

# Response to the Department of Health working document 'The functions of GP Commissioning Consortia'

May 2011

## Introduction

In March 2011, the Department of Health (DH) published a document outlining the proposed functions, powers and duties (henceforth referred to as 'duties') which *could* be attributed to clinically-led commissioning consortia. We believe that it is important to emphasise the word *could*, as the document fails to draw the reader's attention to the fact that the duties being outlined as if they were confirmed facts are based on a Bill which has yet to be passed into law. This was among a number of concerns that led to the BMA declining the offer to co-sign the functions document. It is essential the GPs and fledgling pathfinder consortia bear in mind that the suggestions in the DH document remain open for debate as well as parliamentary ratification, and we would strongly advise considering the concerns that this response document highlights before making any decisions. The DH document can be accessed here:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_124979](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124979)

## Role of consortia

In his introductory message, David Nicholson states that it is 'important for prospective consortia to understand the statutory basis of their critical role in the new system'. This is seriously misleading as it implies that this document will assist consortia in gaining this understanding, despite the fact that there is currently **no statutory basis** for their role. This discrepancy undermines the DH position and we are concerned that GPs are being encouraged to develop consortia before the legal framework is formally approved by Parliament. Similarly, Dame Barbara Hakin's foreword mentions the "must dos" for consortia, a concept that can only make sense once there is a legal framework in place for consortia and the Bill has progressed through Parliament. Since the publication of the document, the Government has embarked upon a 'listening exercise on NHS modernisation'. This further increases the possibility of changes to the Bill, increasing the need for GPs to take a cautious approach to the consortia functions document.

The introductory message also includes the claim that 'the core purpose of the new commissioning system is to improve health outcomes for NHS patients'. While it is possible that the Government does consider this to be the primary aim, it is disingenuous not to mention that the introduction of competition and limiting of spending and the removal of layers of NHS management are major motivations.

## Geography

There continues to be a **lack of clarity as to how consortia commissioning will operate geographically**. It is stated that consortia will have a duty 'to commission healthcare for...people who live within *the consortium's defined geographic area* who are not registered with any GP practice'. It is our understanding that a consortium's geographical area will be defined by the practices that are within it. If practices are free to choose which of the local consortia they wish to join rather than being defined as a particular group solely based on geography (as we find with the current PCT system), then it is likely that there will be many more areas where practice boundaries overlap. If, for example, two or three practices have overlapping areas from which they draw their patients and each are in different consortia, it is unclear how it is to be determined which of these practices has responsibility for the overlapping areas

This issue would arise with regard to the suggestion in the Governance section that the consortium's constitution will have to include 'the area for which the consortium is responsible'. There has been some suggestion that in certain circumstances, consortia would be able to eject practices. It would have to be taken into consideration that any change in the membership of a consortium would have a knock-on effect in the areas for which the consortium is responsible.

Indeed, the matter is **further complicated by the Government's stated aim of removing practice boundaries** entirely; a proposal about which the BMA has many substantial concerns. If practices cannot have defined boundaries, it is unclear how it would be possible to have geographical definitions for consortia. Furthermore, we are extremely doubtful about a duty to meet safeguarding duties, as outlined in the section on 'General duties falling on relevant public bodies'. If practice boundaries are removed, it will undermine all existing safeguarding methods as they are heavily reliant on geographical demarcation and coterminosity with social service structures. The geographical location of a patient confers irrefutable responsibilities on the social services department for that geographical area

Our concerns about the proposed removal of practice boundaries can be found in a document at the following link:

[http://www.bma.org.uk/healthcare\\_policy/reformgpboundaries.jsp](http://www.bma.org.uk/healthcare_policy/reformgpboundaries.jsp)

## Information

One of our major concerns throughout the document is **a lack of clarity on the provision of information**. In the 'General duties' section, it is stated that a duty for consortia will be to 'provide the NHS Commissioning Board with *specific information*, if considered necessary by the Secretary of State for the purposes of carrying out his functions in relation to the health services'. While it is stated that this is 'likely to be primarily financial information', we require watertight undertakings that consortia will be in a position to protect patients from the release of their confidential information. This is essential if patients are to continue to put their full trust in their GP.

In Dame Barbara's introduction, it is stated that the intention is to use 'informatics and technology to give patients greater choice and control'; something which almost inevitably means increased costs. **We do not believe that greater patient choice is compatible with a programme of spending restrictions.**

The 'Monitoring services section' also lacks clarity on the provision of information. There is a duty to 'provide information, where required, to the Information Centre', but it is not clear the full extent of what this could include. **There must be restrictions on the provision of information based on a patient's right to confidentiality and the Data Protection Act.**

PCTs have a number of duties relating to information technology, all of which are absent from this document. If consortia are to have no responsibility for information technology it is important to clarify where such responsibilities will lie.

## Scope of responsibilities

This section outlines the areas for which consortia will hold commissioning responsibility. Yet by the time consortia have statutory responsibility, it is likely that the funding for a number of these areas will have been passed to local authorities, and so in this scenario we would also want assurances that the statutory responsibility would be transferred.

It is stated that consortia will be 'expected to play a major role in improving the quality of primary care and will have a statutory duty to assist and support the NHS Commissioning Board (CB) in doing so'; however what this duty and support may mean in practice is not clarified. It suggests that consortia could have a role in performance management and even regulation; something which could cause significant conflicts of interest, with GP commissioners holding responsibility for assessing colleagues and GPs from competitor providers. It is also not clear what is expected from consortia influencing 'the NHS CB's commissioning decisions in...prison (and forensic) healthcare services, military healthcare services, high security psychiatric services and designated specialised services'. It would be helpful to have more clarity on the roles that consortia would be expected to perform as commissioning for these areas requires particular expertise.

While the document highlights that consortia 'may choose to buy in support from external organisations *including* private and voluntary sector bodies', **it is increasingly clear that pressure is being applied on fledgling pathfinder consortia to sign contracts with private companies**. Consortia should be permitted the opportunity to set-up their own support units and it is difficult to see how this kind of interference complies with the Government's stated aim of ending 'top-down' reorganisation of the NHS.

While it is not unreasonable that consortia have responsibility for the 'cost of prescriptions written by GP practices', we would wish to clarify that possible responsibility 'for the associated dispensing costs' would not include those costs generated in pharmacies. It is wholly unreasonable that prescribing decisions taken by nurses and other independent prescribers working in or for other providers should be visited on a consortium that has no control over their activity.

## General duties

We have significant concerns about the duty which requires consortia to 'exercise their functions with a view to securing *continuous improvements* in the quality of services for patients and in outcomes'. This is unrealistic given the financial constraints being imposed on the NHS, and the significant "efficiency savings" expected of practices agreed in national contract negotiations in particular, and **fails to take into account the possibility that *maintaining high standards could be considered an achievement***. Similarly, while we support the idea behind a duty to 'promote patient and carer involvement in decisions about them and enable patients to make choices with respect to aspects of their healthcare', this can only be carried out within the constraints of the resources available and with consideration to all relevant circumstances.

The duty to 'commission healthcare to the extent the consortium considers necessary to meet the *reasonable* requirements of patients', does not make it clear how, and by whom, the reasonableness of patients' requirements will be established. If consortia are to be responsible for establishing reasonableness, it is important that this is explicit and clearly differentiated from the usual legal tests of reasonableness.

It is stated that consortia will have a duty to 'co-operate' with local authorities and 'other NHS bodies'. We accept the notion that there will need to be some co-operation between these bodies; however we would be keen for this co-operation to be better defined. It is reasonable for each body to have knowledge of what can be expected of them in terms of co-operation.

There is currently a duty to ensure that 'the consortium obtains advice from people with professional expertise in relation to people's physical and mental health'. We would like to ensure that this duty applies not only to the physical and mental health of individuals, but also of communities.

Where duties require the involvement of other professionals, it would be helpful to state which groups of professionals this may include, for example hospital doctors, specialists in public health and clinical academics, and the type of advice that they may be expected to provide.

## Planning services and finances

It remains a concern that there is an intention for consortia to operate a yearly commissioning cycle, as we believe this will prevent them from planning and budgeting effectively. This is because investments within year are very unlikely to show savings in the immediate term. Strict in-year accounting also introduces perverse incentives to use budgets before the end of March. It will also prohibit and stall investment on service redesign in some consortia mid-year where this would mean a temporary overspend for only a few of months, in order to realise savings after the fiscal year end in March. Business is not predicated upon arbitrary fiscal year investment plans.

**We believe that a rolling three year commissioning cycle would be more conducive to successful outcomes.**

It is not apparent what is meant by the 'power to raise additional income for improving health services'. We would like clarification on the intended scope of these powers. We would not wish to see a scenario, for example, where it would be possible for consortia to escape from financial trouble by privatising, and charging for, particular services.

We do not believe that it is necessarily practical to 'develop arrangements to manage financial risk...with other consortia, the NHS CB and other potential partners'. **Risk can be better managed on larger scales**, and we would not want to see consortia fail as a result of inadequate risk sharing. We believe that a programme of national co-ordination would be more suitable.

More clarity is required on powers to 'pool resources' with local authorities and the commissioning board. We believe **it is important to ensure that funding for GP practices remains separate from other budgets**, as there would be significant complications should GP consortia become responsible for an amalgamated budget that included managing standard GP contracts. This issue arises again in the section on 'Improving Quality of Primary Care', in which there is a duty which delegates responsibility for aspects of GP contract management. This is very likely to create significant conflicts of interest, particularly where GP commissioners also have a stake in provider organisations. While there are applicable GMC guidelines on conflicts of interest, the nature of the proposed commissioning consortia means that conflicts will arise more frequently and it is essential that harm is not caused to patients' perceptions of GPs.

We would like to see an expansion of the 'power to pool commissioning funds with other consortia', to take into account the need for collaborative commissioning by groups of consortia for small or highly specialised services (rarer cancers, for example) which are currently provided at regional or supra-regional level, but which might not fall under the remit of the National Commissioning Board.

## Agreeing services

We do not agree that decisions on funding of specific treatments, including high-cost drugs and new interventions, should be determined entirely at a local level as this risks making consortia accountable for a post-code lottery. National guidance has an important role to play and we would wish to see it continue. Local determination in combination with the removal of practice boundaries is only likely to benefit those patients who are able to travel around the country to the areas in which the drug they seek is available. This will lead to increased health inequalities.

We wish to ensure that the duty to 'enable patients to be reimbursed for treatment provided abroad' does not come at the expense of those patients who are not able to make such arrangements. It would serve to increase health inequalities if those not able to travel for treatment suffer as a result of this duty.

## Improving quality of primary care

We are concerned that LMCs are only mentioned in relation to identifying poor performance. **LMCs should have a key monitoring, scrutiny and advisory role in almost all aspects of this document**, and it is essential that this role is recognised in all relevant guidance notes. LMCs also have the potential to act as an 'honest broker'; taking on a mediatory role in disputes.

Many enhanced services are most appropriately provided by the practices with which patients are registered. It is essential that this system is not hampered by the shift to a centrally held contract. Also, it would not be fair on patients for these services to be shifted elsewhere purely on the basis that all contracts should be open to 'any willing or qualified provider'.

Consortia have been prescribed a role in relation to the proposed 'quality premium'. However, as it remains unclear how this system will operate, it is difficult to fully imagine what a consortium's role might entail. It is clear that further work is required on the quality premium, but **the BMA remains opposed to the quality premium as outlined** and concerned about the ethical basis of rewarding GPs for particular elements of their commissioning performance which could seriously undermine the doctor-patient relationship.

## Governance

Consortia should not be entirely free to 'decide on pay, terms and conditions for employees'. A minimum set of terms & conditions should be in place and any GPs employed should be on the model salaried contract.

We do not believe that it is possible for Accountable Officers to be 'responsible for ensuring that the consortium carries out its functions in a way that ensures continuous improvements in quality and proper stewardship of public money'. Given the current financial climate there would be Accountable Officers who fail this duty for reasons beyond their control. We suggest that it would be more realistic for the officer to "act with a view to ensuring" that this duty is carried out.

## Research

PCTs have played a significant role in supporting medical research, and we would wish to ensure that this function is not overlooked in the restructuring process. The work of Primary Care Research Networks should continue and we would suggest that lead research consortia should, therefore, be identified.

## Specific duties of co-operation

We believe that there should be a general duty to meet obligations on collaborative arrangements, not just in relation to the Mental Health Act.

## Conclusion

The Department of Health's working document, 'The Functions of GP Commissioning Consortia' is a useful starting point in trying to establish the scope of consortia responsibilities. The BMA's views were fed into the process that led to the creation of the document, and we agree with the majority of what has been included. In this response document we have highlighted a number of areas that are of outstanding concern and we believe that these issues must be addressed before consortia can contemplate using the DH functions document as the basis for their development. A lack of clarity on the provision of information and geographical demarcation are recurrent themes among our concerns, however our overriding problem with the document is that it encourages GPs to view the Health Bill proposals as if they have already been passed into legislation. **It remains possible that any section of the functions document could yet be modified and we urge all GPs to keep this in mind and remain appropriately cautious until the Bill has passed and a more definitive version of the document has been published.**