Working with GP commissioners: a guide for local councillors and officers

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Key points

- The NHS is currently undergoing one of the most significant organisational changes in its history.
- Councillors are likely to find the new structures very different to work with, partly because they will be working alongside GPs, who have taken on commissioning responsibilities.
- There are many ways that councillors can expect to benefit from these new relationships, but they will need to aware of areas of difference, show understanding, and be open and honest with their new partners.

This short guide summarises some of the major changes in NHS commissioning and what this means for partners in local government. It presents advice from GPs, NHS managers, local councillors and officers on how to handle some the differences that often arise when working across the NHS-local government divide.

Health and wellbeing boards (HWBs) bring together NHS, local government and Healthwatch representatives to improve the lives of their local populations. The model relies on strong productive partnerships and mature relationships that are sustainable in the long-term. To succeed, board members will need a good understanding of how their partner organisations differ from their own. For councillors, this includes learning how to work with GP commissioners and the new clinical commissioning groups.

At a glance

- **Audience**: This document is aimed at councillors, as well as local authority staff, working with the NHS through health and wellbeing boards.
- **Purpose**: To help local councillors and officers understand some of the structural and cultural differences between local government and the NHS, and suggest ways of bridging these to build strong, productive local partnerships.
- **Background**: This document was developed by a health and wellbeing board learning set (see back cover for details) and supported by the Department of Health, the NHS Confederation, the Local Government Association and the NHS Institute for Innovation and Improvement.

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Top tips for councillors when working with health colleagues

- Focus on learning from health colleagues about the NHS and the current local health-related challenges and opportunities. They will have particular insight into issues affecting their patients, such as supporting those with long-term conditions, prevention, and relationships with secondary providers.
- Build relationships with health colleagues before trying to tackle specific (especially contentious) issues.
- Recognise many GPs will have previously been responsible only for their patient lists, which is a different perspective to addressing population health issues across the whole local community. They may need support to transition to this new way of working.
- Understand that in 2012/13 the local NHS will be undergoing the most dramatic structural changes in its history, and it will be a demanding time professionally and personally for health colleagues.
- Plan for how local authority democratic cycles could affect health colleagues' relationships with elected representatives on the board. Discuss with the board how to minimise the impact of this on future decision-making and ensure that other members of your council are engaged with the work of the health and wellbeing board.
- Remember that clinicians practise 'evidence-based medicine'. This may be particularly helpful following the influential 2010 report *Fair society, healthy lives: the Marmot review*, which made a strong case for prioritising upstream, preventative approaches to tackle health inequalities. Local authorities will need to build a strong evidence base to strengthen investments upstream in order to prevent illness and more expensive forms of treatment and care.

What do changes to the local NHS mean?

The Health and Social Care Act 2012 brings into being major changes to local health and social care systems. These include:

- changes to the commissioning of NHS services
- changes to who is responsible for local public health
- a far greater focus on integrated planning, commissioning and provision of services
- a focus on improving health outcomes and reducing health inequalities.

Primary care trusts (PCTs) are to be abolished and, from April 2013, responsibility for commissioning health services will be transferred to clinical commissioning groups (CCGs) and the NHS Commissioning Board, and to local authorities in relation to public health improvement. CCGs, made up of GPs working closely with professional and clinical colleagues and patients, will commission a range of clinical services including most hospital and mental health services. Primary care and regional specialist services will be the responsibility of the NHS Commissioning Board. Every GP practice must be a member of a CCG, and every CCG must be represented on a health a wellbeing board – although if there is more than one CCG in an area they can designate one CCG to act on behalf of all.

Shifting primary responsibility for commissioning NHS services from PCTs to CCGs is a significant organisational change for the NHS. The roles and responsibilities of GPs, especially those on the CCG board, will change from assessing the health needs of their patients at a practice level to planning for the health needs of the whole local population, including people who are not registered with GPs and who often have the most severe health needs. Commissioning local health services will also bring with it a significant change in budgetary responsibility. The total commissioning budget for the NHS is £80 billion, the majority of which will be held by CCGs. The allocation of funding for CCGs will be determined by the NHS Commissioning Board, though commissioning priorities will need to 'have regard' to the priorities identified in the local Joint Health and Wellbeing Strategy.

Beyond certain requirements, CCGs will be able to decide their own organisational form, governance arrangements and priorities, and will be able to contract out commissioning services – both support and direct commissioning – to councils, the private sector, not for profit organisations and NHS commissioning support services. CCGs receive funding from and are primarily

accountable to the NHS Commissioning Board. However, they will also have a web of other relationships that differ from PCTs, including clinical networks, clinical senates, individual GP practices and health and wellbeing boards.

Responsibility for local public health is to be transferred from PCTs to local authorities and a new organisation, Public Health England, will be established from April 2013. Local authorities will be required to jointly appoint a director of public health (DPH) with Public Health England. Local authorities' public health responsibilities will be supported by ring-fenced funding from the Department of Health. A key part of the DPH's role will be helping to produce the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy that are legal requirements for all health and wellbeing boards.

A new consumer champion for health and care services, called Healthwatch, has been established with a duty to promote the views and interests of patients, people using services and the public. Local Healthwatch organisations will be commissioned by local authorities (replacing local involvement networks (LINks) in most areas) and will have a member on each local health and wellbeing board.

How to foster strong, productive partnerships with GP commissioners

For positive working relationships to develop, it is important that all members of a health and wellbeing board are clear about their own roles and responsibilities, and how these compare to others on the board.

Professional and personal differences can be a challenge if misunderstood or create added value if acknowledged and harnessed. GP commissioners and elected members are keen to make a difference to the health of their population – and quickly. They will be a powerful combination if working together.

Elected members and GP commissioners may not have previously worked together and there are some areas that need to be considered when developing a partnership:

Professional backgrounds, values and legitimacy

- A GP is used to acting autonomously insofar as they make independent judgments within their work and there is a strongly held value of 'professional freedom'. GPs have completed considerable professional training and education as clinicians. As commissioners, some will have extensive experience through practice-based commissioning groups, although many will be new to planning services across a population.
- GPs and councillors often have demanding day jobs in addition to their health and wellbeing board responsibilities.
- Legitimacy for councillors is derived from their mandate from the local population, whereas for GPs it will be both local (representing the nearby GP practices) and national (as part of a National Health Service). GPs and councillors use evidence to guide their decision making, although the evidence they use may be of different forms.
- Councillors and GPs have a degree of visibility and status within the local community and both roles are dedicated to serving others.

Insight: Working with the local authority – Dr Karen West

Dr West is a GP executive for **Aylesbury Vale Clinical Commissioning Group**, Vice Chair of Buckinghamshire Health and Wellbeing Board, and a member of the collective leadership learning set for health and wellbeing boards.

She says: "From the beginning we realised that the health and wellbeing board would be bringing together two very different cultures and ways of working. We wanted to respect and harness those differences, which is why we brought in an external facilitator to guide our early discussions, and had the public involved from the start.

"It's been interesting to see how the council perceive differences between us and the PCT. They (the PCT) were used to working with essentially a management organisation, but that top-down direction isn't there now.

"There are some things that some GPs find hard to get used to – the role of elected representatives being just one. But there are some real shared interests – particularly when the councillors began to realise just how public-facing we GPs are. From my perspective a good local government partner will be honest and be themselves. We need to know what the other really thinks and share openly, at least so that there are no surprises later on."

Structural

- Councillors and GPs are both accountable to others. A councillor is accountable to people in their wards, their council and to their political party, whereas a GP commissioning lead is accountable to the members of their CCG, local patients and other parts of the NHS structure (particularly the NHS Commissioning Board).
- Councillors and GPs will both come from organisations which may have developed well-established ways of working over time but which are now required to develop new partnerships and collaborative approaches.

Procedural and financial

- There are differences in the planning, budget cycles, funding mechanisms and resource flows within councils and the NHS, which will need to be managed in the context of the health and wellbeing board.
- NHS organisations are not bound by the same democratic cycles as local authorities. However, from time to time CCGs will also hold elections where their members will vote for who sits on their governing body.

Top tips for strong and cohesive working on health and wellbeing boards

- Make collaborative leadership for local community wellbeing a priority. Board members should think of themselves as health and wellbeing board advocates as well as representatives for their own organisation.
- Establish a shared vision.
- Promote a culture of honesty and openness, including issues on which there is disagreement.
- Agree that 'this isn't like before'. All partners need to be open and willing to change – there are no 'sacred cows'.
- Recognise the diversity of knowledge and experience on the board and use it effectively.
- Ensure roles and responsibilities are clearly defined for all board members.
- Nurture relationships between organisations and key individuals as equally critical.
- Regularly meet to share problems and solutions.

This document was developed as part of the National Learning Network for Health and Wellbeing Boards, a programme funded by the Department of Health and supported by the NHS Confederation, the Local Government Association and the NHS Institute for Innovation and Improvement. Each health and wellbeing board learning set focused on a theme that early implementers had said was of most interest and importance. It aims to provide health and wellbeing board members with an accessible and helpful resource and does not necessarily showcase best practice but represents key learning on the issues. For further information, or to comment, please email hwb@nhsconfed.org

The collective leadership health and wellbeing board learning set that developed this publication included:

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- Cllr Roger Gough, Kent County Council
- Liam Hughes, Oldham Shadow Health and Wellbeing Board
- Graham Mackenzie, NHS Wandsworth
- Ian Parker, Middlesbrough Borough Council
- Cllr. Grant Monahan, Plymouth City Council
- Cllr. Colin Noble, Suffolk County Council
- Cllr. Shoaib Patel, London Borough of Redbridge
- Dr Jane Rossini, NHS Heywood, Middleton and Rochdale
- Caroline Taylor, Torbay Council
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Further information

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