General Practitioners Committee

NHS WHITE PAPER

The form and structure of GP-led commissioning consortia

GPC guide to the NHS White Paper

November 2010

STANDING UP FOR DOCTORS

BMA

Contents

Key points

- LMCs remain local leaders of the profession – they must seek to lead GPs through the development of consortia and engage with PCTs, local authorities and other clinicians in this process.
- PCTs remain the legally accountable local health body while they exist.
- The NHS Commissioning Board is unlikely to authorise the formal creation of a consortium until it is satisfied there is complete consortia coverage in an area.
- When forming a consortium, practices will need to consider the natural health community in an area, the consortium's relationship with its practices and external organisations and its ability to manage financial risk.
- Strong leadership that has the support of the constituent practices will be essential to the successful operation of consortia.
- Shadow consortia must remain flexible at this stage to enable future changes
- Consortia will be in shadow form until 2012/13 – they should focus on working out exactly what it is they will do, before considering how to do it or embarking upon the actual process of commissioning.
- GP-led consortia commissioning is a bottom-up initiative; to succeed it will require clinicians to take genuine ownership of their decisions.
- Practices may apply to SHAs to form a pathfinder consortium from October 2010.

Introduction

The government has set out its intentions for the future of commissioning in the NHS in the White Paper 'Equality and excellence: Liberating the NHS' and the supporting consultation document 'Equality and excellence: Commissioning for patients'. These documents were published in July 2010 with a public consultation closing in early October. We expect the government to provide more information on these proposals in December.

In many parts of the country, GPs have already begun to consider what these proposals will mean for them, and how they can prepare themselves for the potential changes ahead. The GPC has already provided initial advice on these matters through a series of guides to the White Paper. These are all available on the BMA website here:

http://www.bma.org.uk/healthcare_policy/nhs_white_paper/gpcwhitepaperguidance.jsp

The idea underpinning the commissioning proposals is that they will be locally-led. There will be a great deal of flexibility and variability concerning the future structures of commissioning, and this guidance document provides GPs and practices with a range of considerations regarding the discussions they will need to have locally, the relationships they will need to build and the decisions that they will need to make as this agenda moves forward. However, this is not a definitive handbook – the political environment may change and proposals may be revised. GPs should make sure they check the BMA website for the most up-to-date GPC guidance before making any firm agreements. The only constant in this process will be the LMC – the GPC strongly advises that GPs and practices discuss these issues with their LMC.

The timetable for change

The government's timetable for change is achievable. There is sufficient time for GPs and practices to fully comprehend what is being asked of them before establishing appropriate structures and building the necessary relationships. The White Paper proposed the following indicative timetable:

2010/11

- GP-led consortia to begin to form on a shadow basis
- Pathfinder sites to be established from December 2010 with applications open from October.

2011/12

- A comprehensive system of shadow GP-led consortia to be in place, taking on increased responsibility from PCTs, including the leadership of the existing Quality, Innovation, Productivity and Prevention (QIPP) initiative
- NHS Commissioning Board to be established in shadow form as a Special Health Authority from April 2011 and to have a role in supporting the development of GP-led consortia

2012/13

- Formal establishment of GP-led consortia, together with indicative budget allocations
- NHS Commissioning Board to be established as an independent statutory body; SHAs to be abolished
- NHS Commissioning Board to announce (in the third quarter of 2012/13) the allocations that will be made directly to consortia for 2013/14

2013/14

- GP consortia to be fully operational, with real budgets and holding contracts with providers; PCTs to be abolished

At the present time, the government is only asking practices to form *shadow* consortia. These will not have full commissioning responsibilities, and it is likely that they will spend the interim period up to 2012/13 working out what it is that consortia will do by themselves, and what they will do in conjunction with other organisations, before considering how any of this will work in practice.

The duties of consortia are known in general terms only. Consortia will be responsible for commissioning secondary care, community care, mental health and urgent care (including out-of-hours and ambulance services), but not responsible for commissioning any primary care services. However, the detail is not known, and it is likely that this will influence the development of the structure and management of consortia. It is therefore important to avoid making any firm agreements with PCTs, between practices, or other organisations at this stage: form must follow function. Where GPs are developing shadow arrangements, these should remain flexible and responsive to any changes in policy. What is clear is that the PCT remains the legally accountable local health body until it has been abolished.

The Secretary of State confirmed this approach in his letter to all GPs, dated 24 September 2010[1]:

> *"You should not feel under pressure to form new working arrangements at this stage. The White Paper sets out a proposed timetable… anticipating that formal establishment of all GP consortia will take place in the year after next. At the moment, you will wish to consider what the appropriate organisational form which most suits your own particular local circumstances might be, in consultation with your GP colleagues, other health and social care professionals, your colleagues in PCTs and local government and patient groups"*

Once established, the NHS Commissioning Board will be given the power to authorise the establishment of consortia; ensuring that they:

- are of sufficient size to manage financial risk and allow for accurate budget allocations
- have the necessary arrangements and capabilities to fulfil their statutory duties
- provide comprehensive coverage of consortia across the country

With particular regard to this last criterion, it is likely that the NHS Commissioning Board will not be able to authorise the establishment of any individual consortium until it is clear that there is complete consortia coverage across an area, and that there are no practices that are not part of a consortium. Consequently, shadow consortia should bear in mind that they may be allocated practices during this process that had not previously been part of a consortium. Similarly, the NHS Commissioning Board may not approve consortia formations that cherry-pick like-minded practices within a region and leave out areas with greater health inequalities.

1 Letter to all GPs setting out the next steps on GP-led commissioning, 24 September 2010
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_119751.pdf

Engagement with the process

Previous NHS commissioning initiatives have been largely top-down in approach, and although there have been some local successes; they have not achieved their national objectives. The government's vision for GP commissioning consortia is that they will be led from the bottom-up, with individual practices taking responsibility for their clinical behaviour, and directing how services for their patients should be developed. These proposals will only work if there is broad engagement across the whole profession – if it is led by a small group of enthusiasts then GP consortia will not be able to make the improvements to patient care and NHS services that have been envisaged. Moreover, it is inevitable that the judgement on this policy will be significantly informed by the worst performers – all GPs therefore need to be engaged in this process if the record of clinician-led decision-making is positive.

Many LMCs have already held White Paper meetings and conferences to discuss these issues with local GPs. The GPC strongly encourages all LMCs to do this. We would also encourage all practices to consider (perhaps in their practice management meetings) what these proposals mean for them and how they will fit into them. In particular, LMCs need to consider how to engage with those GPs (including salaried GPs and locums) who have not had an opportunity to be part of previous initiatives, such as practice based commissioning, or practices who have taken no interest, or only reluctant interest, in the potential changes. As part of this process, LMCs should also make efforts to develop a dialogue on how these proposals may be developed, with the local PCT, practice-based commissioning leads, secondary care and public health specialists, and the local authority. It is essential that LMCs are proactive in the development of local consortia; protecting the interests of GPs but also embedding their involvement in future management structures.

The formation of consortia

The Department of Health has been clear that it will leave the formation of consortia to local determination. The Secretary of State's letter to the profession stated that:

> *"…you are best placed to determine what is best for you and your patients. We envisage that consortia should be of an appropriate size to discharge their statutory functions but are not proposing to prescribe from the centre what you are best placed to determine."*

There are four factors that need to be considered when discussing the size and boundaries of a consortium:

- The natural health community within an area
- How the consortium will relate to its constituent practices
- How the consortium will relate to external organisations, such acute trusts and local authorities
- How financial risk can be managed

The first factor will be a constant in any given area. A natural health community takes account of the local health economy and is sensitive to dispersed rural populations and social communities – unusual urban boundaries and local transport problems can create groups of patients more likely to seek healthcare in an area other than that in which they live. The GPC agrees that it would be inappropriate to specific strict boundaries for the size of the consortia population but it is likely that an individual community-facing consortium would serve a population in the range of 100,000 to 750,000 people, which reflects the size of most large towns in England.

The remaining factors are all variables whose significance will change depending on the people that lead the consortium. Strong leadership is therefore essential if GP commissioning consortia are to achieve their potential and claim a commanding role within the local health economy. There are a number of options that need to be considered regarding a consortium's relationship with its constituent practices and external organisations, and its ability to manage financial risk. The most practical options (small consortia, locality groups with large consortia, federated consortia and a service agency model that provides commissioning management support) are discussed below, accompanied by the strengths and weaknesses of each form. This assessment is not definitive, the right people will be able to ameliorate many of the identified disadvantages, while poor leaders may not realise the strengths within a well developed structure.

Small consortia

For example: an autonomous single consortium of around 100,000 patients with a direct accountability link between practices and consortium management.

Advantages	Disadvantages
• A strong sense of ownership of consortia by constituent practices: they may take greater responsibility for their clinical behaviour • Close relationship between the consortium and practices can benefit the process of GP engagement • Consortia should be able to closely manage the performance of practices • May be particularly suitable for small urban areas or some rural areas with defined health communities • Close understanding of patient needs when developing new care pathways • Simple consortium organisation that may appeal to many existing groups of practices where such a structure is already familiar.	• May face difficulties in financial risk management, especially in terms of investing in services to achieve savings at a later date • More susceptible to small variations in the commissioning budget • Where acute trust serves a much larger area, this may lead to an unequal relationship: consortia may face difficulties commissioning and performance managing secondary care services • Limited management allowance: difficulties in utilising economies of scale and employing people with the necessary level of skill • May not be sufficient capacity and capability within the local area to provide the necessary clinical leaders • The efforts of the best clinical leaders will be limited to a relatively small area. • It may be hard to focus on the management of consortia rather than the personalities that lead the organisations • Familiarity within small consortia may lead to favouritism and accusations of bias in commissioning decisions

Large consortia with locality commissioning groups

For example: a single autonomous consortium of around 500,000 patients comprised of perhaps 4-6 locality commissioning groups each of 70,000-150,000 patients.

The locality groups would have a degree of devolved autonomy from the main consortium so that local commissioning decisions could be made at the most sensible level. For example, prescribing or community services issues may be better managed at a local level than at the full consortium level.

Although there would be only one Accountable Officer for such a consortium and one management board, each individual local commissioning group would be represented on this board and feed locality views into its management and accountability structure, while conveying the decisions of the consortium to its constituent practices.

Advantages	Disadvantages
• Large commissioning budget will enable the consortium to effectively manage financial risk, and provide greater stability in the face of budget fluctuations • Relate well to large external organisations (such as acute trusts) with a strong base for negotiations, while making it easy for external bodies to liaise with the consortium • Locality groups likely to ensure the relevance of commissioning decisions for individual practices • The provision of data at the level of the wider health economy may enable consortia to make better commissioning decisions • Able to employ effective economies of scale in the process of commissioning • With greater management funding, better able to attract and employ the best commissioning managers • Larger management structure may make it easier to undertake those statutory consortia functions which apply regardless of size. • Where small PBC groups already exist in an area, this model will be familiar to many GPs • Universal suitability	• May require additional tiers of management to operate effectively: these will need to maintain a unity of purpose and avoid internal division. The operation of these additional management tiers may consume a greater proportion of the consortia management allowance than in other models of consortia organisation • The direct linkage between the actions of practices and the consortium may be lost, diluting communication and accountability mechanisms • Increased distance between the practices and consortia management could reduce the sense of practice ownership of decisions • Practices may find funding decisions feel remote. • The long-term future of locality structures may be vulnerable to shifts in funding, as has been previously seen with the Primary Care Groups.

Federation and lead consortium model

For example: a number of consortia across a region join together as a group or federation and elect or appoint a lead consortium to undertake agreed functions on behalf of the group.

A federation may commission services for a very large number of patients, potentially several million. The individual consortia within the federation would remain accountable to the NHS Commissioning Board, but the lead consortium would make decisions relating to the commissioning of low volume or regional services. It would also take responsibility for managing the process of commissioning on behalf of the consortia (for example, the engagement of external procurement experts when this is necessary). The lead consortium would therefore direct a proportion of the commissioning and management budget of the individual consortia. Alternatively, there may be a number of lead consortia within the federation, each leading on a distinct area within the commissioning remit on behalf of the federation, such as ambulance services, mental health services, etc. An internal accountability mechanism would be required to ensure that the lead consortium was answerable to the constituent consortia within the federation, while very strong bonds between all the consortia in the federation would be required to maintain the integrity and effective operation of the organisation.

Advantages	Disadvantages
• Consortia should be able to effectively manage financial risk within the federation. • Economies of scale may be easily achieved • Able to commission all services for a population, up to and possibly include regional specialist services. • Size of federation may provide a strong base for negotiations between acute trusts or local authorities and the federated consortia. • May be particularly suitable for defined regions or areas where the population is dispersed • Larger management structure may make it easier to undertake those statutory consortia functions which apply regardless of size. • The provision of data at the level of the wider health economy may enable consortia to make better commissioning decisions, whilst allowing greater benchmarking, peer review and even comparison between consortia.	• Potentially complicated internal governance and accountability structure within federation may add bureaucracy to decision making. The level of sophistication that will be required in this structure is rare in new organisations • The direct linkage between the actions of practices and the lead consortium may be lost, diluting communication and accountability mechanisms • Increased distance between the practices and lead consortia could reduce the sense of practice ownership of decisions • Potential difficulties in engaging with individual practices and clinicians and exercising peer pressure on practice behaviour • Potential for disagreements between lead consortium and member consortia. There is a risk that the lead consortium may become the dominant partner to the detriment of the other consortia in the federation.

Consortium service agency model

For example: a number of consortia join together in a group and pool a portion of their management allowance to engage a service agency to provide commissioning management support for the group.

This is broadly similar to the lead consortium model of organisation. Each consortium would retain responsibility for their own commissioning decisions, but would benefit from the expertise that they could jointly access from the service agency. This agency may support the consortia in a number of areas such as financial transactions and financial modelling, contracting and procurement, human resources for employed staff, commissioning data analysis, professional communications and estates management. The agency could also provide some form of risk-pooling function to the consortia with which it is engaged.

The service agency could be an autonomous, arms-length organisation that was managed and owned by the consortia group. Each consortium would have shares in the agency, which would be part of the NHS family. In some areas, GP-owned service agencies already exist to assist with staff salaries and the purchase of medical or office goods. Alternatively, it could be that an LMC has the appropriate skills and expertise to offer this service. Whatever type of service agency is chosen, this model is of greatest benefit when there are a number of agencies available to consortia to ensure that the services they offer remain competitive.

Advantages	Disadvantages
• Economies of scale may be easily achieved • Risk-pooling may be feasible • Individual consortia will retain their close relationships with constituent practices • Will provide small consortia with the flexibility to receive management support as required and as needs change, without the cost of maintaining a full management structure. Will also offer more highly skilled people to a greater number of consortia than would be possible if each consortium employed its own staff. • A support agency would be directed by the consortia rather than sit above it as in a lead consortium arrangement • Consortia may benefit from the success of a service agency if they shareholders in the organisation • The provision of data at the level of the wider health economy may enable consortia to make better commissioning decisions, whilst allowing greater benchmarking, peer review and even comparison between consortia. • Could allow individual consortia to access different levels of service depending on what they chose to do within their consortium themselves.	• Risk that if the service agency provided this function for a number of different consortia groups, the agency may not be focussed on the needs of the individual consortium. In the worse case, the agency may start to influence or direct the actions and decisions of the consortium • Where individual consortia are small and acute trusts much larger, consortia may face difficulties commissioning and performance managing secondary care services • Unless owned by the consortia or LMC, there would be a risk that ownership of the service agency could change and the benefits of this model for consortia vary.

These are some of the considerations that GPs and practices should make as they discuss how to begin arranging shadow consortia. Whichever form is eventually chosen, it is the government's intention that GP-led consortia will be statutory bodies, with their powers and functions set out through primary and secondary legislation. They will have essential requirements in relation to areas such as financial probity and accountability, reporting and audit, but beyond this will have flexibility in their internal governance arrangements. Nonetheless, the business of commissioning will create a number of demands on consortia that will need to be addressed. Each of the models discussed above will enable consortia to meet these demands, but consortia will need to decide which model is most appropriate for their circumstances. In broad terms these demands will include:

Financial management

- Financial and resource planning
- Budget management
- Transaction processing
- Financial modelling

Information and knowledge management

- Predictive demand and risk modelling and pathway design
- Data returns management
- Data validation and protection
- IT systems management

Provider management

- Contract negotiations and procurement
- Contract performance management
- Provider payment systems
- Stakeholder engagement: patients and the public, local authorities, secondary care and public health specialists

Consortium management

- Human resources systems for employed staff
- Estates management
- Consortium corporate governance
- Legal services to manage and advise on complaints, claims and legal matters
- External auditing

Pathfinder consortia

At the end of October, the Department of Health announced the introduction of an early adopters, or pathfinders, programme for GP commissioning consortia.[2] The purpose of the programme is to identify and support groups of practices who are keen to make faster progress and can demonstrate capability and capacity. It will enable GPs to work with other health and care professionals, to test different design concepts for GP-led consortia and identify issues and areas of learning. They will create learning networks to enable others to learn from experience and best practice.

Applications for groups of GPs to form pathfinder sites can be made to SHAs from October 2010. It is expected that by December there will be about 30 pathfinder sites announced, and these will be established and operational by January 2011. It is expected that other groups will follow shortly after.

To join the pathfinder programme, a group of practices needs to be able to demonstrate:

- Evidence of local GP Leadership and support
- Evidence of LA engagement
- Ability to contribute to the local QIPP agenda in their locality

Once established it is essential that the pathfinder sites are flexible. The initial leaders may not be the eventual leaders of the consortium, while the shape and size of the consortium may evolve in time. The early progress made by pathfinders will support emerging consortia; in sharing their experiences they will shape the way in which GP-led consortia work in the future.

2 GP Consortia Pathfinder Programme letter from Dame Barbara Hakin, 26 October 2010, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_120888.pdf

Transition issues

Once fully-formed and with an operational commissioning budget, GP-led consortia will be allocated a maximum management allowance as a proportion of their commissioning budget with which to run the process of commissioning. However, while consortia are in shadow form, the funding for shadow consortia and for considering how consortia are to be established will come from PCTs. The initial cohort of GP clinical leaders that seek to implement these proposals may therefore be employed or funded by the PCT. It is very important that these GPs receive appropriate backfill funding for their practice from the PCT. Similarly, it is likely that a large number of GPs will be required to attend meetings and discussions as consortia are established, and there should be backfill for the time spent on this also. LMCs will want to discuss with PCTs how this can be achieved.

Sessional GPs

As shadow consortia begin to develop locally, consideration will need to be given to how they engage with the GP population on whose behalf they will eventually commission. Sessional GPs make up a significant proportion of the GP population and may even form the majority in some urban areas. Shadow consortia will need to reflect upon the greater flexibility and availability that local sessional GPs may offer and how to best utilise their capabilities in this process. LMCs will have a key role in supporting sessional GP involvement in the development of GP-led consortia and encouraging practices to include them in practice discussions about commissioning. The GPC will be providing detailed guidance on the election and appointment of clinical leaders to consortia, and a separate document on the opportunities for sessional GPs presented by these proposals in due course.

Cultural change

If consortia are to be successful in improving NHS services, they will require the right leadership, governance and culture, to endow the constituent practices with a sense of professionalism, ownership and peer involvement. GPs should endeavour to ensure that all actions during the transition period on the path to establishing shadow (and then full consortia) aim to instil these ethics within the new organisation.

These proposals will require PCTs to evolve into different organisations in the final years of their existence. This will require strong and visionary PCTs, and a genuine change in the mindset of clinicians and commissioners. 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. The success of these proposals will be marked by a cultural shift, which will enable ordinary clinicians to take 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 essential to facilitate this.

The role of the LMC

LMCs are the local representatives of the profession. The commissioning proposals will not change this, and consortia leaders will not become the de facto local leaders of the profession. Many LMCs are already involved in the development of local commissioning by using their ability to lead and inform local GPs and practices. Their role at this stage in leading local GPs is crucial. The GPC strongly encourages LMCs to play an active part in the development of local pathfinder sites and shadow commissioning consortia. They should seek to engage with all local GPs – principals, salaried and locum GPs – to help ensure that these proposals develop in a manner acceptable to the local profession. As an 'honest broker' they can support the creation of geographical and organisational shadow consortia structures by surveying all GPs locally to ascertain their views, facilitating discussions between local GPs and practices to reach agreement on shadow consortia boundaries, and by organising the appointment / election of their leadership. Forming a dialogue with local authorities, secondary care specialists and public health specialists will also be beneficial. In the future, LMCs will also well-placed to mediate if a dispute were to arise between the practices within a consortium, or between the consortium and its constituent practices.

The GPC will be providing detailed guidance on the function of the LMC within the commissioning proposals in the near future, but LMCs must seek an active role in this process at the earliest opportunity.