General Practitioners Committee

NHS WHITE PAPER

GP consortia commissioning: the key issues

Report of a GPC round-table meeting exploring the NHS White Paper commissioning proposals

September 2010

STANDING UP FOR DOCTORS

BMA

GP consortia commissioning: the key issues

On 18 August the British Medical Association's General Practitioners Committee (GPC) hosted a half-day event to consider GP commissioning in light of the English Government's plans set out in the White Paper *Equity and Excellence: Liberating the NHS* and the consultation document *Liberating the NHS: Commissioning for patients.* Representatives from several national organisations as well as a number of local commissioning groups were present. A list of individuals and organisations attending this event can be found in Appendix 1.

Key areas of consensus

The points below represent the majority view from the meeting – not all of the delegates agreed with every point.

1) GP commissioning will only make a difference if it involves and engages all grassroots GPs. However, only a minority of GPs will need to be involved in running GP consortia.
2) Engagement from the majority of GPs will only happen if GP consortia have democratic and representative legitimacy.
3) In GP consortia, size does matter. Larger patient populations may find the management of risk, credible local engagement, and economies of scale within commissioning easier to achieve. The government or the profession's leaders should provide guidelines in this area. Locality arrangements can be put in place under larger consortia to help engage GPs and develop locally relevant patient pathways.
4) Any transition to a 'fair share' commissioning budget must be gradual if the health service is not to be destabilised.
5) Ideally, GP commissioning needs to be established on a foundation of sensible accountancy practice, with financial timescales longer than a year, to enable investment in service redesign which will realise savings beyond the March fiscal year end. Consortium success should not be judged on the basis of in-year accounts.
6) Risk-pooling and insurance mechanisms are needed to provide stability to consortia. Systems need to be put in place to deal with planned overspends, and unplanned service debts as well as 'avoidable' debts caused by poor management. Existing structural debts incurred by PCTs should perhaps be handled at a national level rather than inherited by consortia.
7) All PCT functions need to be maintained until consortia are established; some functions will need to be managed by alternative structures where they do not fall inside consortia responsibilities once PCTs have been disbanded.
8) A cultural shift within the NHS is required to allow GPs to take ownerships of their decisions.
9) 'Early adopters' must share their learning experiences with consortia that are slower to form.
10) Consortia need clarity on the rules and expectations relating to the purchaser-provider split and how conflicts of interest will be avoided.

The meeting heard introductory speeches from Dr Laurence Buckman, Chairman of the GPC and Dr Clare Gerada, Chairman elect of the RCGP. Dame Barbara Hakin, Director of Commissioning Development at the Department of Health, also provided an opening address to the meeting, but was unable to stay for the discussions. Delegates then had an opportunity to work in smaller groups to identify key questions raised by the commissioning proposals within the Government's white paper and consider some of potential solutions to these problems. A half day meeting was by no means long enough to consider all aspects of the White Paper, but it provided an opportunity for some of the most pressing questions to be discussed and debated by the key stakeholders and experienced commissioners that were present.

Most of the key questions raised by the commissioning proposals could be broadly classified into three themes: organisation and governance of commissioning consortia, budgets and finance and managing the transition to GP commissioning.

Organisation and governance of commissioning consortia

Clinician engagement

All delegates believed that the proposed commissioning arrangements should be designed in such a way that grassroots GPs would get involved. All recognised that only a minority of GPs would need to be involved directly in running consortia but there was consensus that GP commissioning could only work with buy-in from all GPs. It was felt that the success of GP commissioning would be determined by the clinical behaviour of GPs and their adherence to the improved care pathways designed by the consortium. The biggest initial challenge would be to get practices engaging in the process and working together.

Delegates agreed that systems have to be designed in such a way that motivated GPs with relevant commissioning, management and leadership expertise are enabled to work for consortia, through, for example, the provision of adequate back-fill for their clinical work. It was agreed that full engagement from the majority of GPs would only follow if GP consortia have democratic and representative legitimacy as well as accountability to constituent practices.

Delegates considered the interaction between consortia and local authorities as well as the key role that other professionals had to play in making GP commissioning work. It was suggested that public health professionals will have an important role to play in communication between consortia and local authorities. The development of meaningful and collaborative relationships between GP consortia and secondary care clinicians was considered vital for the proper commissioning of NHS services, and a mutually beneficial activity.

The size of commissioning consortia

What the optimal population size should be for GP commissioning consortia was a significant area of discussion. The majority of delegates felt that anything smaller than a population of around 500,000 may face difficulties and carry too much risk, while it would not be able to take advantage of the necessary economies of scale to ensure that commissioning was efficient. There was also recognition that commissioning groups would need to be of sufficient size for credible interaction with acute trusts and local authorities. However, it was noted that commissioning, either within a consortium or across a number of smaller consortia, will operate at multiple levels and the size of the population required to effectively commission would vary from task to task and will also be related to the size and geography of the local health economy. Although the Government plans to leave consortia size to local determination, most at this event felt that size was so integral to success that the profession's leaders should be willing to set out some guidelines. Some delegates currently involved in practice-based commissioning (PBC) suggested that smaller commissioning groups are more successful in achieving GP buy-in and ensuring that clinicians take responsibility for their clinical behaviour, and that they are better at designing beneficial changes in patient care. It was suggested that within commissioning groups covering 500,000 or more patients, locality arrangements could be put in place to facilitate local engagement and the development of locally relevant patient pathways. Where consortia are smaller than this, it is likely that they would need to collaborate with their neighbours and where appropriate form larger federations.

Consortia responsibilities and governance

There is currently little clarity about what consortia will be charged with doing and what will be held by the commissioning board or other bodies. Consortia will need clarification about the balance between central direction and localism. There is a role for GP leaders now to decide which commissioning rules need to be dictated nationally.

There is also little clarity about the role of consortia accountable officers. It is not currently specified that accountable officers should be GPs but delegates felt that, where this was the case, and many felt it desirable, the GP should retain some sort of clinical role. The extent of accountable officers' liability for consortia decisions is still undefined. It was agreed that the GMC had to consider how responsibility for consortia could affect GMC registration, for example in the event that a GP accountable officer was held responsible for the consortia's financial or clinical failings. The GPC agreed to discuss this with the GMC.

Those present that discussed organisation and governance agreed that consortia should not replicate PCT board structure and that they should develop good governance arrangements that are much leaner.

Support for consortia

Delegates discussed what form support services for consortia would take. It was agreed that outsourcing and the use of external support agencies carries a risk of shifting power away from GP commissioners over time, particularly if external support is widely commissioned from large companies which start aggregating their roles across consortia throughout England. It was suggested that consortia should engage the many NHS managers who will have previously worked in PCTs and SHAs, as a capable and experienced source of commissioning support.

Budgets and finance under GP commissioning

Commissioning budget setting and the budget cycle

Delegates were keen to understand how consortia budgets would be affected by current PCT debts, under-spends and budgets. Whilst delegates wanted to avoid entrenching health inequalities, it was acknowledged that any move to fair share budgets for consortia could result in major instability in the local health economy unless implemented in a gradual manner, especially where current PCT budgets are over and above their 'fair share funding'. Delegates agreed that imposing 'fair share funding' on consortia from the beginning was a guarantee of failure in many areas where a phased transition to 'fair share funding' would be the only viable option.

There was agreement that consortium success should not be judged on the basis of in-year accounts but that success was far more likely within a three year cycle. 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. It was pointed out that business is not predicated upon arbitrary fiscal year investment plans. GP commissioning needs to be established on a foundation of sensible accountancy practice, though it was noted that HM Treasury would likely be opposed to the concept of providing consortia with budgets for more than one year. If so, it will need to be considered how mechanisms can be developed that provide flexibility within this restriction.

Decisions need to be taken about what comes under consortia budgets and what is covered by other budgets. For example, it makes sense for the NHS Commissioning Board to take responsibility for the commissioning and funding of specialist services. Many delegates thought that consortia would be very unwilling to take on debt caused by PCTs, particularly structural debt tied in with PFI schemes, LIFT and other initiatives that GPs may even have opposed in the past. It was suggested that all debts outwith the control of consortia should be dealt with separately by a central fund that top-sliced the budget allocated to the Commissioning Board.

It was suggested that premises funding would have to be considered as part of any plan to improve patient services.

Financial risk

In discussions focusing on budgets and finance there was consensus that it is a priority to ensure the stability and viability of consortia budgets through risk-pooling and insurance mechanisms. Without adequate risk-pooling there will be no-one willing to become an accountable officer. Systems would have to be put into place to help consortia facing difficulty caused by:

a) planned in-year debt, for example that caused by investment in improving services. Could a planned overspend come out of a subsequent year's budget? Where could loans be obtained?

b) unplanned debt caused by unusual expenditure on patient care, either for individual patients or expenditure on the population as a whole. This is an actuarial problem that should probably be covered by a central, probably national, contingency fund resourced through annual payments from each consortium. This can be based on established models of stop loss insurance and could be organised on a mutual model owned jointly by all consortia. Membership of this contingency fund should be obligatory.

c) other 'avoidable' debts incurred by consortia through, for example, poor accounting. It is not yet clear what would happen to consortia in this situation. What are the consequences of failure?

Managing the transition to GP commissioning

The demise of PCTs

There is uncertainty over how PCTs will handle the transition to GP commissioning. Delegates generally supported the bottom-up model suggested by the government. With the abolition of PCTs, delegates wanted to consider which existing PCT functions could be discarded and which vital roles had to be accommodated somewhere under the new arrangements. There was particular concern that functions such as patient safeguarding, IT infrastructure management and other PCT support functions would not fit into the work of commissioning consortia, nor the NHS Commissioning Board. It was also noted that the proposed new NHS structure did not have a facility for regional and local strategic planning. This is a core function of PCTs and SHAs, and with their loss, may mean that strategy becomes the accumulation of small scale commissioning decisions. Although some commissioning decisions will still be made on a regional or national basis, the impact of the loss of strategic planning on the health service, and particularly health inequalities, needs to be understood.

Cultural change

Delegates acknowledged that the proposals required a genuine change in the mindset of clinicians and commissioners for them to succeed. The old manager-clinician dynamic is obsolete; past disputes and local feuds will need to be forgotten otherwise GP commissioning will be dogged by the inertia of previous commissioning initiatives and former NHS structures. It was felt that the key change was for ordinary clinicians to have ownership of the difficult decisions that need to be made, and respond to the changes that their peers determine are necessary. Local clinical leadership will be required to facilitate this.

The formation of consortia

Delegates were keen to prevent 'early adopters' from gaining an advantage over other GPs and consortia that were more cautious about engaging with these proposals. A culture of 'winners' and 'losers' would be unacceptable – the success of GP commissioning will be judged on the worst performers. There is a responsibility on the whole profession to engage in the process, but those who are successful first should share their experiences with others so that they can get things right first time.

The discussion focussing on transition considered the possibility of a mosaic of consortia in high density urban areas. In such areas, adjacent practices may not need to be in the same consortium – a number of consortia could overlap within the same geography. This would provide patients not only with a choice of practice, but of consortia too. In this scenario it would help to ensure that consortia included a range of practices, 'good' and 'bad'. To avoid cherry-picking it will also be important to ensure that a consortium is not able to include only those practices from affluent areas or those with low spending patterns.

The development of practice incentives

There was a debate over how incentives for practices should be aligned to the effort that they put into commissioning and redesigning care pathways. It was suggested that the income that practices receive as a result of their commissioning activity should be based on the quality of the care that is available to patients as a result of the commissioning process, rather than the achievement of financial savings. This would be an effective route to enabling wide-scale GP engagement.

Wider issues

The purchase-provider split

There was great interest in the extent of the purchaser-provider split under GP commissioning. It was acknowledged that some existing provider groups are keen to get involved in commissioning. For this reason, there seems to be potential for GP commissioning to blur the purchaser-provider split, yet the White Paper puts emphasis on the importance of competition. There was consensus that efforts have to be made to mitigate any potential conflicts of interest. Delegates were interested in the sort of rules that would need to be imposed centrally to prevent conflicts of interest.

The role of practices as commissioners

Delegates were very interested in the future interaction between GP commissioning leaders and constituent practices. There was an acknowledgement that some accountability for the success of consortia must sit at practice level and that a mixture of incentives would need to be put in place to encourage practices to comply with consortia decisions. Commissioning groups will have an important role to play in demand management at practice level using peer influence. It was suggested that good information systems within practices could help prompt GPs to follow

consortia policy. Referral reviews at practice level are probably inevitable but must be combined with consideration of case-mix and the demographics of the population served.

Patient involvement

The White Paper places a lot of emphasis on interaction with patients. Delegates agreed that patients would be concerned about postcode lotteries under local systems. Patient engagement will be important and needs further discussion, although consortia could usefully learn from PCT experiences in patient engagement. Although GPs have always been involved in rationing, patients may perceive their role as changing under GP commissioning. There is a risk that some patients will lose trust in their GP's willingness to make decisions based on their best clinical interest rather than on consortium policy, particularly if practices have any incentive to do this. GPs will need to help patients understand the new system and find ways of managing their expectations about the care that can be afforded by the NHS.

Delegates also identified possible risks to GP education and training structures within the White Paper proposals but recognised the significant lack of detail in the White Paper on this important area.

Appendix 1

A list of individuals and organisations attending the event

Dr David Bailey	Negotiator, GPC & Chairman GPC Wales
Carol Basham	Chair, BMA Patient Liaison Group
Dr Pauline Brimblecombe	Cambridgeshire Association to Commission Health
Dr Laurence Buckman	Chairman, GPC
Andrew Clapperton	Head of Primary Care Workforce & Contracting, NHS Employers
Janet Davies	Director – Nursing and Service Delivery, Royal College of Nursing
Dr Brian Dunn	Negotiator, GPC & Chairman GPC Northern Ireland
Dr Clare Gerada	Chair Elect, Royal College of General Practitioners Council
Nick Goodwin	Senior Fellow, The King's Fund
Dr Peter Holden	Negotiator, GPC
Professor David Katz	Deputy Chairman, Medical Academic Staff Committee, BMA
Dr Dean Marshall	Negotiator, GPC & Chairman, Scottish GPC
Dr Johnny Marshall	Chairman, National Association of Primary Care
Dr Beth McCarron-Nash	Negotiator, GPC
Dr Hamish Meldrum	Chairman, BMA Council
Kieran Mullan	Director of Strategy and Engagement, The Patients Association
John Murray	Specialised Healthcare Alliance
Dr Chaand Nagpaul	Negotiator, GPC
Dr Keith Reid	Deputy Chairman, BMA Public Health Medical Committee
Dr Rebecca Rosen	Senior Fellow, The Nuffield Trust
Dr Darin Seiger	Chair, Nene Commissioning Community Interest Company
David Stout	Director – PCT Network, NHS Confederation
Dr Peter Swinyard	National Chairman, Family Doctor Association
Dr Richard Vautrey	Deputy Chairman, GPC
Elizabeth Wade	Senior Policy Manager, NHS Confederation
Dr Nigel Watson	Chairman, Commissioning & Service Development subcommittee of the GPC
Dr Vicky Weeks	Chairman, Sessional GPs subcommittee of the GPC

British Medical Association, BMA House, Tavistock Square, London, WC1H 9JP
www.bma.org.uk

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