COMMISSIONING TOGETHER FOR SHEFFIELD:

WHAT REALLY MATTERS?

THURSDAY 19 MAY 2011

Summary of Main Themes/Outcomes

July 2011

This event aimed to give Sheffield GPs and Practice Managers the opportunity to:

- share knowledge;
- express concerns, hopes, fears etc;
- explore the common values GPs hold and how these relate to patients' values;
- look at the Royal College of General Practitioner's (RCGP) values and an educational / supportive approach to commissioning;
- gather ideas and address some of the issues raised during the evening.

The idea was that GPs and Practice Managers could think individually and in groups about what they know, what they do not know, what they need to find out, whether others are thinking the same way etc.

To facilitate this, the event was divided into sections, with each section comprising of a brief introduction (by LMC or RCGP representatives), round table discussions and audience feedback. Representatives from secondary care were also present to listen and contribute to the round table discussions.

The main outcomes and themes of the audience feedback have been collated and this paper provides a summary which we hope will be an informative reflection of current concerns and hopes about the future of the GP commissioning agenda, as well as suggestions and proposals for moving the agenda forward and seeing real benefits and improvements for the city.

The LMC welcomes further feedback about this event, proposals for future events, GP commissioning, the Health and Social Care Bill etc. It is vital that Sheffield GPs feel able to air their views and participate in these important areas of work and debate.

Please forward your comments to the LMC office via email to:

manager@sheffieldlmc.org.uk.

WHAT DO WE THINK OF IT SO FAR?
WHAT ARE THE LOCAL ISSUES?

Threats

- Change is too rapid.
- Privatisation.
- Gambling with the health of the nation.
- Ignorance/reluctance of GPs.
- Lack of training.
- Loss of jobs.
- Loss of autonomy.
- Are we the right people to make decisions?
- Has it all been tested?
- Will it be piloted?
- How will I balance being a GP, a commissioner and a manager?
- Will it work?

Opportunities

- Primary care is the best and most cost effective way to deliver health care and this is an opportunity to have more influence.
- GPs need to have some input into how to best spend NHS money for patients.
- The idea of money following the patient is good.
- This will act as a means of standardisation, which is probably a good thing.
- Re-empowerment of GPs and empowerment of hospital clinicians.
- Increased efficiency.
- Reduced management.
- Standardised and evidence based practice.
- Use this as an opportunity to commission the services our patients need, where they need them (in the community).

Primary Care/Secondary Care Interface

- Major issue is about improving relationships with secondary care. Need to get secondary care to talk about doing things differently.
- Primary care perhaps has a lot less influence on secondary care, which needs addressing, so that primary care can take on appropriate services from secondary care.
- Current links between primary and secondary care will not be sufficient going forward – how do you make those changes happen?
- Important to work with secondary care – not see them as the other side. We need to avoid seeing secondary care as just another provider taking our business and actually involve them in pathways.
- Concerns about the primary/secondary care interface - there is insecurity and the concerns are felt equally in secondary care – needs addressing with all due speed.
- Working collaboratively is the key to this succeeding.
- There is an urgency to engage and work together.
- Secondary care wants the best care but they have a secondary care view and do not understand that primary care is often the best way to deliver care.
- We need to be showing a professional front in our negotiations with secondary care.

Primary Care/Public Health Interface

- If we have choice about what we can deliver, it will be very important to involve public health.
- Public Health has experience in delivering healthcare to populations and GPs have experience in delivering healthcare to individuals – important to bring this experience together.

Patient Involvement

- Need to address somehow retraining patients into what is available and cost restraints.
- Key thing we need to consider is doing what is right for Sheffield patients.
- Need to be involving patients so they have a say.
- Patient participation is often at a practice level – patient talking to their GP – there has to be a way for patient input to be increased and broadened.

GP/Primary Care Team Engagement

- Insufficient involvement of our staff, particularly nurses, who will be very important.
- Managers are more involved in the development of some of these services – some GPs think it might go away when in fact it needs more GP input.
- Need to be more opportunities like this event, where people have an opportunity to be involved. Whoever the clinical leads and lead commissioners are, they need more contact with people like this.
- As far as the bigger picture is concerned, we do not know what is happening nationally, so it is difficult to engage when we have no idea what the structure might be – need to do something but what?
- What is going to change in my surgery – the effect on jobbing GPs?
- This needs practices to work together and think outside of the box.
- Need to support each other to make it work.

GP Commissioning Structures

- The most immediate issue is about sorting out commissioning structures in Sheffield – single or not?
- Until structures are agreed it seems impossible to move forward with the process of commissioning. The uncertainty is causing increased negativity and lowering morale.
- We seem to be at a stalemate.
- We are concerned about the transitional period being used to try out different models. The transitional time is about getting systems/services set up, not about sorting out structure.
- Inevitably there needs to be citywide working, with sensitivity but not worrying about locality sizes – have groupings as needed.
- General agreement that there should be a citywide structure with one Accountable Officer, although views varied on the degree of locality working and the independence of Central Consortium during the shadow period.
- We need to be powerful enough as GPs to sit down with Chief Executives and secondary care trusts and talk with one voice.
- Citywide working makes sense, but we should not get hung up on whether Central is involved or not.
- We can be clear that services do need to be provided on a citywide basis, but there may need to be differences in different parts of the city - important thing is that we work together.

LMC's Role

- The role of the LMC appears to be clearer and needs to be very clear – acting as an honest broker rather than being intimately involved in the decision making process.

Miscellaneous

- Need increased and/or improved use of technology to make things work better – reminders about pathways etc.

WHAT ARE THE VALUES WE HOLD TO?

Principles/Values

- Fairness.
- Being open and honest.
- Need to balance patients' interests, responsibility for the health system and our own interests.
- Have own financial issues, but must avoid being perceived as self-interested.
- Have strong views about addressing inequalities and avoiding a postcode lottery.
- Standardisation of care required – huge discrepancies citywide, such as in referral rates.
- Value pathways in order to ensure equity.
- Few GPs in attendance and low response rate to LMC poll - does that reflect our interest/values? Is this apathy or uncertainty?
- Need to promote the NHS values we hold dear and avoid privatisation.
- Should be cherishing NHS, looking at preventative medicine, good history and examination and not wasting money.
- Traditionally patient advocate and gatekeeper but these values have been challenged.
- Need consistent criteria and pathways in order to ensure confidence in every commissioning decision.

Patient Choice/Involvement

- Patient perception is affected by media – how much influence can we have on patients' views?
- Blatant hypocrisy of patients being bombarded about choice when we have to use evidence based medicine, pathways etc.
- Patient centred services and individual patients having what they want loses the idea of the NHS providing the best care for the greatest number of people.
- Problems when it comes to individuals wanting best care for themselves and their families – difficult to hear patient voice in a consistent way.
- Choice is chaos.
- GPs are good at being the patient's advocate but it is not a bottomless pit and there is rationing.
- The Health & Social Care Bill is less about patients and more about saving money.
- Giving patients choice is at odds with the way forward.
- Patient participation enshrined in QOF but needs to be looked at differently – not currently successful.
- Community assemblies in existence but we do not engage with them - might help us engage with patients.
- Use public health and patient assemblies/groups that exist to present and justify a different system and be able to juggle our differing priorities and roles.
- Want to engage with our patients, but how do we make that representative of the population across Sheffield?
- Can we be the patient advocate? I want what's best for the patient in front of me but the practice down the road might not get that service.
- If things not going right, need to be able to tell our patients and say you do not have a choice.
- Frightening scenario of losing practice boundaries/lists.

Primary Care/Secondary Care Interface

- This is not just about primary care, but also secondary care and looking at the difficult message of promoting self-care in patients.
- Secondary care should learn to value us as much as we value them.
- What can we offer that is not available in secondary care?
- Hard for consultants to look beyond the immediate problem they are dealing with and look at the patient as a whole. We can help with that - we have information about their social circumstances etc.

Demise of PCTs/Development of GP Commissioning

- Important to get an understanding of the role the PCT has played and get a handle on what it means to be accountable to the public.
- Need to get a handle on the significant amount of work that goes on behind the scenes in the PCT.
- Need an understanding across the city and consistency.
- Primary Care has been very responsive - this is a real opportunity for practices to work together.
- Inconsistencies across primary care - need to look at this and develop a very strong primary care setting, which will help negotiations with secondary care, who do not think we are consistent and strong.
- Why would anybody want to do commissioning in the first place?
- This is carrot & stick but there is far more stick trying to motivate us to get involved.
- How do we choose commissioners and how do we measure their outcomes – financial or for the patient?
- Now it seems we are to be the key master – how do we manage that?
- How do you stop services? GPs have gatekeeping and commissioning roles but also have to deal with decommissioning role. GPs will feel very uncomfortable in that and GPs are going to be tested.

WHAT ARE THE POTENTIAL SOLUTIONS?
HOW DO WE TAKE THIS FORWARD?

Communication

- Way forward is communication.
- Information flows from Department of Health to PCT but nobody else knows what is going on.
- Needs to be totally clear communication about what is going on.
- Lots of spin going on against GPs and commissioning – someone needs to stand up and communicate our perspective.
- This is a good starting point – need more practice collaboration/communication and practices providing services in a locality.
- Spreading the word amongst colleagues important, as well as more work at practice level.
- How do we make sure that we (commissioners) disseminate information before and after an election, rather than hope we will come up with things people will sign up to?
- Things going on we want to be able to communicate and get people to feed in to, so people know what we are doing.
- Debate between secondary and primary care – need to recognise that the debate needs to link through the contractual process, so joining up of PCT functions with GP commissioning is vital.

GP Commissioning Structures

- Need to get on with a mandate for commissioning imminently – this is dragging on.
- Elephant in the room may well be equity – must be a level playing field before we start.
- Key is the structure in the city.
- Only going to work if practices get engaged, but practices do not know what they are engaging in.
- Need an elected (not imposed) management team.
- Election for commissioners should be on a 1 GP 1 vote basis.
- Feeling of frustration and indignation - deconstructing PCT to reconstruct it.
- Impression we have all signed up to this but some people feel it cannot be done.
- Role for keeping PCT managers in areas of expertise we have not got, but also look for new managers in liaison roles across practices and localities.
- Decisions being made – the sooner we get proper mandate, structure and accountability the better.
- Muddling through and doing our best and it is now good to see the process coming to some conclusions and more constructive and direct communications.
- Lots of debate about citywide and locality issue and there is a polarity there but, when you talk about issues, we want the same thing in the same way – forget structure and get on with what we need to do.
- The engine room for all of this needs to happen soon.
- Talk of Sheffield moving to fair shares but do not understand enough about that.
- Needs to be citywide commissioning, engaging experienced managerial staff.
- Need a hero/heroin to lead the city forward.
- Need a citywide team of GPs with enthusiasm, experience and accountability.
- GPs out there need to embrace this, take responsibility and get involved.

Service Redesign

- Need to evaluate and possibly rationalise services to make sure they are clinically effective so we can meet the competition.
- There are a number of pathways but it comes back to communication – ones that work are evidence based, designed by primary care and cost effective.

Patient Choice/Involvement

- Need to manage patient expectation.
- At practice level patient involvement is vital – need to be selling general practice.
- Need to be honest with patients and feed back to them.
- Solution to all of this is remove choice – unlikely to be within our local gift though.
- Need to engage more with patients at practice level and at individual level, look at feed back and how we can make savings.

LMC's Role

- LMC might have a role in brokering resolution in how we all move forward together, recognising the good things Central want to continue with.