical value".

The other vital ingredient in Right Care is patient involvement in decisions about their care. Evidence suggests that when they understand the options, including possible implications of a procedure, some patients reject surgery.

Numerous studies have shown that the use of decision support tools by doctors and patients reduces the level of surgical interventions. Right Care emphasises the value of evidence from the patient.

As Colin-Thomé puts it: "Only the patient can say if the care had been right for them... The key question to ask about an intervention is 'Has it made a difference to the patient?' The answer forms part of the evidence you present to subsequent patients to help them decide on the right care for them."

Commissioning resources

NEW PCCA TOOL ADDS QOF AND FLU DATA

Version 84 of the Primary Care Commissioning Application (PCCA) is now available. The update includes QOF 2010/11 and influenza immunisation at practice level, with the same functionality of grouping practices at CCG level for comparison. <http://bit.ly/yd2BHj>

IMPROVING HEALTH AND SOCIAL CARE IN LONDON: SUPPORTING INTEGRATED COMMISSIONING

This report finds that joining up support services for health and social care services could mean that there is as much as £50 per head available which can be used to support local planning and decision making. It would also mean that the boroughs and newly formed clinical commissioning groups would not waste public money and time replicating work. <http://bit.ly/yBdyRC>

PAYING FOR QUALITY: CQUINS IN LONDON

This report provides a detailed analysis of the impact of CQUINS in London. It found that in 2010/11, London hospitals missed out on nearly £22m or 23% of revenue as a result of missed CQUIN goals. <http://bit.ly/yMollf>

FOUR NEW GUIDES TO IMPROVE MENTAL HEALTH COMMISSIONING

The RCGP has published four practical guides to planning high quality mental health services. <http://bit.ly/zjVEPF>

COMMISSIONING SUPPORT RESOURCES FOR CCGs

The NHS Commissioning Board has issued a fact sheet and FAQ about commissioning support, part of a suite of resources for CCGs. <http://bit.ly/yzMYTM>

WESTMINSTER REPORTS ON 'EXPERIENCE LED COMMISSIONING' OF END OF LIFE CARE

The University of Westminster has carried out an independent evaluation of the effectiveness of "experience led commissioning" (ELC) in improving end-of-life care. ELC is a commissioning methodology based on patient experience and involvement. <http://bit.ly/yK83RN>

EMERGENCY DAY SURGERY: IMPROVING PRODUCTIVITY AND REDUCING BED DAYS

This case study is about improving the management of patients with minor emergency surgical conditions (principally abscesses) by assessing them and admitting them if possible as emergency day cases the following day. This should save bed days and avoid unnecessary fasting for patients. <http://bit.ly/xabmiv>

GUIDANCE FOR LOCAL PUBLIC HEALTH TEAMS AND CCGs

The Department of Health has issued draft guidance on public health advice - also known as the "core offer" - aimed at helping commissioners with local planning in this transition year.

Subject to the health and social care bill, from 2013/14 clinical commissioning groups will have access to public health advice, information and expertise provided by local public health teams based in local authorities. This will be a mandatory requirement but the detail of the arrangements will need to be agreed locally. <http://bit.ly/yHPHLE>

Exorcising some expensive ghosts

PCC has published a guide to list cleansing - a form of administrative spring cleaning commissioners cannot afford to ignore.

Tackling list inflation reminds primary care trusts (PCTs) that GP practice lists in England contain some 1m more people than Office for National Statistics figures suggest they should hold.

This means PCTs are almost certainly over-paying many practices, with obvious implications for both efficiency and fairness.

PCC associate director Mark Beesley, who co-authored the new guidance, says: "Commissioners face significant challenges targetting their resources to meet health needs and improve the quality of care. Spending money to care for patients that don't exist is clearly absurd. Identifying and removing such patients is a challenge but a manageable one."

There is growing pressure on PCTs to tackle the problem before handing over responsibility to the NHS Commissioning Board: the 2012-13 NHS Operating Framework includes a new indicator (PHF06) measuring the percentage of lists reviewed and cleaned. The operating framework suggests that 5% of registrations are actually ghost patients and says PCTs should be striving to get that figure below 3%.

Department of Health (DH) figures suggest that such a reduction would release £85m currently overpaid to practices for PCTs to invest in other ways. As DH allocations to PCTs are based on ONS figures rather than patient lists, reducing list size by removing the ghost patients will not affect PCT income. It will ensure it is fairly distributed amongst practices and other services, however.

The guide sets out practical steps PCTs can take to tackle list inflation (see box) but the challenge is likely to be greater in some areas than others.

The average variation between ONS and list figures might be 5% but it is thought that in some PCT areas this can reach 30%.

However in responding to new monitoring arrangements, PCTs with variations well above the 5% average will need to plan and act sensitively.

Beesley says: "Initiatives to identify ghost patients and remove them from practice lists can potentially impact on patient care and hit the finances of individual practices. Removing a patient from a list means he or she will be excluded from national screening programmes: inappropriate removal can mean re-registering the person as a new patient – bringing its own extra costs.

"Before beginning any large-scale action to reduce variation, PCTs should talk to both individual practices and the local medical committee. Many cleansing measures require access to practice records but such open communication will also help prepare practices for a possible drop in income if a significant percentage of their patients are removed."

The guide sets out several other principles to underpin list maintenance, including:

- List maintenance should be an on-going exercise involving commissioners working with their practices and local family health service agency or similar. This will require practices to have a good understanding of the removal process, particularly the role of the FP69 – effectively a flag to the practice that the patient will be removed from the list unless a new address is supplied within six months
- PCTs need to understand the make-up of their populations as some groups – such as students and those living in multi-occupancy houses – are more likely to be inappropriately registered and more suitable for targeted steps
- An equality impact assessment can help ensure initiatives do not indirectly discriminate against vulnerable groups such as immigrants and older people
- Budget for list maintenance operational costs - the removal process takes up to six months so savings are not immediate.

With this approach providing a solid base, PCTs should feel confident in clearing ghosts from the attic.

<http://bit.ly/xYKl6D>

TARGETED MEASURES

1 Student checks: Students form a large transient population in some areas. NHS Nottingham City has agreed with its university practices a process that involves sending letters to all patients aged 18-20 at first registration who are still registered four years later. Follow-up letters and FP69 actions can follow, depending on the response to the first letter.

2 Multi-occupancy dwellings: FHS providers are able to extract addresses where 10 or more residents are registered. Letters can be sent to all those registered at that address.

3 Immigrant contact: Some areas contact immigrants a year after registering with the practice, often with a note in several languages asking them to contact the practice.

4 Routine communication: Undelivered letters from screening and vaccination programmes should prompt follow-up action to see if the registration remains valid.

Moving DVT services to the community

BY CHRIS MAHONY

A clinician-owned provider of healthcare services has produced big savings while moving NHS deep vein thrombosis (DVT) diagnosis and treatment services from secondary care to the community.

The Community DVT service is one of seven services that GP Care has successfully bid to run for the NHS across Bristol, South Gloucestershire and North Somerset. Each is based on improving the patient pathway with community-based services that benefit both the patient and the NHS.

GP Care has contracts to provide DVT services to NHS South Gloucestershire and NHS Bristol.

The price to the commissioner is around 70% lower than under the old model of referral to hospitals for diagnosis and treatment. The new way of working typically requires significantly fewer visits by the patient, and these are to a community-based centre where they are diagnosed and treated.

GP Care was formed in 2005. Shareholders are GP practices. The limited company's chair, Dr Phil Yates, says it was a direct response to the perception that large private players could dominate NHS services that commissioners wish to move from hospitals to the community in coming years.

He told a PCC event recently: "We felt in Bristol that independent and small partners such as practices are not going to get a look in at winning contracts because commissioning organisations would not want to contract with 50 smaller practices or partners."

The services GP Care secures are sub-contracted to GP practices with appropriate expertise and qualifications, the district nursing community interest company and other local NHS organisations – including local NHS acute trusts whose

specialists are contracted to work in the community. Patients suspected by their GP of having had a DVT are referred to a local clinic for an ultrasound scan (D-dimer). All patients are offered a scan on the day of referral or the next day. If the scan confirms the DVT, the individual is provided with Warfarin and begins anticoagulation treatment. This involves daily injections until blood tests have confirmed the Warfarin has taken effect – normally between five and eight days.

Treatment is initiated within minutes of a positive D-dimer where previously it could take hours or even days for the patient to access treatment – leaving individuals at some risk during that period.

Both the initial and daily treatments are provided at the local clinic most convenient to the individual, perhaps contributing to satisfaction levels running at close to 100%.

Presumably the commissioners' finance teams are equally satisfied: last year the community service provided savings of £344,000 against the hospital tariff for anticoagulation treatment in south Gloucestershire. Savings in D-dimer testing and ultrasound will increase that figure, Yates says.

The latest quarterly report produced for the PCT suggested that the 40 people diagnosed and treated for DVT in the last three months of 2011 would have incurred costs of around £132,000 if they had attended hospital. The cost on the GP Care pathway was £29,000 producing a saving of £103,000.

Yates concludes: "The secret of service redesign is to plan a service the way you would want it to be for you. This means local, fast and free access. It requires skilled, knowledgeable and communicative staff and good links to the registered GP. Much of the gain for the patient is in focussing unrelentingly on tracking and assisting with each step the patient takes. With a service like DVT when you apply this thinking it would be hard to imagine how hospital delivery could ever be the best solution."

USEFUL DOCUMENTS

ATLAS CHARTS VARIATION IN THE YOUNG

Right Care will publish a series of themed atlases of variation in healthcare during 2012. The first of these, the NHS Atlas of Variation in Healthcare for Children and Young Adults has been developed with the Child and Maternal Health Observatory (ChiMat). For the first time, variations across child health services provided by NHS England are presented together to allow clinicians, commissioners and service users to identify priority areas for improving outcome, quality and productivity.
<http://bit.ly/zME9mE>

COMMISSIONING INTELLIGENCE REPORT

The NHS Commissioning Board has published results of a large-scale engagement exercise to understand the information needs of emerging clinical commissioning groups (CCGs). The requirements are presented in the form of a commissioning intelligence model, developed to facilitate discussions between local PCT clusters, emerging CCGs, public health and emerging clinical support organisations. <http://bit.ly/Aku8MI>

NEW QOF CKD TOOLKIT AVAILABLE

The latest version of the Quality and Outcomes Framework CKD toolkit, which incorporates 2010/11 data, is now available to download on NHS Kidney Care website. The updated toolkit demonstrates the QOF CKD measures reported for GP practices. It helps in making comparisons against results from other GPs, PCTs and PCT clusters, clinical commissioning groups and SHAs.
<http://bit.ly/AsqSB6>

PERSONAL HEALTH BUDGETS AND NHS CONTINUING HEALTHCARE

The Department of Health has published a discussion paper which explores personal health budgets for people receiving NHS continuing healthcare. This is aimed at healthcare professionals who will have a specific role in this initiative or are considering the future implementation of personal health budgets. <http://bit.ly/yxjCm8>

BASELINE SPENDING ESTIMATES FOR NEW NHS AND PUBLIC HEALTH COMMISSIONING

The Department of Health has published estimates of how 2010/11 spend by primary care trusts (PCTs) would be deployed under the new commissioning arrangements proposed in the health and social care bill. The baseline estimates, which have been uplifted to 2012/13 values, provide emerging clinical commissioning groups (CCG) and local authorities with the information they need to support initial planning for the commissioning responsibilities they will take on in the future.
<http://bit.ly/zy98En>



Seen to be clean

BY CHRIS MAHONY

Just as a bit of stress is almost a requirement for living, conflicts of interest are an integral part of professional life.

As with stress, it is knowing how to respond that matters.

Addressing a recent PCC event, GP Dennis Cox suggested that “to have no conflict of interest is to have no interest”.

The arrival of clinical commissioning groups dominated by GPs has pushed that issue up the NHS agenda, raising the fear of medics using public money to commission services from themselves.

Cox, who is medical director at legal firm Capsticks, co-authored last autumn’s Royal College of General Practitioners’ (RCGP) guidance on the ethics of commissioning. That document urged new commissioners to carry out the ‘Paxman test’ when spending public money: would the decision withstand the ferocious and unyielding gaze of the BBC’s inquisitor-in-chief?

The RCGP guide noted: “For members of a clinical commissioning group, a conflict of interest would exist when their duties as a commissioner could be, or could be perceived to be, influenced or impaired by their other concerns and obligations.”

The greatest danger, Cox suggested, is GPs and their colleagues sleepwalking into potential illegality and opprobrium.

“Take the example of MPs’ expenses. A lot of that came about through custom and practice, MPs telling each other that one particular claim would be alright. It is quite easy to think that we are not doing anything wrong but you have to manage how it might be seen by others. That is what you might sleepwalk into because we are providers of healthcare.”

Cox fears such a nightmare scenario could deter some GPs from standing for election to CCG boards.

He pointed out that with a history of under-investment in primary care infrastructure, the push to move services from secondary care into the community could see quite a few practices adding extensions from which to provide new services. Impressive new buildings funded ultimately by a cash-strapped NHS will invite examination of how the contracts for those services were awarded, not

to mention who benefits from the valuable new extension.

“We want GPs to be local heroes but it is so easy for that to be switched,” he said.

The hazard expands beyond the state of your own bank account. Conflicts of interest can arise (or appear to arise), for example, out of loyalties to family or colleagues or because an individual has a particular interest in a certain treatment or condition because it affects them or a family member.

However, both Cox and his Capsticks colleague Peter Edwards emphasised that the NHS is used to dealing with potential conflicts of interest. Openness and transparency – allied to some practical measures – can help avoid trouble, they believe.

The pair urged CCGs to:

- Develop scenarios for potential conflicts of interest
- Include the issue in induction training
- Put in place prompts such as invitations to declare an interest at the start of meetings.

The trick is to do that without simply reinventing the bureaucratic mind-set the current reforms are meant to be sweeping away.

Edwards advised the nascent CCGs and those contemplating leading them to be guided by the principles within the Nolan Committee’s code of conduct in public life. Initially developed as a worldly version of the Ten Commandments for parliamentarians during John Major’s troubled premiership, the seven principles enshrined within it could be a relatively straightforward guide for CCGs and their medical leaders.

Medical members of CCG boards could even come to see the principles as a commissioning equivalent of the Hippocratic Oath.

In other words, while conflict of interest is something they need to think about, clinical commissioners should not let it send their stress levels soaring.

‘Take the example of MPs’ expenses. A lot of that came about through custom and practice, MPs telling each other that one particular claim would be alright.’



KEEPING IT LOCAL but looking big

BY CHRIS MAHONY

The spirit of primary care groups (PCGs), briefly the favoured commissioning model a decade ago, lives on in at least one corner of England.

Outlining how his emerging clinical commissioning group (CCG) will keep significant power and decision-making within its three localities, Stewart Findlay pointed to PCGs as an example of the effectiveness of small but local commissioners.

Findlay is chair of the Durham Dales locality (population 96,000) within the Durham Dales, Easington and Sedgfield CCG (population 280,000). The no-nonsense name is perhaps itself a signal of the determination to keep things local.

Acknowledging that his area's stance goes against the prevailing wisdom of the medical professional bodies, Findlay is unrepentant.

"The BMA is talking about having huge populations. We know that the large primary care trusts (PCTs) did not have local GP engagement. PCTs are great at writing plans but do they deliver? GPs have often not even read those plans. You have got to take it right down to the local level."

Espousing his own version of the "Devolution Max" option now being touted as an alternative to Scottish independence, Findlay continues: "We are now a fairly large CCG because of merging the three localities but we still intend to work through federation. Durham Dales is a rural locality with very different needs and priorities to Easington. We will be using locality boards where appropriate to ensure ownership at the local level. Some areas, like remuneration, we will pass up to the CCG because they are things we do not want to deal with."

This, he says, is rather similar to the relationship PCGs had with the old health authorities.

Some budgets could be devolved down to practice level, he suggests. With its sleekness comes an

ability to be "fleet of foot", Findlay says, noting that the locality has developed six pathways this year.

Having initially favoured a CCG serving fewer than 100,000 people, Findlay is now comfortable about the merger of the three localities.

"As long as we have strong local leads we could have the best of both worlds: the structures and economies of scale of a large CCG and devolved budgets and operations to localities with performance management at CCG level."

Each locality will have two primary care representatives on the CCG board and Findlay says it will be up to these people to ensure that the localities have real autonomy and commissioning clout.

Speaking at a recent PCC event on the authorisation process, Findlay countered arguments that a locality-based model would lead to that ubiquitous NHS cliché, the postcode lottery.

"We will be building up our priorities from the localities then look at what we have as CCG-wide priorities. If there are specific issues in your locality that you need to prioritise then you need to have the data to support that. We will have CCG priorities and locality priorities. We have to accept it is messy rather than a grand plan."

It is likely that data showing it has close to the worst dental health in England will result in extra investment in dental services. With relatively long ambulance response times because of its rural nature, the locality is also likely to invest in first responder paramedics.

Such decisions will be led by monthly meetings of the locality clinical group, within which is a GP and practice manager from each of the 12 practices and two lay members. The latter will come from a committee of lay people drawn from each of the practices' patient representative groups. It is this pool that is also likely to make up the lay representation on the CCG board.

They will doubtless be expected to work with clinical colleagues in keeping a focus on the local in this CCG.

'We will be building up our priorities from the localities then look at what we have as CCG-wide priorities.'



WINTERBOURNE commissioning lessons

The abuse by staff at Winterbourne View hospital, revealed last year, raised important questions about services for people with learning disabilities who display challenging behaviour.

Last month the Department of Health wrote to strategic health authorities and local authorities setting out actions they should be taking ahead of the publication of a review into the scandal.

When individuals with learning disabilities and behaviour described as challenging are supported well, they enjoy a good quality of life within their local communities. However, they are at greater risk of experiencing service failures that can lead to placements in inappropriate settings.

Such placements are expensive (often more than £150,000 per year) and can offer little or no therapeutic benefit. Around 24 adults per 100,000 of the general population present serious challenges to services at any one time.

Better commissioning improves outcomes for individuals, their families and services while potentially reducing costs. It also helps prevent scandals such as Winterbourne that damage both patients and the reputation of local commissioners and services.

TOP TIPS FOR COMMISSIONING

1 Effective individual planning could prevent most secure or out-of-area placements. This involves:

- Working in partnership with families, children's services, education, health and social care to identify people whose home life and support is at risk of breakdown
- Genuine person-centred planning alongside individuals, their families and services
- Commissioning preventative support such as training, behavioural support, respite care and long-term provider development.

2 Developing local support and services to meet individual needs takes time and leadership. It begins with commissioners and procurement teams understanding best practice. Specialist knowledge is needed to identify need, develop appropriate support and service specifications and oversee contracting and monitoring processes.

Effective commissioning for this group requires:

- Development of specialist community support services that deliver person-centred support to individuals and their families as well as training and guidance to staff teams
- Working with local service providers to enhance their skills and develop new services
- Assessing evidence from service providers about their skills and experience. This will include looking at staff training and supervision, management understanding and the experience of other individuals, families and commissioners
- Designating people within commissioning teams to build and

maintain best practice knowledge. This will include outcome-focused contracts and reviews, and attention to safeguarding

- Ensuring that the skills required for local services are reflected in workforce planning.

3 It might still be necessary to commission out-of-area placements until local, less-restrictive alternatives are in place. Ensure there is a clear timescale for periods of assessment or rehabilitation and an agreed discharge plan.

Contracting should be based on the delivery of person-centred outcomes, rather than inputs.

Ensure that deprivation of liberty safeguards and Mental Health Act rights are observed.

4 Any crisis in support is likely to be a time of great distress and confusion for the individual, but it is essential to find ways to engage them in decision-making about short and longer term plans. Despite their knowledge and skills, families and supporters may not always be in a position to act as advocates when they are under great pressure.

It takes great skill and experience to play an advocacy role in monitoring and challenging specialist services effectively. Commission independent, skilled and experienced advocates.

5 Families must be supported to play a key role in immediate and long term decision-making. Commissioners should ensure that independent support and advice is available to them. Engagement of families should be part of the review process.

6 Given the evidence of potential negative outcomes, the commissioning of secure or out-of-area placements should never be done in isolation and without high levels of senior oversight and accountability.

Ensure that any decision to place someone in secure accommodation is multi-disciplinary and genuinely involves the individual and family.

Information about any such placements (including planned outcomes, length of stay, costs, evidence of provider competence, date of review and responsible person) should be reviewed and reported regularly as part of local governance.

Close working relationships should be forged between those with responsibilities for commissioning and for safeguarding, and between commissioners, local HealthWatch and the Care Quality Commission.

7 In addition to robust plans for individuals, joint strategic needs assessments and health and wellbeing strategies must reflect the needs of this group. This requires a good database of information about individuals and their current and future support needs.

Authors: Alison Giraud-Saunders, chair, National Family Carer Network; Bill Love, head of learning disabilities, National Development Team for Inclusion. See also the Challenging Behaviour Foundation <http://bit.ly/FSvpc1>



WILL GPS MAKE THE GRADE AS SHEEPDOGS?

BY JULIAN PATTERSON

For details of PCC events see www.pcc-events.co.uk

To access documents mentioned in this issue, an online version is available at www.pcc.nhs.uk/ce

If you have a case study for Commissioning Excellence please contact julian.patterson@pcc.nhs.uk

It is unlikely that many children playing in the schoolyard will ever say they want to be an accountable officer when they grow up.

Some GPs are doubtless now enticed by the idea of leading a clinical commissioning group (CCG) and the opportunity to reshape local health services and priorities.

Yet this new breed might find themselves marooned in the CCG HQ.

During a panel discussion at a recent PCC event, GPs suggested that colleagues seeking the role should consider if they need the equivalent of a return ticket.

After all, many practices are likely to balk at the idea of a partner whose time is dominated by the cut-and-thrust of commissioning decisions and service re-design.

Dr Stewart Findlay, chair of the Durham Dales Locality, encapsulated the dilemma: "There is a real problem if you want to have some younger people doing this job because they will almost have to re-train and build up again. That is asking an awful lot of people."

This raises the spectre of the post becoming a final career move for GPs.

Findlay asks: "Why is it wrong for mostly senior people to do this job and then leave (the profession)?"

This already happens with medical directors of PCTs and chairs of professional executive committees.

Senior roles in CCGs can't simply be grafted on to the GP's day job. Another of the panellists, Dr Katie Armstrong works part-time at her practice and three days a week as executive chair of a CCG federation. But she is not expecting this arrangement to be widely replicated when the new structures are in place and CCGs have been authorised. Nor would she recommend it as a recipe for a quiet life.

In the early years of the new era the battle-hardened, experienced GPs might be the most effective in reshaping service delivery. Their experience will also be an asset in some of the other challenges they will face, including battles with acute hospitals and their consultants.

A key test for the new organisations will be how they exercise genuine influence over secondary care when PCTs have been seen as failing.

One panellist observed: "No matter how much you pay a sheep, it will never be a sheepdog."

Yet perhaps ultra-experienced GPs who know that they can retire gracefully from local NHS battlefields in a few years will be fearsome in such challenges.

The challenge is more likely to be in managing their flock – GP colleagues in local practices whose own performance will need to be held to account.

The health secretary is keen to see a GP in at least one of the top roles in the CCG – the accountable officer and chair. The trouble is that GPs who are genuinely passionate about improving patient care and shaping services to local needs are often the people who wish to remain with their patients.

Armstrong had an interesting perspective on this: "We want clinicians who choose to make a difference for patients. It is exhausting to be a GP five days a week so it is actually really good to get out and do something different that can also really benefit patients."

If she's right, the medically-minded children of the future may like to reconsider their career options.

Diary dates

Management of professional performance
Leeds 16 May

<http://bit.ly/GDsZ1w>

Introduction to service user involvement
Nottingham 23 May

<http://bit.ly/GDymIk>

Negotiation training for commissioners and service providers
Birmingham 14 June

<http://bit.ly/GFu8DU>