
Implementing GP Commissioning

Eve Norridge



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Executive Summary

The government is planning to abolish Primary Care Trusts by April 2013 and transfer responsibility for NHS commissioning to groups of GPs – to be known as consortia. This report explores possible implementation models for GP consortia and critical factors for the success of the policy. It is based on interviews with the GP leaders or managers of 16 ‘pathfinder’ consortia and with other experts. It also draws heavily on the discussion at a round table meeting held at Policy Exchange on 15 February 2011.

Implementation models for GP consortia

GP commissioning has been evolving in the NHS for almost two decades. Previous schemes have included GP Fundholding, Total Purchasing Pilots and, ‘Practice-Based Commissioning’, under which GPs have held notional patient budgets since 2005. Many of the new GP pathfinder consortia have developed from successful Practice-Based Commissioning groups. In one case (Cumbria), GPs have been gradually taking on almost entire responsibility for commissioning since 2006-07. Although still legally accountable for commissioning, the Primary Care Trust has formally devolved the majority of its responsibilities to GP leaders. The principle of giving GPs, as opposed to NHS managers, much greater involvement in commissioning has been advocated for some time by a wide range of experts and, broadly speaking, there is political consensus around it.

The benefits of GP commissioning are well-established. It aligns clinical decisions and their financial consequences. There is also evidence that GP commissioners deliver better quality care for patients, while avoiding costly, unnecessary hospital admissions. In South Manchester, a Practice-Based Commissioning Group has already designed two innovative new schemes. One provides minor surgery in the community, cutting costs and receiving a patient satisfaction rating of 98%. Another brings care directly to patients in nursing homes. It has reduced hospital admissions by 53% and saved almost £300,000 a year. Although there is widespread support for giving GPs more involvement in commissioning, there is not the same evidence and consensus around abolishing the Primary Care Trust structure (as opposed to giving GPs greater commissioning responsibilities while retaining the existing structure).

GPs will need new skills to be successful commissioners. They are used to making decisions based on evidence and data but may have less experience in the ‘softer’ skills needed to build effective local partnerships. They also lack expertise in dealing with conditions that they encounter less regularly. For example, 25% of GPs have a specialism in diabetes, but only 5% have a specialism in cancer.

Our 16 consortia interviews allowed us to draw some conclusions about how pathfinder groups are starting to operate. A few of the consortia leads were not

supportive of the government's plans, but most GPs are showing enthusiasm and innovation as they get more involved in commissioning. A very small consortium in Fleetwood, operating in an area of high deprivation, is making it a priority to give patients a voice by including a majority of directly elected patient representatives on its board. A consortium in Kingston has made getting buy-in from local GPs its first priority. This has been time-consuming but the lead GPs believe it to be a fundamental foundation for the consortium's success. All consortia except the very largest plan to 'flex up' and work with other consortia to deliver some aspects of commissioning (most often to achieve economies of scale and negotiating weight with hospitals). All consortia but two plan to 'flex down' or divide into smaller groups to carry out some of their functions. Almost all consortia said they would monitor referrals at practice or GP level. Patient involvement plans are relatively undeveloped – consortia have innovative ideas but most of these have not been implemented yet. Four consortia are currently using private companies for some support or have done so under Practice-Based Commissioning. The majority of consortia said they are using Primary Care Trust staff first but many of them are open-minded about looking elsewhere. A small number of consortia said they would not use the private sector, either for ideological reasons or because it is not an option in their area.

In the United States, some primary care doctors already have extensive commissioning experience. The Nuffield Trust recently published a report on lessons that can be learnt from these groups. They have invested considerable time in engaging all their doctors in decision-making. Data on referral rates and patient satisfaction are fed back to individual doctors and peer competition on these issues is considered a powerful tool for improvement. Groups were able to exclude doctors who did not share their ethos. They also emphasised the importance of investment in management support and leadership. Where this was lacking, it

has been identified as the 'primary reason' why groups failed.

There is little empirical evidence about the relationship between size of commissioning group and performance. However, the Fundholding and Total Purchasing Pilot groups that are often cited as positive examples of GP commissioning were very small – on average representing just 10,000 and 30,000 patients respectively. Broadly speaking there are two opposing visions

of GP consortia. The first is of small groups of between 50,000 and 100,000 patients which are flexible, responsive to changes in healthcare needs and do much more to involve patients in decisions about their care. The second is of large, regional organisations, benefiting from economies of scale. Consortia will need to combine elements of both of these visions if they are to be successful.

The pathfinders we interviewed that look to be enthusiastic and innovative are generally tending to perform similar tasks at similar levels, regardless of their size. (There is a range from 14,000 to 660,000 patients under the first two pathfinder waves.) They are 'flexing down' or 'flexing up' as necessary. We identified three

“One lead GP said that he felt the key to success was that a GP from every member practice should be able to sit round a table to agree every key decision – and he raised concern that this would not be possible in consortia with a very large number of member practices”

potential levels for the performance of tasks: individual GP or practice level; a mid level at which a number of practices come together; and a county or regional level.

Individual GP practices are tending to have at least some involvement on most issues. Their involvement in decision-making was particularly emphasized. One lead GP said that he felt the key to success was that a GP from every member practice should be able to sit round a table to agree every key decision – and he raised concern that this would not be possible in consortia with a very large number of member practices. Individual GP practices are also tending to lead on emerging plans for patient involvement. There was almost universal agreement that referral rates and prescribing needed to be monitored at least at GP practice and ideally at individual GP level. Not every GP will get involved in every aspect of commissioning, but a number of consortia described how they would have some or all of their GPs on specialist committees looking at issues such as cancer commissioning, population health or local variations to hospital contracts.

The hub of the group where GP practices come together to take decisions and from which transformational change is driven is tending to sit at the mid level. This 'hub' is likely to need to represent between 30,000 and 210,000 patients – big enough to handle the financial risk of not overspending an allocated budget for a given patient population but small enough for a representative from each member GP practice to be able to sit round a table to make decisions.

Regardless of the actual size of the pathfinder consortium interviewed, there seemed to be consistency of opinion that core commissioning is best led on a reasonably large scale. Most of the smaller consortia interviewed were planning to work together with other consortia in the area to carry out the key tasks involved. However, there was also widespread agreement that once large scale regional contracts had been agreed there was need for local variation to those contracts. Even the largest consortia generally said they would devolve this to a locality level within their group. Where the mid-level of the consortium that sits on the scale (between 30,000 and 210,000) will generally define how much of its core commissioning and contracting activity it carries out at the mid level and how much it plans to 'flex up' on this.

Critical factors for the success of GP commissioning

The NHS is weary of organisational change and it is therefore crucial that GP consortia accomplish more than would have been achieved by simply putting GPs in charge of Primary Care Trusts. Many GPs and experts identified this as the single most critical issue for the successful implementation of the government's plans. One pathfinder manager mentioned how she was very concerned that another nearby consortium was simply replicating the Primary Care Trust structure. One GP leader said that he had little enthusiasm for the policy and although he would of course implement it as best he could, he did not believe his patients would see any real difference.

There are four issues that need to be addressed if consortia are to avoid becoming Primary Care Trusts by another name. Firstly, commissioning decisions must be brought much closer to patients. Current projections for the size of GP consortia mean that commissioning could be no closer to patients than it was in 2002. A lead GP of one of the very largest pathfinder consortia revealed that he

and other local GPs had wanted to create seven different groups. However, they were told that the Department of Health only wanted three or four pathfinders in the whole region so they had no choice but to form one huge group.

Secondly, there needs to be potential for competition between consortia so that patients have the option of moving to another consortium if it can offer better care. There is tension between this and the government's plans for consortia to cover a defined geographical area, which is generally being interpreted as meaning that consortia must have a rigid catchment area rather than trying out innovative new configurations.

Thirdly, GPs need to be able to work in like-minded groups. In the current NHS legislation, ensuring that consortia cover a defined geographic area seems to take precedence over this. One lead GP reported that his consortium had been forced to work with a group of practices which did not share the ethos of the rest of the group.

Fourthly, GPs expressed concerns about the consequences of the short timescale for the abolition of Primary Care Trusts. Some fear that commissioning knowledge and expertise which has built up will be lost in the transition and that if GPs are left with a vacuum they will not be able to try out innovative but potentially risky ideas. Others do not like the pressure they are coming under to take on Primary Care Trust staff regardless of their skills and are worried about having to take on all of the bureaucratic functions of Primary Care Trusts. There is a danger that the government's rapid abolition of Primary Care Trusts is increasing the likelihood of a replication of the status quo rather than being a catalyst for innovation and change. The need for a slower pace is supported by the evidence from Cumbria.

Successful GP consortia will need to be able to access external support easily – whether from social enterprises or the private sector. There is concern that the government is not bringing this onto the agenda early enough and has not yet developed a framework for external support providers to engage with consortia. Many potential providers of external support are also worried that they are not facing a level playing field because of the pressure consortia are coming under to work with Primary Care Trust staff. One Strategic Health Authority has even given its GPs a blanket ban on working with the private sector. GP consortia need to be free to work with the best people even if it means rejecting staff from their local Primary Care Trust. Several GPs expressed this view very strongly. There is also concern that the expertise built up by specialist support organisations that already work with commissioners, such as cancer networks, may be lost in the handover.

As commissioners, GP consortia will need to be able to show that they are above reproach in their dealings with providers of NHS care. It will be important for the public to see that GPs are not receiving inappropriate gifts, funding or hospitality. In turn, providers will want assurance that they are being treated fairly and that GPs are not behaving anti-competitively in any contracts they negotiate. GPs themselves already provide a number of services in the community to which they may refer their patients. Some GPs also have financial interests in private provider companies. It would seem foolhardy to outlaw these behaviours completely as they often allow GPs to find more efficient and innovative ways of delivering patient care. However, their benefits are not automatic, and there is still a perverse incentive in the system for GPs to refer primarily for their own financial benefit. A transparent and fair regime to deal with the conflict of interest between GPs' commissioning and provision roles will need to be developed.

There are a few tensions in the government's plans which need to be clarified as far as possible, even if they cannot be fully resolved. Firstly, GP commissioning may cause friction in the GP-patient relationship. Good communication and involving patients in decisions will be crucial in ensuring that the high level of trust patients currently place in their GP is not jeopardised, particularly in cases where GPs are not providing a drug or treatment that a patient wants. Secondly, many GPs are worried about whether a culture of bureaucracy is really ending. The government has said it will stop micromanagement and slash bureaucracy but GPs are unsure that this rhetoric will be backed up by reality. The government has said very little about the size and structure of the NHS commissioning board which will oversee the new commissioning system. The current legislation would give the Board wide-ranging powers to intervene in the operations of consortia and GPs are concerned about how these powers might be used. Given the list of functions assigned to the Board, it is unsurprising that many think a large body, with strong regional presence, will be needed.

We found very little evidence of better consortia tending to operate in wealthier areas. However, there are still not enough GPs operating in areas of deprivation. The transfer of commissioning budgets to GPs is an opportunity to provide much stronger incentives for them to work in deprived areas, as Policy Exchange recommended in its report, *Which Doctor: Putting patients in control of primary care*.

According to media reports, there are still large numbers of GPs who are unenthusiastic about the government's plans. We also found this to be true of a small number of those leading or managing pathfinder consortia. Although they are in the minority, it is worrying that some of the GPs and managers in charge of the groups that should be paving the way for the new policy do not feel they can fully back it. GPs are professionals and it is unlikely that this will prove disastrous for their patients as most will still do their best in the situation in which they find themselves. However, where GPs lack enthusiasm it does call into question the likelihood of them delivering transformation in NHS care. Before pathfinder groups can become established, work needs to be done at a local level to win the support of their members – and to address the concerns of their leaders. The Department of Health is driving forward the pathfinder programme at high speed. There is a danger that they are pushing groups together before the ground work has been done to bring the group members on board. This ground work was crucial in Cumbria and the consortium we studied in Kingston has also emphasised its importance.

In order to win the support of more GPs, best practice needs to be shared. GPs that are enthusiastic and innovative need to be sent out to inspire others. The leaders of consortia also need to be chosen in a transparent, fair way so that they are felt to represent the whole group. One GP we spoke to expressed concern that “self-appointed ‘leaders’ may not necessarily be those best placed to actually deliver the improvement required”. Another said that his consortium leader “seems biased and does not listen to all of the members”.

In addition, GPs need to be able to develop the skills that they feel they lack. Kingston consortium, for example, is providing sessions specifically for newer and less experienced GPs to give them the support they need to get involved. Commissioning-related tasks must not be an ‘extra-curricular’ activity that GPs are forced to fit in on top of their other work. Like doctors in medical

groups in the United States they should be compensated for the time they give to specialist commissioning committees.

Finally, GP consortia must be allowed to develop more slowly where time is needed to win over local GPs. The government's timetable is ambitious in expecting all GP consortia to take on full commissioning responsibilities by April 2013. Some will be ready for this but others will not. This will be particularly the case where consortia are developing from scratch rather than from successful Practice-Based Commissioning groups, which have already had years to evolve. It will be counter-productive to push these groups into taking on full commissioning responsibilities too quickly. A much better approach will be to get the foundations right so that, when these groups do start commissioning, they can do so successfully.

Summary conclusion

The GP pathfinder programme is at an early stage, but already some new and innovative proposals are emerging and many of the pathfinder groups seem extremely promising. If their plans are realised then patients will see real benefits. Success will take time, though. The government will need to build up solid data on what works so that there is a body of evidence available for GPs to draw on, particularly since there has been no pilot scheme for the proposals. In recent years, GP involvement in commissioning has received widespread support from politicians of all parties and across the NHS. It would be a loss to everyone if it were discredited and the emerging consensus destroyed through overly rapid implementation. The changes that are planned are a natural next step from trials in the 1990s and from Labour's Practice-Based Commissioning programme. However, the government has lost many potential supporters, both inside and outside the NHS, through pressing ahead with them so quickly. If these issues are simply swept under the carpet then patient care may suffer in the transfer to the new system and further undermine confidence in the proposals. On the other hand, if the hard work is done to slow things down, to bring sceptics back on board and to lay a solid evidence base for the scheme, then its potential to deliver real and lasting transformation in the NHS is enormous.

List of recommendations

1. Consortia leaders need to be trained and equipped to communicate and influence effectively and to build strong relationships internally and externally. More GPs need to develop specialisms in order to ensure that patients with conditions that GPs encounter less regularly still receive the best care.
2. All GPs need to play a role in commissioning. A representative of every GP practice in a consortium should be able to sit round a table to agree key decisions. Patient engagement should be led at GP practice level. GP practices should take responsibility for their referral rates and individual GPs should join specialist committees to lead on particular aspects of commissioning.
3. The decision-making 'hub' of a consortium should represent between 30,000 and 210,000 patients in order to ensure that risk can be managed, but that decisions can still be taken effectively.

4. GP consortia should be statutorily established at the size level where most decisions are best taken – between 30,000 and 210,000 patients. In order to achieve the stated aim of bringing commissioning closer to patients and best align clinical and financial decision-making, their size should tend towards the lower end of this scale.
5. The government and local NHS managers should not impede GP consortia from forming like-minded groups and should give them the freedom to exclude doctors who compromise the success of the consortium.
6. The government should slow down its plans for the abolition of Primary Care Trusts in order to give GP commissioning the time and space to develop innovatively, to ensure expertise is not lost in the transition and in order to allow responsibilities to be handed over to GPs at a slower pace where this is appropriate.
7. As an early priority, the government should develop a simple framework for a wide range of external support providers to engage with GP consortia. It should give consortia clear information and options about how to engage with these organisations should they wish to do so.
8. The government needs to ensure that GPs are not coming under pressure to employ or outsource work to Primary Care Trust staff, where they do not want to do so. Emerging GP consortia must be given the freedom to work with the organisations they think will best meet their needs.
9. The government needs to work with the organisations that currently provide specialist support to the NHS for particular conditions (such as cancer networks) to ensure that they are equipped to work in the new system and so that the expertise they have built up is not lost in the handover.
10. Consortia and their GPs should be required to declare publicly any hospitality or gifts they or their practice receive from providers of NHS care to ensure that public trust in their referral practices is maintained. When developing a regime to avoid conflicts of interests between GPs' provision and commissioning roles, regulators will need to ensure that transparent information is widely available on the volume and value of GP referrals to providers in which they have a stake. In turn, GPs will need to ensure that they offer patients unbiased advice on their choice of provider and that they are transparent to their patients about any financial interests they may have.
11. GPs will need to maintain high standards of communication with their patients to ensure that trust is maintained. They will need to be able to demonstrate strong examples of successful commissioning from an early stage, involve patients in decision-making and make sure they have very clear supporting evidence in cases where they are not providing a particular drug or treatment to a patient. Consortia need to make sure that they do not make patient involvement a secondary issue, but embed it in their plans from the start.
12. The government needs to clarify how it intends to implement its plans for an NHS Commissioning Board and to confirm that in abolishing Primary Care Trusts it is not simply displacing many of their bureaucratic functions to this new entity.
13. The government should look again at its plans for GP consortia to cover a defined geographic area. There needs to be the potential for consortia to look at innovative new configurations and to provide patients within an area with real choice, driving up standards across the board.

14. As it works on a formula for allocations to consortia, the government should provide a stronger incentive for GPs to work in deprived areas through giving a higher 'patient premium' to those GPs who do so.
15. To help GPs fully back the government's plans for commissioning: best practice needs to be shared around the country; consortia leaders need to be chosen fairly; GPs need help to develop the skills they feel they lack; commissioning must not be an unremunerated, 'extra-curricular' activity; and GP consortia must be allowed to develop more slowly where more time is needed to win over their GPs.

Introduction: A New Role for GPs

“Commissioning in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population. It is a complex process with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers.”

Department of Health website

NHS Commissioning is, in essence, the purchase of patient care from organisations, such as hospitals, that provide care. These providers do not necessarily need to be state-owned or run, but they do need to be able to offer care at NHS standards and the NHS price. Commissioners hold the budgets that the government has allocated to pay for NHS treatment that their patient population will need. However, NHS commissioning is much more complicated than most of the transactions we encounter in our daily lives. The specific care products which commissioners might want to purchase often do not yet exist and successful commissioners will frequently need to help design them. Moreover, in order to ensure that patient care is high quality and that spending is efficient, commissioners must always be seeking better and more cost-effective ways of delivering care. They must also be continually monitoring the performance of care providers. The concept of commissioning has been developing in the NHS since the reforms of 1991, of which a key part was to separate purchasing and provision in the NHS. Since 2002, NHS care has been commissioned by organisations known as ‘Primary Care Trusts’. Although Primary Care Trusts have generally had provider arms and included doctors and nurses on their staff, most of their commissioning has been undertaken by managers and financial professionals rather than clinicians.

“In order to ensure that patient care is high quality and that spending is efficient, commissioners must always be seeking better and more cost-effective ways of delivering care”

Both the Conservatives and the Liberal Democrats made manifesto pledges in the 2010 General Election to change the way NHS care is commissioned – either to hand this responsibility to GPs or to new ‘elected Local Health Boards’. The coalition agreement, published on 20 May 2010 settled on putting GPs in charge of NHS commissioning. This was also the approach Policy Exchange advocated in its 2009 report, *Which doctor? Putting patients in control of primary care*. However, when the government published its White Paper, *Equity and excellence: liberating the NHS*, in July 2010 it proposed greater changes to NHS commissioning than had been anticipated. The assumption had been that GPs would take on responsibility for commissioning under the existing Primary Care Trust structure. Instead, the government announced that groups of GPs (to be known as ‘consortia’) would

take on full responsibility for NHS commissioning under the oversight of a new National Commissioning Board. Primary Care Trusts would be abolished entirely within three years. The plans for the abolition of Primary Care Trusts came as a surprise to the NHS, experts and, according to newspaper reports, even to senior members of the coalition.¹ One of the Conservative criticisms of Labour's management of the NHS had been the frequent reorganisations that took place and the Conservative manifesto and coalition agreement had both promised an end to these.

After consulting on the proposals in the White Paper, the government has now confirmed its intention to proceed with the policy. It is currently working on a programme of GP 'pathfinder' consortia. In April 2012 it will begin the process of authorising a comprehensive system of GP consortia with "all practices becoming members, acting under delegated arrangements with Primary Care Trusts". Then in April 2013, Primary Care Trusts will be abolished and consortia will take on their full statutory responsibilities.² Legislation to deliver this is currently making its way through Parliament.

The aim of this report is to explore what steps the NHS needs to take over the next two years to ensure a smooth transition from Primary Care Trusts to GP consortia. It will look first at possible implementation models for GP consortia and then, secondly, at critical factors for the success of the policy. Much of the information gathered is based on interviews with those involved in pathfinder consortia and with other experts in the field. The report also draws heavily on the discussion at a round table meeting held at Policy Exchange on 15 February 2011.

¹ *The Guardian*, 19 January 2011

² Department of Health, *Liberating the NHS: Legislative framework and next steps*, December 2010

1

Implementation Models for GP Consortia

1.1 The desired benefits of the government's plans

The concept of GP commissioning has been floated for some time, although in varying forms. Prior to 1997, the last Conservative government experimented with GP fundholding (under which half of all GPs opted to hold certain patient budgets)³ and Total Purchasing Pilots (under which GPs held the entire patient budget). From 2005, the recent Labour government had also given GPs a greater role in commissioning, through allowing them to hold notional budgets on behalf of their patients – a programme known as ‘Practice-Based Commissioning’. This scheme has paved the way for the current policy. Many of the GP groups that are now forming pathfinder consortia have developed from successful Practice-Based Commissioning groups. There is even an innovative example in NHS Cumbria (which developed under the last Labour government and is described in more detail later in this report) of GPs already taking almost entire responsibility under existing legislation for commissioning and commissioning budgets. The principle of giving GPs, as opposed to NHS managers, much greater involvement in commissioning has been advocated for some time by a wide range of experts⁴ and, broadly speaking, there is political consensus around it.⁵ The main benefits of GP commissioning can be summarised as follows:

- **Aligning clinical decisions and their financial consequences.** Unless it is an emergency, GPs usually make the first decision to refer patients for NHS treatment. However, at present they are not responsible for the funding which pays for this treatment. They therefore have little incentive to consider the cost implications of different options, even though each might deliver similar results. The NHS is an organisation with a limited budget and savings made in one area can improve care in another. GP commissioning means that the responsibility for quality care and the responsibility for efficient spending rest with the same people.
- **Innovation to keep patients out of hospital and save money.** Patients usually prefer to be treated out of hospital if possible and this is also much cheaper for the NHS.⁶ Primary Care Trusts currently spend by far the largest part of their patient care budgets on treatment in hospitals. In 2009-10, they spent around £36 billion on general and acute secondary care, 45% of their budget (up from 43% in 2007-08). In contrast, they spent only 24% of their budget on primary care and 10% on community health services.⁷ There is evidence that once GPs take responsibility for budgets as well as referrals, they may have more success

³ Department of Health, *Health and Social Care Bill 2011: Impact Assessments*

⁴ For example, on 23 June 2010, six major national organisations published a briefing paper, *Giving GPs budgets for commissioning: what needs to be done?*, which highlighted the potential benefits that GP commissioning could bring if implemented well. They were the Nuffield Trust, the King's Fund, the National Association for Primary Care, the NHS Confederation and the Royal College of General Practitioners.

⁵ Labour is also broadly supportive of the idea. In addition to the Practice-Based Commissioning programme launched by the recent Labour government, Shadow Health Secretary, John Healey recently cited Cumbria, where GPs have now taken on almost entire responsibility for commissioning as a 'model within the current system' (Speech to the King's Fund, 20 January 2011).

⁶ Taking end of life care as an example, the National Audit Office has found that between 56 and 74% of people would prefer to die in hospital yet 58% of all deaths occur in a hospital. Achieving people's preferences in cancer care alone would save the NHS £104 million a year (National Audit Office, *End of life care*, 26 November 2008).

⁷ National Audit Office, *Health Resource Allocation. A briefing for the House of Commons Health Select Committee*, December 2010

in keeping people out of hospital. As well the alignment of incentives described above, GPs are often better placed to find new ways of providing treatment because they have a better understanding of the needs of their patients. In Cumbria, for example, where GPs have already taken responsibility for some patient budgets, GPs have started providing community ophthalmology services at 50-65% of the amount that had previously been paid to the hospital.⁸ Medical Groups in the United States provide similar examples of primary care doctors making savings through reducing unnecessary hospital admissions.⁹

- **Bringing commissioning closer to patients.** Patients see their GP regularly and have a high level of respect for their local doctor – 94% say they have trust and confidence in their GP.¹⁰ With managers responsible for commissioning there is an extra tier of distance between the commissioner and the patient. On the other hand, if the doctor a patient sees regularly has responsibility for the decisions about their care then the patient feels more involved and in a better position to influence those decisions.
- **Higher quality care for patients.** Because GPs see patients often they are well-placed to assess whether the care their patients have received from other providers has been of high quality. If a patient's illness persists after secondary treatment then the GP is likely to be the first to see that patient again. As a clinician, the GP is then well-placed to judge whether any continuation of illness has resulted from the unavoidable progress of the disease or from poor-quality secondary care. It was also the widely held view of those interviewed in the course of this study that GPs are better placed than managers to hold hospitals to account for quality standards because hospital doctors are more likely to respect and adhere to the views of another clinician than those of a manager.

Box 1: Benefits of GP involvement in commissioning in South Manchester

Under the Practice-Based Commissioning programme, South Manchester Commissioning Consortium has delivered two schemes with proven benefits:

1. Beacon Minor Surgery Service. This was set up to “transform the patient experience by providing locally accessible, equitable, safe and excellent quality minor surgery in the community setting”. Under the scheme, minor surgery is provided in local GP practices rather than in hospital. It is not only much cheaper, but patients approve – the service has a very high patient satisfaction score of 98%. The quality of the care provided has been high. There have been no serious untoward incidents and no complaints about clinical quality. The service has a complications rate of only 0.5% and refers just 2% of cases on to secondary care.

2. South Manchester Nursing Home Service. This scheme was established to improve the quality of care provided to patients in nursing homes and avoid them being admitted to hospital unnecessarily. Such changes often cause them undue distress and can accelerate deterioration in their clinical condition. This programme brings the care they need directly to them. It is led by a consultant geriatrician, supported by a dedicated GP, advanced practitioner and nurse case manager. It has reduced admissions to hospital by 53%, saving almost £300,000 a year.

⁸ Paul Corrigan, *Practice makes perfect*, October 2010

⁹ Nuffield Trust: Thorlby, R., Rosen, R. and Smith, J., *GP commissioning: insights from medical groups in the United States*, January 2011

¹⁰ Department of Health, *GP Patient Survey October 2009 to September 2010*, 16 December 2010

Given the established evidence about the benefits of GP commissioning and the schemes that have already been tried, the government is by no means starting from scratch. However, none of the previous schemes have given such widespread and extensive responsibility to GPs as the government is now planning. It should also be noted that although there is widespread support for giving GPs more involvement in commissioning, there is not the same evidence and consensus around abolishing the Primary Care Trust structure (as opposed to giving GPs commissioning responsibility while retaining the existing structure). Nevertheless, the government has put forward the following reasons:

“None of the previous schemes have given such widespread and extensive responsibility to GPs as the government is now planning”

- **An end to interference and micromanagement.** The government has described the current system as being: “Beset by political interference and micro-management, with a rhetoric of Primary Care Trusts being free to reflect local health priorities but the reality of having to pursue targets and Ministerial demands”.¹¹ The Health Secretary has promised that the government’s plans will bring “an end to the top-down management of the NHS’ and ‘a fundamental turn-around of the traditional culture”.¹²
- **Savings will be made.** The government also claims that abolishing Primary Care Trusts will lead to massive cost savings and allow that money to be reinvested in providing better patient care. The Prime Minister has said: “We are cutting £1 billion of administration from the NHS. We are cutting administration costs by 45% over the next Parliament... We say that the primary care trusts and the strategic health authorities – all that additional bureaucracy – should go. We want the money to be spent on treatments, on patients, on doctors and on nurses.”¹³
- **Primary Care Trusts will be redundant.** Finally, in taking responsibilities away from Primary Care Trusts the government claims that they will no longer have a role and it makes no sense to keep them. The Health Secretary has said: “If you’ve transferred the responsibility for designing and purchasing services to general practice consortia and if you’ve transferred the public health responsibility and the democratic accountability to local authorities, there wasn’t a job to be done by primary care trusts. What’s the point of keeping tiers of management if there’s not a responsibility in that organisation?”¹⁴

1.2 Commissioning functions and tasks and the skills GPs will need

Commissioning and the running of a successful commissioning organisation involve a variety of tasks. Under the new system, GPs will not necessarily perform all of these themselves, but they will need to take responsibility for ensuring that they happen. Drawing on two local case studies and documentation from the Department of Health’s recent *World-Class Commissioning* programme, Table 1 makes an assessment of the tasks involved in commissioning and groups these tasks by their broad function.

11 Department of Health, *Liberating the NHS: Commissioning for patients – a consultation on proposals*, July 2010

12 Speech to the National Association of Primary Care’s Annual Conference, 21 October 2010

13 *Hansard*, 14 July 2010, Col.943

14 *The Andrew Marr Show*, 30 January 2011

Table 1: Commissioning functions and tasks

Function	Tasks
Leadership	<ul style="list-style-type: none"> • Decision making • Agreeing and reviewing priorities for health and healthcare • Leading the involvement of commissioners on local or regional NHS issues
Communication	<ul style="list-style-type: none"> • Engaging with patients and the local public, including obtaining feedback from them • Engaging with hospitals and their clinicians • Engaging with private and third sector providers of care where they believe they could deliver NHS services more efficiently and to higher standards
Joint working	<ul style="list-style-type: none"> • Ensuring continuing care for patients who need it when they leave hospital • Participation in health and social care joint commissioning programmes • Working with local authority to deliver public health objectives
Core commissioning	<ul style="list-style-type: none"> • Assessment of population needs and trends • Assessment of government standards and guidance • The development of models of care • The development of service specifications including quality outcomes • The placing of service contracts with providers • Performance management of contracts, including monitoring of quality • Re-engineering models of care • Continual reassessment
Technical/professional	<ul style="list-style-type: none"> • Finance and risk management • IT • Human resources • Estates planning and management • Governance and organisational resilience • Resource allocation if budgets are to be devolved below consortium level

Sources: Report from a GP pathfinder consortium; NHS Cumbria, *Moving towards locality devolution and integrated care*, March 2010; Department of Health, *World class commissioning competencies*

Looking specifically at the core commissioning function, there are broadly four levels at which this is performed: primary care; secondary care delivered in the community; secondary care delivered in a hospital setting and specialist or tertiary care for rare conditions. The government intends that the National Commissioning Board will take responsibility for the first and the last of these, which leaves GPs with responsibility for secondary care at both levels.

Although GPs will be able to procure external support for some tasks, they themselves will still need some particular skills to become successful commissioners. Many people do not appreciate that GPs are also businesspeople. As such, they are generally familiar with the need to make decisions based on evidence and data. We heard evidence that this has not always been common practice in Primary Care Trusts. One area in which we heard that GPs may have

less experience is the ‘softer’ skills they will need to partner effectively with local authorities, hospital clinicians and with their patients. There was a feeling amongst those who attended the round table that work would need to be done to help GPs develop these competencies.

Another area in which GPs may lack some of the expertise necessary for commissioning is in dealing with specific types of illness. As generalists, they do not have specific qualifications in this. In the course of their work they will naturally come across some conditions far more regularly than others and therefore be more likely to develop specific skills in diagnosing and assessing the right treatment for them. Research for Macmillan Cancer Support, for example, has found that 25% of GPs have a specialism or area of particular interest in diabetes, but only 5% have a specialism in cancer and only 1% have a specialism in stroke care.¹⁵ Even in larger consortia, this level of specialist expertise will probably be insufficient. One option would be for consortia to share skills or to buy them in from external support providers. But even if they take this path, it is still likely to be beneficial for increased numbers of GPs to develop specialist interests and potentially gain specialist qualifications (if these could be developed) to ensure that patient care does not suffer when they take on commissioning responsibilities. The more GPs have at least some of this expertise themselves the more they will be able to monitor whether the care they are commissioning is high quality and the more they will be able to assess whether any external support they buy in is delivering benefits.

Recommendation

Consortia leaders need to be trained and equipped to communicate and influence effectively and to build strong relationships internally and externally. More GPs need to develop specialisms so that patients with conditions that GPs encounter less regularly still receive the best care.

One of the small consortia interviewed for this report described how every GP or nurse within the consortium is being asked to specialise in a particular illness. This is a good model as it not only helps to ensure that most conditions are covered but also gets every GP involved. For larger consortia this approach could easily be multiplied up, with several GPs taking responsibility for a particular condition depending on how common it is.

1.3 GP consortia – case studies

As the pathfinder programme develops across England, a variety of different models are emerging. Pathfinder groups vary in size from just one GP practice to 90 practices and from 14,000 to 660,000 patients.¹⁶ It is still too early to tell which consortia will be the most successful, but this report has reviewed three case studies, where the model being used looks promising (see box 2 below). It also considers the results of interviews with a further 13 consortia, amongst which the potential for real change in the care patients receive looks more variable. These 16 consortia studied are of varying sizes and located in different

¹⁵ Primary Healthcare Professionals Monitor, September 2010, nfpSynergy, Survey based on 200 doctors and 200 nurses working in Primary Care

¹⁶ Note that all statistics on pathfinder consortia in this report are based on the first two waves announced by the Department of Health, which can be found at <http://healthandcare.dh.gov.uk/context/consortia/>

parts of the country. Interviews were mostly conducted with the consortium's lead GP or, in a few cases, the consortium's manager. Appendix 1 provides more details on the data gathered from them. We also spoke to a small number of GPs involved in but not leading pathfinder consortia. We mainly focussed on those GPs who are already either involved in or leading consortia as they are the ones who are furthest ahead in considering the issues involved in the implementation of the government's plans.

Box 2: Three GP pathfinder consortia case studies

1. Fleetwood Community Commissioning Group (Three practices, 11 GPs, 25,000 patients)

Bringing patients on board

The Fleetwood consortium covers an area of high deprivation where life expectancy is well below the national average – only around 67 years for males, compared with the national average of 78 years.¹⁷ Its GPs believe that the advantages of smallness outweigh the disadvantages of the lack of economies of scale. Of the 11 GPs in the consortium, one or two will take on most of the commissioning responsibilities but each GP or senior nurse will take responsibility for a specialist area such as cancer or diabetes.

The consortium has a two-tier commissioning plan. Tier 1 services (those delivered in the community) will be commissioned in house. Commissioning support for hospital care at tier 2 (finance, contracting, informatics) will be bought in from a new social enterprise being developed by Blackpool PCT. At least three other consortia will be using this social enterprise and each one would have representatives on its board.

One of the consortium's main aims is to engage the local community and empower local people to get involved. Patient representatives make up a majority of the board, which at present is composed of: two GPs; two practice managers; and five members of the public. A PCT public health representative also attends. It is unusual for patient representatives to constitute a majority on a board. The longer term aim is for all the public representatives to be directly elected to the board (by April 2012). At present, two of the members of the public are town councillors and one is a borough councillor. They are also helped by their local council, which runs a public engagement programme called the Fleetwood forum, which holds regular public meetings. The consortium has a standard item on the agenda at these meetings.

2. Cumbria Senate (86 practices, 420 GPs, 517,000 patients)

A successful track record in GP commissioning

Cumbria is rural and many of its GPs work in small practices. Its deprivation levels are similar on average to the rest of England. In Cumbria, GP commissioning is already happening. GPs have been taking increasing responsibility for commissioning budgets and the management of their patients' care as part of a programme under development since 2006-07. The project began when the Primary Care Trust brought in a new and innovative Chief Executive to turn around a budget deficit and discontent in the region about how services were being run.

The Primary Care Trust's first step was to develop and strengthen six GP-led localities to help them face outwards into their communities and to increase GP involvement in decisions about commissioning. Alongside this, it also launched a programme to help each

¹⁷ Office for National Statistics, *Life expectancy data, 2007-09*

locality deliver more services in the community and fewer in acute hospitals. Over these first two years the GPs learnt to work together more collectively and grew in their support of the GPs leading their locality. They also began to see real improvements in care for their patients. In 2009, GPs and the Primary Care Trust together decided that the logical next step was for GPs to take on full financial and legal responsibility for commissioning budgets for their patients, which they agreed would happen from April 2010.

2010-11 is now a transition year for Cumbria in which new governance arrangements are being fully implemented. Although, still legally accountable for commissioning, the Primary Care Trust has formally devolved the majority of its responsibilities to the GP leaders and many Primary Care Trust staff are now working in the six localities. In recognition of the need for a Cumbria-wide body, the GP leaders agreed to form a clinical senate. They sit on the senate's board alongside the executive directors of the Primary Care Trust and the senate is taking responsibility for regional strategy and standards and the devolving of budgets to localities.¹⁸

3. Kingston (27 practices, 130 GPs, 195,000 patients)

Pressing ahead with innovation

The Kingston consortium has made getting buy-in from local GPs its first priority. This has been time-consuming and labour intensive but the lead GPs believe it to be a fundamental foundation for the consortium's success. The consortium is determined to focus on the overall health of its population, not just individual treatment needs as they arise. Its vision is innovative – and this has helped to motivate and enthuse colleagues. In the longer-term, it sees itself increasing patient satisfaction by providing a more convenient and personal service (for example, by using tele-medicine and online consultations where patients want them). It also wants to make the work of its doctors and nurses more rewarding (for example, by involving them in the design of new care pathways for specific conditions).

The consortium has already started work on two innovative new ideas. It wants to be able to demonstrate early evidence of success. The first is a scheme to stop hospitals overcharging commissioners for the treatment they provide to their patients. The way that the NHS tariff is structured means that there is a strong incentive for hospitals to class patients in more costly ways (for example, classing a patient as a day case rather than an outpatient means they can make up to 16 times as much). The consortium has designed a system whereby GPs make an estimate of the expected cost of a patient's treatment using a computer programme then automatically compare it with the actual cost once that patient has received treatment. Where there is a large discrepancy this can be followed up and there is a contractual agreement that hospitals will receive a financial penalty if they are found to be overcharging. Kingston consortium has worked with the NHS in South West London to have this accepted as commissioning policy from this year.

The second project the consortium is working on is a pilot scheme for an NHS currency for the treatment and rehabilitation of drug addicts. At present treatment providers are paid according to activity rather than the overall results they achieve. The government wants to change this so that people receive the help they need to come off drugs entirely. Kingston is one of five areas experimenting with a new system. It has developed a tariff for providers and measures of success against which they will be judged and paid. It is to be implemented from April 2011.

18 Much of the information in this summary is drawn from: Paul Corrigan, *Practice makes perfect*, October 2010

From the case study and interview data, we can draw some conclusions about the way in which GP consortia are starting to operate:

- **Enthusiasm.** Most of the consortia were enthusiastic about the government's proposals, although there were exceptions. Two consortia were not enthusiastic and two expressed only qualified enthusiasm. A further consortium was enthusiastic about GP commissioning but not the abolition of Primary Care Trusts.
- **'Flexing up'.** Almost all consortia (except the very largest which are already big enough to cover a whole county) plan to 'flex up' and work with other consortia to deliver some aspects of commissioning. The most common reasons given for this were to achieve economies of scale (particularly around back-office functions); to share pathway designs and ideas; and to achieve negotiating weight with hospitals.
- **'Flexing down'.** All consortia but two plan to 'flex down' or divide into smaller groups to carry out some of their functions. This was true of even the smallest groups, which tended to have a very strong belief in the value of their small size and the importance of involving all their GPs. Each practice might take responsibility for its own patient engagement operations, for example. A number of the larger consortia are dividing into localities or clusters for much of their decision-making and daily operations.
- **Patient involvement.** Overall this area is less developed than others. A number of consortia said they would have patient representatives on their board and most also had some patients forums already in existence. A number of consortia have innovative ideas for communicating with patients but most of these have not been implemented yet.
- **Use of external support.** Four consortia are currently using private companies for some support or have done so under Practice-Based Commissioning. The majority of consortia said they are using Primary Care Trust staff first but many of these are open-minded about looking elsewhere, particularly if the Primary Care Trust staff do not meet their needs. A small number of consortia said they would not use the private sector, either for ideological reasons or because it is not an option in their area. One consortium said it would get all its external support from a neighbouring, larger consortium.
- **Role for all GPs.** Almost all consortia said they would monitor referrals at practice or GP level and a few said they would devolve budgets down to this level as well. Most intend to have individual GPs involved in specialist committees and some have a representative from all their GP practices on their board.

1.4 Lessons from the USA – Accountable Care Organisations

In the United States, some primary care doctors have been taking responsibility for budgets for their patients' care for a number of years. Although the American healthcare system is very different to the NHS, and the approach they have taken is not directly transferable, there are still many lessons that can be drawn from their experiences. The US groups that are most comparable to emerging GP consortia are Medical Groups and, in particular, Independent Practitioner

Associations (IPAs). The Nuffield Trust recently published a report looking specifically at four of these organisations, all of which “manage fixed budgets for an enrolled patient population”.¹⁹ The four groups have been operating for around 20 years, surviving a difficult financial period in the 1990s. The report contains some useful lessons as to how they operate:

- **Importance of engaging all doctors.** The four groups “place a high value on engaging their members in decision-making” and their leaders “invested considerable amounts of time in developing and maintaining relationships with rank-and-file doctors”. Groups’ members could get involved through attending general membership meetings and monthly board meetings and through working on specialist committees. They were generally compensated for their attendance at these committees.
- **Performance management.** The report notes that: “All groups closely performance manage their primary care doctors by feeding back data on performance [including referral rates, patient satisfaction and the use of generic drugs] and using financial incentives linked to quality indicators... It was common for data to be reported back to individual physicians, usually with names attached. The leadership of medical groups was clear that intra-peer competition was a powerful tool for improvement.” Groups avoided financial incentives to doctors based on referral rates rather than quality however, and were generally “wary of being seen to deny care on the grounds of cost”.
- **Like-minded group.** Groups were able to exclude doctors who “did not fit into the ethos of the group” as a ultimate sanction. The importance of this is affirmed by Professor Lawrence Casalino, a US expert who has studied IPAs extensively. He has noted the need for a “culture of cooperation amongst physicians” which takes time to build up and can only be built if doctors can exclude those who are not engaging.²⁰
- **Alternatives to hospital care.** A key feature of groups was the development of alternatives to hospital care, such as urgent care centres. They often used ‘hospitalists’ – “doctors who act as agents of the medical group within hospitals”. These doctors monitor admissions, length of stay and provide support for patient on discharge. ‘In the case of emergency admissions, one IPA described how their hospitalist met the patient in the accident and emergency department and, where appropriate, diverted them home or to a skilled nursing facility.’ This type of system is also starting to be used in the UK to some extent. The lead GP of Barking and Dagenham Quality Healthcare Consortium described how his pathfinder group is currently working to reduce hospital admissions through having GPs running the front-end of their local hospital’s A&E department. Anyone coming in is first seen by a GP, who will then decide whether that patient needs emergency treatment. The project has been inspired by lessons from the United States and trials of this approach in other parts of England under Practice-Based Commissioning.
- **Investment in management and back-office tasks.** Groups emphasised the importance of investment in “the high-quality, professional management support needed for contracting, financial management, organisational development and IT” and one leader reported that this had saved them at a

19 Nuffield Trust: Thorlby, R., Rosen, R. and Smith, J., *GP commissioning: insights from medical groups in the United States*, January 2011

20 Nuffield Trust, Podcast interview with Professor Larry Casalino, conducted by Ruth Thorlby, published on 18 October 2010

time when they felt out of their depth. A lack of investment in these areas, along with a lack of investment in leadership, was also identified by Professor Casalino as the “primary reason” why groups failed.²¹

This emergence of organisations of this type in the US is likely to increase in the years ahead, particularly due to the plans for ‘Accountable Care Organisations’ (ACOs) set out in the American government’s recent health bill. These groups are shifting from a ‘fee-for-service’ model for the provision of healthcare to population management based on results for patients.

1.5 An optimum size for GP consortia?

There is debate among experts as to the optimum size of a GP consortium. Much of the problem lies in the fact that there is little empirical evidence about the relationship between size of commissioning groups and their performance. Analysis of the relationship between size of Primary Care Trust and performance in recent years by the think tank, Civitas, has shown no correlation. It notes that: “Neither the theory that larger commissioning organisations are likely to be more efficient and economic, nor the theory that smaller commissioning organisations may be more effective in delivering improved clinical outcomes are supported by the data”.²² However, given that Primary Care Trusts have been relatively inflexible organisations it is unsurprising that there has been relatively little variation in performance between them. They have been subjected to a plethora of government targets and have had little freedom to innovate in their approach to commissioning. Professor Chris Ham, now Chief Executive of the Kings Fund, has described how “Stalinism...targets, performance, management, drive the system hard from the centre – we also have increasing regulation through... a plethora of regulators trying to improve performance”.²³ Another difficulty is that no commissioning system in England has been allowed to remain in place for long enough to make a valid assessment given that any system will take many years to become established (for example, the IPAs in the United States described above have now been in existence for several decades). Research has found that structural changes can stall positive service development for at least 18 months.²⁴

It should be noted, however, that the schemes from the past that are often cited as positive examples of GP involvement in commissioning tended to use very small GP consortia groups. Assessments of the schemes are by no means conclusive but they have shown some benefits. For example, one study found that fundholders reduced referral rates to secondary care by 3.3% in comparison with non-fundholders.²⁵ And another study found that when Total Purchasing Pilots aimed to cut emergency admissions, they did so by an average of 13% compared with the overall admission trend in their host health authorities.²⁶ The size of the groups involved in both of these projects was small. On average, fundholding groups covered just 10,000 patients and Total Purchasing Pilots just 30,000 patients.²⁷ A summary of one study also noted with regard to Total Purchasing Pilots that: “Achievements tended to be small-scale, local and incremental – the larger the size and scope of the pilot, the more time was needed to establish management systems before progress could be made against objectives.”²⁸

21 Ibid.

22 Baird, S., Gubb, J., Walshe, K., *NHS White Paper proposals for GP commissioning: does size matter?*, October 2010

23 House of Commons Health Committee, *Commissioning*, Fourth Report of Session 2009-10

24 Glasby, J., Peck, E., Ham, C., and Dickinson, H., ‘*Things can only get better? – the argument for NHS independence*’, April 2007

25 Dushiesko M, Gravelle H, Jacobs R, Smith P (2003). *The Effect of Budgets on Doctor Behaviour: Evidence from a natural experiment*. Discussion Papers in Economics no 2003/04. York: Department of Economics and Related Studies, University of York, cited in The King’s Fund, Curry, N., Goodwin, N., Naylor, C., Robertson, R., *Practice-Based Commissioning: Reinvigorate, replace or abandon?*, 2008

26 Mays N, Wyke S, Malbon G, Goodwin N eds (2001). *The Purchasing of Health Care by Primary Care Organisations: An evaluation and guide to future policy*. Buckingham and Philadelphia: Open University Press, Cited in Ibid.

27 The King’s Fund, Curry, N., Goodwin, N., Naylor, C., Robertson, R., *Practice-Based Commissioning: Reinvigorate, replace or abandon?*, 2008

28 Ibid.

Broadly speaking there are two opposing visions of GP consortia. The first is of small groups of between 50,000 and 100,000 patients which are flexible, responsive to changes in healthcare needs and make a real difference in involving patients in decisions about their care. Professor Julian Le Grand of the London School of Economics is a strong advocate of this view, recently saying that: “Larger groups find it difficult to change commissioning patterns without destabilising providers. Smaller groups can play the market more easily and are closer to patients.”²⁹ There are others who believe that consortia need to be large, regional organisations, benefiting from economies of scale. Advocates of this view believe this will drive efficiencies, give consortia weight in negotiations with hospitals and allow them to develop sophisticated forms of information management and monitoring so that their decisions are truly based on evidence. Research for this report has indicated that consortia will need to combine elements of both these visions if they are to be successful. And equally, they will need to be given the flexibility and freedom that Primary Care Trusts have not had if they are to flourish in their new responsibilities. There is concern amongst many GPs that the NHS Commissioning Board is starting to look like it will be too big and bureaucratic to permit them the freedom to be truly innovative, an issue Part 2 of this report will consider in more detail.

Interviews with pathfinder consortia and other experts carried out for this report have suggested that the technical size of a pathfinder is having less impact than might be expected on the level at which key tasks are being carried out. Consortia mostly seem to be taking a view in line with that expressed by Professor Martin Roland of Cambridge University, who has said: “Whatever size you are, you have either got to be able to devolve within that larger element to perform those functions that need a smaller group or you have to be able to amalgamate and merge and work with others.”³⁰ The pathfinder groups interviewed in the course of this report that have shown enthusiasm and innovation in their approach to the government’s policy have generally tended to perform similar tasks at similar levels. Based on these interviews and the views of other experts, this report has made an assessment of the level at which specific tasks might be best carried out (out of three possible levels: individual GP or practice level; a mid level group bringing together a number of GP practices; and a county or regional level). Table 2 shows the list of commissioning tasks outlined in section 1.2. Dark orange shading indicates the consortium level that should lead on the performance of each task and pale orange shading indicates secondary involvement. No shading indicates that a consortium level will have little or no involvement in the performance of a task. This assessment should be viewed cautiously as it is mostly based on opinions rather than direct practical experience as the pathfinder programme is at such an early stage. All recommendations in this section come with this caveat. That said, the results indicate that, regardless of which tier is actually known as ‘The Consortium’ there will still be a level which

“Consortia will need to be given the flexibility and freedom that Primary Care Trusts have not had if they are to flourish in their new responsibilities”

²⁹ *The Financial Times*, 19 January 2011

³⁰ House of Commons Health Committee, *Commissioning: Third Report of Session 2010–11*, Volume II, Oral and Written Evidence, 21 January 2011

is the hub of the group. This will be the place where the most decisions are taken and the part of the consortium that is the leading driver for transformational change. The preponderance of dark orange boxes shows that this is likely to be the ‘mid level’ section of the consortium.

Table 2: Commissioning tasks and the level at which they are performed

Function	Tasks	GP/Practice	Mid level	Country/ regional level
Leadership	• Decision making	Dark orange	Dark orange	Pale orange
	• Agreeing and reviewing priorities for health and healthcare	Dark orange	Dark orange	Pale orange
	• Leading the involvement of commissioners on local or regional NHS issues	Pale orange	Dark orange	Dark orange
Communication	• Engaging with patients and the local public, including obtaining feedback from them	Dark orange	Pale orange	Pale orange
	• Engaging with hospitals and their clinicians	Pale orange	Dark orange	Dark orange
	• Engaging with private and third sector providers of care where they believe they could deliver NHS services more efficiently and to higher standards	Pale orange	Dark orange	Dark orange
Joint working	• Ensuring continuing care for patients who need it when they leave hospital	Dark orange	Dark orange	Pale orange
	• Participation in health and social care joint commissioning programmes	Pale orange	Dark orange	Pale orange
	• Working with local authority to deliver public health objectives	Pale orange	Dark orange	Pale orange
Core commissioning	• Assessment of population needs and trends	Pale orange	Dark orange	Dark orange
	• Assessment of government standards and guidance	Pale orange	Dark orange	Dark orange
	• The development of models of care	Pale orange	Dark orange	Dark orange
	• The development of service specifications including quality outcomes	Pale orange	Dark orange	Dark orange
	• The placing of service contracts with providers	Pale orange	Dark orange	Dark orange
	• Performance management of contracts, including monitoring of quality	Pale orange	Dark orange	Dark orange
	• Re-engineering models of care	Pale orange	Dark orange	Dark orange
Technical/professional	• Continual reassessment	Pale orange	Dark orange	Pale orange
	• Finance and risk management	Pale orange	Dark orange	Pale orange
	• IT	Pale orange	Pale orange	Pale orange
	• Human resources	Pale orange	Pale orange	Pale orange
	• Estates planning and management	Pale orange	Pale orange	Pale orange
	• Governance and organisational resilience	Pale orange	Dark orange	Pale orange
	• Resource allocation if budgets are to be devolved below consortium level	Pale orange	Dark orange	Pale orange

Key: Dark orange indicates the consortium level that should lead on the performance of each task; pale orange indicates secondary involvement; no shading indicates that a consortium level will have little or no involvement in the performance of a task.

Functions best performed at individual GP or practice level

Table 2 demonstrates that, on the basis of the information gathered, there are relatively few functions which individual GPs or GP practices will not have at least some involvement in. Those tasks which they do not need to be involved in at all are either technical or relate to local leadership which by nature, is likely to take place at a higher level.

There are some tasks which appear to be best driven forward at GP practice level (those shaded dark orange). In three cases (decision making; agreeing and

reviewing priorities for health and healthcare; and ensuring continuing care), this responsibility is jointly shared with the mid level but every practice must play an important role for them to happen successfully. Having buy-in from all member practices was an issue that the leaders of several consortia strongly emphasized. One lead GP said that he felt the key to success was that a GP from every member practice should be able to sit round a table to agree together every key decision – and he raised concern that this would not be possible in consortia with a very large number of member practices. Kingston consortium (see Box 2) is particularly passionate about this and has invested significant time in getting local GPs on board before proceeding with any other plans. GP practices will also need to help lead the way in ensuring patients are cared for when they leave hospital if they are to bring down the costs of unnecessary readmissions. One GP lead described how he had already put a system in place to monitor this.

There is one task – engaging with patients and the local public, including obtaining feedback from them – which appeared to be best led primarily at GP practice level (although this does not mean the other tiers will have no involvement, as the pale orange boxes show). As noted in section 1.2, plans for patient engagement are not as well developed as some other aspects of GP pathfinder consortia. However, it was noticeable that the consortia that appeared to have some of the most interesting and innovative ideas were either extremely small or were devolving this function right down to GP practice level. Fleetwood consortium, with just three practices (see Box 2) plans to put patient representatives in the majority on its board. Another very small consortium described plans to go directly to every household on its lists for the election of new patient representatives because it felt those involved in its current patient engagement groups did not fully reflect the views and demographic of its local population. A larger consortium (over 200,000 patients) also noted how it is devolving most communication with patients to practice level – and already has some good schemes in place. For example, its GP practices are contacting all patients who have gone to A&E to remind them of the community services that are available as an alternative. They are also contacting patients who have had inpatient stays to hear about the types of medicine and treatment they were given and are surveying patients to seek out those who are most at risk of admission to hospital. Given that a strong argument for GP commissioning is that GPs are the ones who know their patients best, it seems to make sense that they should lead engagement with those patients under the new scheme and drive forward the process of getting to know their patients even better.

Most of the tasks which the GP practice level is not tending to lead on but is having some involvement in relate to core commissioning functions. There was almost universal agreement amongst those interviewed that referral rates and prescribing needed to be monitored at least at GP practice and ideally at individual GP level (although within a system of local and national benchmarks). This view is backed up by the success of such an approach in medical groups in the United States (see section 1.4) in reducing unnecessary hospital admissions. One consortium lead did note that the monitoring of referrals needed to be done in a fair way. He is developing a system whereby

referrals per sick patient are monitored rather than referrals per registered patient so as to avoid penalising practices which have a higher level of illness amongst their patient population. Not every GP will get involved in every aspect of commissioning but a number of consortia described how they would have some or all of their GPs on specialist committees looking at issues such as cancer commissioning, population health or local variations to hospital contracts. As noted above, in some of the very small consortia all GPs and nurse practitioners were to specialise in a particular area. It could be argued that having every GP and senior nurse play a role would be a good model, even for larger groups, because it should help with getting buy-in from every consortium member. This does not mean that they will all spend a large proportion of their time on commissioning-related activities but it does mean that they would all be involved in some way.

Recommendation

All GPs need to play a role in commissioning. A representative of every GP practice in a consortium should be able to sit round a table to agree key decisions. Patient engagement should be led at GP practice level. GP practices should take responsibility for their referral rates and individual GPs should join specialist committees to lead on particular aspects of commissioning.

Functions performed at a mid level – 30,000 to 210,000 patients

As noted above, the predominant view amongst consortia and experts was that most functions are better driven at a higher level than that of the individual GP practice. It is worth trying to define the optimum size for this level of the consortium as in most cases it will be where the ‘hub’ of the group sits. There are two crucial factors which place limits on its size. The first is the need (described previously) for a representative from each member GP practice to be able to sit round a table to make decisions – this imposes an upper limit. And the second is for it to be big enough to handle the financial risk of not overspending an allocated budget for a given patient population – this imposes a lower limit.

Taking decision-making first, there is debate around the optimum size of a consortium board but practical experience suggests that the smaller the group, the easier it will be for it to debate and reach decisions which all parties can buy in to. Many of the GPs interviewed for this report are passionate about the importance of this. They feel strongly that if their GPs are not involved in and supportive of their consortium then the policy will not succeed for two reasons. Firstly, the GPs will not put in the necessary effort to deliver real transformation in the care patients receive and will instead do little to go beyond the status quo. Secondly, there is little chance of patients feeling more involved in commissioning decisions if their GP is not themselves involved. Decision-making would be relatively easy with around 10 GP representatives round a table, would still be feasible with around 20 but extremely difficult with more than 30.³¹ The number of patients per practice so far in the pathfinder programme is around 7,000. Based on these figures, this would mean an optimum decision-making group size of around 70,000 to 140,000 patients up to a maximum of around 210,000.

31 These figures are backed up by data on the sizes of boards in the biggest companies in the United States. The Spencer Stuart Board Index 2010 notes that the average board size for United States S&P 500 companies is 11 members, with the largest board size being 32.

In terms of the lower limit, Professor Gwyn Bevan of the London School of Economics has looked extensively at the issue of risk in commissioning and has concluded that a population of at least 30,000 patients is needed to manage most risk effectively.³² Because of the issue of moral hazard (whereby a consortium is unlikely to put as much care and effort into spending its funding efficiently if all the risk is insured away) it is likely to be healthy for consortia to manage risk at this level. The government's Health and Social Care Bill makes provision for them to enter into risk pooling arrangements but these are unlikely to be beneficial unless they include mechanisms to compensate for moral hazard.

Recommendation

The decision-making 'hub' of a consortium should represent between 30,000 and 210,000 patients in order to ensure that risk can be managed, but that decisions can still be taken effectively.

The analysis above indicates a relatively wide spread of possible sizes for the mid level of a consortium. The majority of the other tasks which are driven at this level, but which we have not yet considered, relate to core commissioning functions. Regardless of the actual size of the pathfinder consortium interviewed, there seemed to be consistency of opinion that core commissioning is best led on a reasonably large scale. Most of the smaller consortia interviewed were planning to work together with other consortia in the area to carry out the key tasks involved. However, there was also widespread agreement that once large scale regional contracts had been agreed there was need for local variation to those contracts. Even the largest consortia generally said they would devolve this to a locality level within their group. Generally it would seem that where the mid-level of the consortium sits on the scale (between 30,000 and 210,000) will define how much of its core commissioning and contracting activity it carries out at the mid level and how much it works together with other local consortia on this. Larger groups will tend to conduct more activity at the mid level and smaller groups will have a greater tendency to 'flex up'.

There was one GP lead of a smaller consortium (around 50,000 patients) who felt strongly that he was in a better position to negotiate with hospitals and agree 'niche' deals as a virtue of his group's small size. This is supported by Professor Julian Le Grand's view (mentioned previously) that smaller groups have an advantage because they are better able to switch patients to other hospitals without destabilising providers. There was no other consortium lead who took this view, but given the other benefits of small size, it would be interesting as part of the pathfinder programme to explore whether negotiating good deals with hospitals is fully possible at this level. The government's recent announcement (see section 2.4) that providers will only be able to compete on quality and not on price should make it more viable for smaller consortia still to get good results for their patients.

The extent to which providers should be destabilised is also a complex issue that would merit more debate. If commissioners stop sending their patients to a particular provider (which under the new system should equate to patients no

32 Backman, M., Bevan, G.,
Determining the size of a total
purchasing site to manage the
financial risks of rare costly
referrals: computer simulation
model, British Medical Journal, 26
October 1996

longer choosing to use that provider) so that its operations are no longer viable then that provider will need to stop providing some services and, in the long-run potentially close entirely. The government and consortia will need to be thinking through how the level at which consortia conduct much of their core commissioning and contracting activity will affect this. If core commissioning and contracting are done at a lower level then providers that are losing business will receive warning signs and, if they do need to close, will probably do so incrementally over a longer period of time. If these tasks are performed on a county or regional scale then strategic decisions can be taken about service provision and unnecessary providers can be decommissioned and closed much more quickly. This avoids the long and protracted demise of a local hospital but it is likely to incur more opposition from patient groups as they suddenly find themselves unable to choose to be treated in a particular place.

Functions performed at county or regional level

Most consortia, (except the very largest, which already span whole counties), felt that there were some commissioning functions that could only be successfully performed through joining with other local consortia across their county or even region. Most of these related to more strategic leadership and decision-making – for example, where there might be a need to reconfigure services or to have very strong negotiating weight with a powerful local hospital (particularly if that hospital had a local monopoly on the provision of care). More specialist services that are not commissioned centrally by the NHS commissioning board (such as cancer care) may also need to be considered at this level – an issue this report will consider in more detail in section 2.2. Equally consortia may need to join with others to deliver any new innovations which require economies of scale to be cost effective. For example, they might wish to invest across a region in new technology to map population health, gather feedback from patients or monitor outcomes of hospital treatment.

Functions performed at national level

It was not included in the table above as the main aim of this report is to consider implementation models for GP consortia themselves, but it is also worth mentioning at this stage that there will be some functions that will rightly need to be performed only once at national level. The government has largely already recognised this, with its plans to give the NHS Commissioning Board responsibility for the commissioning of specialised services and its development of an information regime for the NHS.³³ Nationally comparable data and information will be crucial if commissioners are to hold providers to account and patients are to know where they will receive the best treatment. However, it is also important that the Commissioning Board does not issue try to dictate to GPs the minutiae of their commissioning decisions. Consortia will need a level of central information and advice that is enabling rather than crippling.

Functions performed at any level

Finally, in this section, there are some commissioning functions which are relatively easy to contract out to external support providers. These are mainly technical functions – IT, human resources, estates planning and management and

³³ See the government's consultations and responses on the *Liberating the NHS White Paper* for more details, found at: http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/DH_122624

some finance tasks. They are not necessarily tasks that are specific to the healthcare sector and there are already a variety of organisations that provide support to small businesses in performing them. Because of this, GPs are likely to be able to manage these tasks relatively easily at whichever level these choose. They could be performed 'in house' in a larger consortium but a small consortium would be unlikely to have too much difficulty in finding an organisation to supply these services.

2

Critical Issues for the Successful Implementation of GP Commissioning

Having reviewed some of the emerging implementation models for GP consortia in Part 1 and the lessons that can be learnt from these, this report will now consider some of the factors which the government, NHS management and GP consortia must get right if the policy is to be successfully implemented.

2.1 Avoiding Primary Care Trusts by another name

“You could have simply mandated to ensure GPs had more of an influence on PCT boards – and achieved largely the same results ... It is not too late to change. By doing that GPs would have become heavily involved in making the decisions, we could have still made management savings, but without all the upheaval that the NHS is going through.”

Dr Clare Gerada, Chair, Royal College of GPs³⁴

The NHS is weary of organisational change and a government that plans to put it through such upheaval once again must be able to demonstrate that it is worthwhile. The Royal College of General Practitioners has suggested that an alternative to abolishing Primary Care Trusts would be to put GPs in charge of them. They claim that this would achieve largely the same results as the creation of GP consortia, but would avoid another costly NHS reorganisation. One of the main aims of the government’s plans is to: “bring together responsibility for clinical decisions and for the financial consequences of these decisions”.³⁵ Putting local GPs in charge of Primary Care Trusts would certainly achieve that. All the GPs with practices within a current Primary Care Trust’s boundaries could be brought together into one forum and could elect representatives to sit on the board of the Primary Care Trust. Local GPs would then take responsibility for the budgets for their patients’ care as well as for the clinical referral decisions that dictate how the money is spent. It is crucial that GP consortia achieve more than this. If they do not, then pressing ahead with the abolition of Primary Care Trusts would be a waste of public money and an unnecessary pressure on the NHS at a time when finances are tight. Many GPs and experts identified avoiding Primary Care Trusts ‘by another name’ as the single most critical issue for the successful implementation of the government’s plans.

³⁴ BBC News Online, 17 January 2011

³⁵ Department of Health, *Equity and Excellence: Liberating the NHS*, 12 July 2010

There is a very real danger of at least some GP consortia being little more than the Primary Care Trusts they are replacing. Most GPs and pathfinder managers interviewed were enthusiastic and determined to do more. For example, a manager at one pathfinder spoke of how her group was making transformation its focus right from the outset. But others were less inspired. For example, the same pathfinder manager mentioned how she was very concerned that another nearby consortium was simply replicating the Primary Care Trust structure and there would be little real change. Another GP leading a pathfinder said that he had little enthusiasm for the policy and although he would of course implement it as best he could, he did not believe his patients would see any real difference. As the lead GP of one pathfinder put it: “The biggest danger of the whole policy is that we reproduce what we’ve cast aside and end up with the same system just with different leaders. If we do that then we have failed.” This study has identified four key issues which the government and GPs will need to get right if new GP consortia are to achieve their full potential.

i. Bringing commissioning decisions much closer to patients

One of the main premises of the government’s plans is that GPs are best placed to commission because they are the ones who have the deepest understanding of their patients’ needs. Two of the key desired benefits of GP commissioning are to align clinical and financial decision-making and to bring commissioning closer to patients. The smaller the decision-making ‘hub’ of the consortium is, the more likely it is that these benefits will be realised. This is backed up by the view of one GP member of a pathfinder consortium we spoke to, who said: “GPs will only be interested in the locality view, therefore if commissioning meetings become too big or too generic and the local view is being diluted, they will not feel they can influence and make a difference.” Section 1.5 of this report presented a wide potential size range for the consortium hub (from 30,000 to 210,000 patients). Operationally, it may be feasible for the hub to sit anywhere on that scale. However, if GP consortia are to look significantly different from Primary Care Trusts in terms of their closeness to patients, then their decision-making hub will need to tend towards the lower end. The average population of a Primary Care Trust is currently 337,000, with the smallest having a population of 91,000 and the largest a population of 1,245,000.³⁶ If GP consortia are driven by an entity representing around 210,000 patients then they will not be enormously smaller than the average Primary Care Trust.

This then raises a second question: in the longer-term, does it matter whether the decision-making hub is the entity which is technically termed ‘The consortium’? It is, of course, how the consortium actually operates which matters most, but it is likely that the technical position will heavily influence the consortium’s behaviour. It matters less in the pathfinder programme, where consortia are not yet statutory bodies fully taking on real responsibilities. However, once consortia are statutorily established, it will be the group that is known as ‘The consortium’ which will have legal responsibility for its budgets and for the successful carrying out of its duties. This will tend to give whichever level is known as ‘The consortium’ the greatest strength and leadership in the commissioning process. It therefore does seem important for the optimum-level decision making hub to be statutorily established as ‘The consortium’.

36 Calculated from: NHS Information Centre, *Attribution dataset GP registered populations 2009*, 24 February 2010

Recommendation

GP consortia should be statutorily established at the size level where most decisions are best taken – between 30,000 and 210,000 patients. In order to achieve the stated aim of bringing commissioning closer to patients and best align clinical and financial decision-making, their size should tend towards the lower end of this scale.

The pathfinder consortia established in the first two waves are looking bigger than they ideally should be if the government's policy aims are to be realised. Their average size is 199,000, with a range from 14,000 to 672,000.³⁷ This means that, on current trends there are likely to be around 250 GP consortia in England under the new system, compared with 151 Primary Care Trusts currently. Experience suggests that, over time, consortia may be more likely to merge than divide. The development of Primary Care Trusts is an imperfect comparison as changes were centrally driven, but when the previous government introduced Primary Care Groups in 1999, there were 481. This went down to 303 Primary Care Trusts in 2002 and then 152 Primary Care Trusts in 2006.³⁸ On a practical level, it is generally easier to join together the functions of two organisations together than it is to separate out the functions of one into two. It is by no means impossible, but it will take a braver and more innovative group of GPs to break away from an established consortium than to consolidate with another. Interviews conducted with smaller consortia also suggest that some are contracting out so many of their functions to a larger group from the outset that merging with that group would be a very small step.

Given that on current projections there will be less than 300 GP consortia in England, this means that, even at the outset, commissioning could be no closer to patients than it was in 2002 (with respect to size of commissioning organisation, at least). There is a danger that consortia are starting far too big, leaving no room for consolidation. It would most likely not be long before mergers led to a similar number of consortia to the current number of Primary Care Trusts. This is not what the government intended in developing the policy³⁹ yet it seems that the large size of some consortia is in part being centrally driven. An interview conducted with a lead GP of one of the very largest pathfinder consortia revealed that he and other local GP leaders had, in fact, wanted to create seven different local pathfinder groups. However, they had been told that the Department of Health and the local Strategic Health Authority only wanted three or four pathfinders in the whole region so they had no choice but to form one huge group. Given the aims of the policy, it is concerning that some GPs are being pushed into forming larger groups than they feel is optimum.

ii. The potential for competition between consortia

It is a well-established fact that there is variation in the care available on the NHS in different parts of the country⁴⁰. These variations are unlikely ever to be fully eliminated under any system – whether localised or nationalised. GP consortia will be no different to Primary Care Trusts in that some will be better than others. There is currently no provision for competition between Primary Care Trusts. Therefore, if a patient is unhappy with the level of care offered in one area but

³⁷ Calculated from the Department of Health's list of GP Pathfinder Consortia by Strategic Health Authority Region, to be found at <http://healthandcare.dh.gov.uk/context/consortia/>

³⁸ Audit Commission, *Is the treatment working? Progress with the NHS system reform programme, 2008*

³⁹ The government has said: 'most GP consortia will be smaller organisations than PCTs are at present' (Department of Health, *Analytical Strategy for the White Paper and associated documents*, July 2010)

⁴⁰ See, for example, the *NHS Atlas of Variation*, to be found at <http://www.rightcare.nhs.uk/atlas/>

has heard it is better in another he has had no way to access that better care, short of moving house. There will never be perfect competition between consortia because, as section 1.5 identified, there are certain ways in which consortia will want and need to work together across a country or region, but this does not mean that competition – and the potential benefits it could bring – need be abandoned entirely. The government has provided for competition between GP practices with its plans to abolish GP catchment areas and allow patients to register with a GP of their choice'.⁴¹ Competition between GPs has proven benefits. One study found that those GPs practices that are located close to other rival GP practices provide a higher quality of care than GP practices which lack competitors.⁴² Most patients have little understanding of the commissioning process behind a GP's decisions about their treatment, but as the government's plans for GP commissioning are implemented it is likely to become more apparent that a patient's choice of GP will also be their choice of commissioner. In many ways, it is this secondary choice that will have greater implications for their health. It will give them access to, not just a surgery that is open longer hours, or a local doctor they feel they can connect with, but potentially new and innovative types of treatment, or drugs that may not be on offer elsewhere. Under a system of competing GP consortia, the limitations of the current rigid Primary Care Trust system have the potential to change radically. If a patient was unhappy with the care offered by one consortium and hears that another can offer a better service he could simply switch. Equally, if a consortium with high standards found out that care in a particular area was poor, this would offer the consortium an opportunity to expand into that area and attract patients. In addition, the knowledge that these events could occur should drive up standards across the board as poorly performing consortia raise their game to avoid being outdone. Section 2.5 will consider this issue further.

iii. Transformation through GPs working in like-minded groups

One of the difficulties with simply putting GPs in charge of existing Primary Care Trusts is that GPs would then be forced to work together across a locality regardless of whether they felt they formed a coherent group with a shared vision and goals. New GP consortia have the potential to transform this situation and allow like-minded GPs to get together with others with whom they feel they can build real partnerships to drive forward change that they truly believe in. This was noted to be of high importance to the medical groups in the United States, described in section 1.4 previously. In one part of the country, at least, the pathfinder programme does not appear to be promoting this. One of the pathfinder lead GPs interviewed reported that his consortium had been forced by the local Primary Care Trust and Strategic Health Authority to work with a group of practices which the consortium felt had a different ethos and therefore did not fit with the rest of the group. He hoped that further down the line the rest of the pathfinder would be allowed to break away from these practices. It is not clear that this will be the case, however, as his experience seems to be in line with the approach the government has set out in its Health and Social Care Bill. In the legislation, ensuring that consortia cover a defined geographic area seems to take precedence over allowing GPs to form like-minded groups. The government has said:

41 The government has said it will: 'Give every patient a clear right to choose to register with any GP practice they want with an open list, without being restricted by where they live. People should be able to expect that they can change their GP quickly and straightforwardly if and when it is right for them, but equally that they can stay with their GP if they wish when they move house' (Department of Health, *Equity and Excellence: Liberating the NHS*, 12 July 2010).

42 Pike, C., *An Empirical Analysis of the Effects of GP Competition, Cooperation and Competition Panel*, August 2010

“The Board may change the area specified in a consortium’s constitution, and may add any provider of primary medical services to, or remove any provider from, a consortium’s list of members. Before exercising these powers the Board must consult the consortium and any other consortia affected. The powers can only be exercised if the consortium whose constitution is to be varied agrees to the change, or if the Board considers that it is necessary to make the variation to discharge its duties under section 14A (i.e. to ensure that every provider of primary medical services is a member of a consortium or to ensure that the areas specified in the constitutions of consortia together cover the whole of England).”⁴³

Recommendation

The government and local NHS managers should not impede GP consortia from forming like-minded groups and should give them the freedom to exclude doctors who compromise the success of the consortium.

This, of course, raises the question of what will happen to practices that are excluded from their local consortium. There are a number of possibilities. If there is sufficient competition between local consortia then the practice may be able to find another consortium to join. If the practice is successful then this is not likely to be a problem. In the rare cases where no other local consortium is willing to accept the practice, mostly likely because it is performing poorly, then the commissioning board may need to step in. One option would be for the GPs in the practice to become salaried doctors working for another local practice; another would be for the commissioning board to take on responsibility for commissioning for the practices patients until a longer term solution could be found. A third option would be to provide incentives to another local consortium to take on the practice and turn it around. One GP consortium lead interviewed for this report described how under the Practice-Based Commissioning programme his successful group had been unwilling to merge with a flood of poorly performing practices. However they had agreed to take on a very small number of these (two or three) and had managed to turn around their finances within a very short time.

iv. Not abolishing Primary Care Trusts too quickly

It has been widely reported in the media that Primary Care Trusts are struggling to deal with the transition because good staff are increasingly leaving, knowing that their organisations are set to be abolished in two years time.⁴⁴ Generally, the GPs interviewed for this research were not concerned *per se* about their own ability to take on responsibility for commissioning within the two years set out by the government. But many expressed concern about how the timetable for the abolition of Primary Care Trusts was affecting the process. One consortium manager felt that he was not getting the support he needed from his local primary care trust and that the allocation of staff to his consortium is taking ‘forever’.

The plan to abolish Primary Care Trusts so rapidly leads to four particular risks. Firstly, it means there is a danger that commissioning knowledge and expertise which has built up in Primary Care Trusts will be lost in the transition. One GP lead expressed concern that under the new system Foundation Trusts were becoming much more powerful and established and that therefore good commissioning

⁴³ Health and Social Care Bill as introduced to the House of Commons on 19 January 2011, Explanatory notes

⁴⁴ For example, *BBC News Online*, 18 January 2011

managers in Primary Care Trusts were moving to jobs in Foundation Trusts rather than face an uncertain future in Primary Care. He is worried that if this management expertise is lost then commissioners will be left in a 'David and Goliath' situation, without the skills to provide a counterweight to powerful hospital trusts.

Secondly, if GP leaders are left with a vacuum then they will be less likely to be able to try new and innovative ideas because they will find themselves in an environment where they simply are not able to take that kind of risk.

Thirdly, because the Primary Care Trust staff who are left are very worried about losing their jobs, many emerging GP consortia we spoke to are coming under very heavy pressure from their local Primary Care Trust to take those staff on. Again this is not helpful if the aim is to avoid simply replicating the status quo. There are many good employees working in Primary Care Trusts and some of them will end up working for consortia, but new GP leaders need to be free to make decisions about staffing for themselves, without external pressure. They could take on Primary Care Trust staff, recruit their own staff or buy in staffing support from a social enterprise, local authority or the private sector. Each consortia needs to be free to choose the option it feels is best.

Fourthly, two of the GP pathfinder leaders interviewed said that they were very concerned about having to take on all of the functions of Primary Care Trusts. One raised the issue of Freedom of Information Act requests, for example, and said there was no way his small consortium would be able to deal with the 300+ requests that Primary Care Trusts receive every year. Another felt strongly that GPs would rapidly lose enthusiasm if they were forced to take on all of the functions of Primary Care Trusts and that there needed to be more clarity around this and clearer limits to the requirements to be placed on GPs. All of these factors raise concern about the government's rapid abolition of Primary Care Trusts. As noted above, there is a danger that it is increasing the likelihood of a replication of the status quo rather than being a catalyst for innovation and change. The need for a slower pace is supported by the evidence from Cumbria. The process of transferring commissioning responsibilities to GPs has been running there for four years and it is only now that GPs are starting to take full responsibility for budgets (though by no means for all of the functions of the Primary Care Trust).

The government is attempting to address concerns about loss of Primary Care Trust expertise and the need to have functioning Primary Care Trusts during the transition period by merging Primary Care Trusts into a smaller number of larger organisations by June 2011 (known as 'clusters').⁴⁵ However, in some areas this appears to be making the situation worse as Primary Care Trusts are now distracted by a further reorganisation, according to several GP consortia leads, and now have even less time to give emerging consortia the support they need. And the formation of Primary Care Trust clusters does not change the fact that Primary Care Trusts in their entirety are still set to be abolished by April 2013.⁴⁶

Recommendation

The government should slow down its plans for the abolition of Primary Care Trusts in order to give GP commissioning the time and space to develop innovatively, to ensure expertise is not lost in the transition and in order to allow responsibilities to be handed over to GPs at a slower pace where this is appropriate.

⁴⁵ Department of Health, *PCT cluster implementation guidance*, 31 January 2011

⁴⁶ Ibid.

As noted in section 1.1, the government has said it wants to abolish Primary Care Trusts to end political interference and micromanagement, to allow cost savings to be made and because they will no longer have a role once GP consortia are established. Slowing down their abolition does not mean any of these aims need be abandoned in the longer-term. Nor does it mean that individual Primary Care Trusts cannot start to reduce their management overheads year by year – as has happened in Cumbria where resources have gradually been moved from the Primary Care Trust to the GP commissioning groups. At a time when the public

“The government should not be too ambitious in the management savings it expects to make through transferring commissioning responsibilities to GPs, particularly in the early stage of the new scheme”

finances are tight the government clearly needs to make every pound of public money go as far as it can. Equally it does not mean that the government would need to run parallel bureaucracies as in many cases the rationale for keeping the Primary Care Trust for longer would be that some or all GPs are not yet ready to take on full commissioning responsibilities and

those responsibilities would then be retained in the Primary Care Trust until the GPs are ready to take them on – again, following Cumbria’s experience. However, the government should also not be too ambitious in the management savings it expects to make through transferring commissioning responsibilities to GPs, particularly in the early stage of the new scheme. Successes under the Total Purchasing Pilots programme were linked in an evaluation report to higher management costs.⁴⁷ And Professor Lawrence Casalino has noted in his studies of medical groups in the United States that management funds needed to be quite generous in the early years for these organisations to be successful. He has observed a very high failure rate amongst these organisations, particularly after they first start up, but that this can be mitigated by investment in management and leadership.⁴⁸

2.2. External support

Primary Care Trusts have been accessing external support for commissioning for some time, most recently through the Framework for procuring External Support for Commissioners (FESC), published by the Department of Health in 2007 (although this framework has been far from perfect⁴⁹). As GPs take on responsibility for commissioning and Primary Care Trusts are abolished, their need for external support will be even greater. This is particularly the case if, as identified in section 2.1, consortia will need to tend towards the smaller end of the scale if they are to perform their functions in a new and innovative way. As groups become established, they will be faced with a choice: either they can carry out their activities ‘in house’ or they can contract them out entirely or in part to external support organisations. The reasons why they might choose to use external support include: not wishing to have to manage a large and cumbersome organisation; the need for economies of scale to deliver many functions cost effectively; and a desire to access skills, ideas and expertise that they do not have within the organisation.

⁴⁷ *British Medical Journal*, 25 July 1998

⁴⁸ Nuffield Trust, Podcast interview with Professor Larry Casalino, conducted by Ruth Thorlby, published on 18 October 2010

⁴⁹ For example the House of Commons Select Committee has raised concerns that Primary Care Trusts’ use of external support has not always represented best value for money (*Commissioning*, Fourth Report of Session 2009-10, 30 March 2010).

There are broadly four forms in which external support can be provided: “short-term consultancy projects of an essentially advisory nature; longer-term joint delivery models where internal and external teams commission in partnership; outsourcing of discrete elements of the commissioning process; and full outsourcing of all or most of the commissioning function”.⁵⁰ Under the new system, there will be at least seven potential types of external support provider: Primary Care Trust staff that have grouped into new social enterprises; local authorities (who already provide back-office support to some Primary Care Trusts); management consultancy firms; private healthcare companies with specialist expertise in commissioning support (of which there are a small number currently operating in the UK); private companies that provide large-scale specialist support in areas like IT and human resources; specialist networks that have been created within the NHS such as cancer networks (see case study below); and charities who have specialist expertise in areas such as mental health or care for the elderly who may be able to help in areas such as the design of new treatment pathways for patients or the monitoring of quality.

There is potential for consortia to access support at all three of the levels (GP practice, hub level and county or regional level) that this report identified in section 1.5. For example, at practice level, around 6,500 GP practices are already using a tool provided by a private company to help them ensure they are prescribing at optimum levels. The software package presents them with data at the moment when they are writing a prescription for a patient to assist them in their decision from both a quality and efficiency perspective.⁵¹ Equally, one very small consortium hub said that it is already working with a management consultancy firm and another that it was developing a scheme to assess risk amongst its patient population. A third consortium described how it is working with other pathfinders in the region and a private IT company to develop a referrals gateway for the whole area. It will be essential that GP consortia can access the external support they need if they are to flourish. The research for this report has identified widespread concern about a number of problems in this area.

First, many providers of external support and a number of GPs were worried that the issue is not being brought onto the agenda early enough. This is a particular issue of concern where providers would need to make investments to be able to offer services or solutions – and it is true as much for social enterprises as it is for the private sector. The government has provided little clarification as to the framework and terms under which external support providers might operate and there is widespread feeling that the Department of Health needs to do more to engage with potential providers of external support at an early stage. There is a risk that if they do not do so, potential providers of external support will give up because they feel the enthusiasm and leadership is not there and the benefits that their ideas and expertise could bring to commissioners and ultimately patients will not be realised. One private healthcare company, Humana, has already taken a decision to exit the UK market, saying: “The DH [Department of Health] has made it clear that the priority at the moment is sorting out the NHS staff from the PCTs and the SHAs, and that the market [for private sector commissioning support] is unlikely to develop dramatically in the next year or so.”⁵² There have been problems with the FESC and providers and commissioners have often found it cumbersome and bureaucratic to use. However, it has at least

50 The King's Fund, Naylor, C. and Goodwin, N., *Building high-quality commissioning: What role can external organisations play?*, 2010

51 United Health, *ScriptSwitch application*

52 *Health Service Journal*, 18 January 2011

provided clarity for external support organisations and allowed them to market themselves to commissioners as organisations approved to work in the NHS. It has also provided a mechanism for commissioners to find out easily which external support providers can offer which services, with the assurance that these providers will meet certain standards.

Recommendation

As an early priority, the government should develop a simple framework for a wide range of external support providers to engage with GP consortia. It should give consortia clear information and options about how to engage with these organisations should they wish to do so.

Second, potential providers of external support are concerned that they are not facing a level playing field. A number of GP leads have said they would like to look elsewhere but are experiencing heavy pressure to work with Primary Care Trust staff first. We even heard that one Strategic Health Authority has given its GPs a blanket ban on working with the private sector. This is compromising the successful delivery of the policy. GP consortia need to be free to work with the best people – and if they feel that staff in their local Primary Care Trust are not up to the job then they need to be free to reject them. Several GPs expressed this view very strongly. If the Department of Health does not give GPs free choice in their use of external support then a market will not be given the space to develop. This would have serious implications for the success of the policy. It increases the likelihood of the status quo being replicated and reduces the potential for introducing innovative new approaches into the system. As one interviewee put it, we do not want to end up with a limited pool of monolithic organisations (probably mostly made up of ex Primary Care Trust staff) saying that they can provide everything. There are many potential providers who have expertise in different areas and GPs need to be able to ‘mix and match’, employing external support organisations to do the things that they are best at. GPs also need to be outsourcing to providers who are genuinely innovative and efficient – not simply because the GPs needed someone and the provider was the only organisation that the GPs could find.

Recommendation

The government needs to ensure that GPs are not coming under pressure to employ or outsource work to Primary Care Trust staff where they do not want to do so. Emerging GP consortia must be given the freedom to work with the organisations they think will best meet their needs.

Thirdly, external support providers are worried about a loss of expertise in the handover. Private companies are keen that lessons learnt and expertise built up through the FESC programme should not be lost. NHS cancer networks are even more concerned about this issue, as the case study below shows. They are not the

only specialist network in the NHS (there is also a group of cardiac and stroke networks, for example) but, as Box 3 shows, there are many unresolved issues as to what will happen to these groups under the new system. The Department of Health has said that they “may well wish to turn into social enterprises”, that “it is very likely that GP consortia will wish to purchase support from a new style of cancer network” (which might be hosted by the Commissioning Board).⁵³ These changes will not happen automatically, however, and forming a social enterprise takes time. If further clarity is not provided soon, then there is a risk that specialist expertise will be lost in the vacuum that ensues.

Recommendation

The government needs to work with the organisations that currently provide specialist support to the NHS for particular conditions (such as cancer networks) to ensure that they are equipped to work in the new system and so that the expertise they have built up is not lost in the handover.

Box 3: Case study in external support: Cancer Networks

Cancer networks currently work on a relatively large scale (mostly at regional level) and support both Primary Care Trusts in their commissioning of cancer care and hospitals in their provision. They do not carry out actual contracting work, but they do provide advice and support on the mapping of population need, the prevention of cancer, the design of care pathways, the monitoring of outcomes, the benchmarking of hospitals and strategic service provision. One of their important functions is that they bring together all the groups in an area with an interest or expertise in cancer and help them work together.

Most GPs see only around eight patients with cancer in a year. On the one hand, that means they are likely to take a strong interest in the commissioning of the services they need because having a patient with cancer is a rare and serious event for them; on the other hand, they are likely to lack the skills and expertise to commission those services well because it is not something that they deal with often. Cancer networks want to have a role in the new system but there are number of issues of concern:

- GP consortia may not realise what they do not know and therefore may not always be aware that they need specialist help – if they do not access such help then some patients may receive sub-standard care;
- Cancer needs to be treated as a whole, but it is to be divided with some cancers to be looked after by GPs and others to be looked after by the Commissioning Board. This is not consistent with practice in the NHS, where a surgeon may perform one operation that may be classed as non-specialised followed by another that is classed as specialised;
- A large part of the work cancer networks do relates to coordination of services across a region. How will this work if not all consortia choose to be involved?; and
- Networks are uncertain about how much, if any, of the statutory funding they receive will continue.

⁵³ Department of Health, *Improving outcomes: a strategy for cancer*, January 2011

2.3 Getting the incentives right

The government's plans to change the commissioners of NHS care will cause a subsequent change in the incentives for major players in the new system. Appendix 2 provides an analysis of these new incentives. It starts with the entities that will be profit centres, assesses which other groups will be causing money to flow to these profit centres and then assesses the behaviours that will result. There are several places where the way incentives are structured risks creating sub-optimum behaviours and where corrective action will be needed to safeguard the integrity of the system. Two of these are considered in this section. Section 2.5 below will consider a third in more detail – whether GP practices and consortia may be unwilling to take on patients in deprived areas who are more likely to become ill and therefore impose financial costs on the consortium.

Providers of services marketing themselves to consortia, GPs and to patients

Given that consortia, GPs and patients will have the power to decide which organisations provide NHS care, there will be a strong incentive for providers to market themselves heavily to these groups. This will be particularly true in cases where there is competition for the provision of services or where a new provider is seeking to enter the market and win business. Firstly, GPs and consortia will need to be above reproach in their dealing with providers and suppliers and in accepting any gifts or hospitality from them. It will be important for the public to see that GPs are not gaining personally from the providers they are using. GPs will also need to be able to show that they are not behaving anti-competitively in any contracts they negotiate and that all suppliers and providers are treated fairly, with none being squeezed out of the market inappropriately. With its powers as the NHS competition regulator, Monitor will be overseeing this under European competition law.

Secondly, it will be important that providers are not marketing to patients in misleading ways. Patients will have significant power of choice under the new system – they should, in theory, be able to be treated by any NHS provider in the country – but they will often lack the knowledge to know whether the claims that providers are making stand up to scrutiny. This highlights the importance of accurate and comparable information being available on the results that providers achieve for patients. The government has a work stream in place on this issue and it is beyond the scope of this report to consider it here in detail. However, it is worth noting that getting the new information regime right will have huge implications for the successful operation of GP consortia. Assuming that GPs will have access to good information on the performance of providers, they will then need to help and guide patients as to whether what they have heard about different hospitals is accurate. They will need to be seen as impartial and informative. They will need to provide challenge where patients may have heard something that is not backed up by evidence and be helpful in supplying additional information where patients may lack it. The GP consultation room is likely to be the most common forum for these discussions. This means that all GPs, not just the leaders of consortia, will need to make sure they are either in a position to offer patients this type of advice and support themselves. Or, alternatively, they will need to know which of their colleagues to refer their patients to in cases where those colleagues have developed specialist expertise.

GP consortia self-referrals where they or their member practices are also providers of care

“If you are an innovator, and many of the people who are going to get involved in commissioning are going to be innovative practices and innovative people because they are going to be the people who want to be commissioners just naturally, and if they are going to be excluded from providing or being involved in provider services, then it is going to put them all off either commissioning or providing. I think that is just daft. We are going to commission and provide. That is the reality. We have just got to work out a system of making that transparent and safe. I think that is a really difficult thing to do but it can be done.”

Dr Paul Charlson, GP from Hull, Evidence to the House of Commons Health Committee, 2 November 2010

GPs already provide a number of services to which they may refer their patients. Some of the most common of these are vaccinations, physiotherapy, health checks and maternity care. Some GPs also have financial interests in private companies set up to provide services in the community. As consortia develop new and innovative ways of keeping patients out of hospital it is likely that more care will be provided in these ways, often with significant benefits for patients (as some of our case studies show). It would therefore seem foolhardy to outlaw these behaviours. However, the benefit to patients is not automatic, and it has to be acknowledged that there is a perverse incentive in the system for GPs to refer patients to their own services because this will financially benefit them rather than because those services are necessarily delivering the best results at lowest cost.

A way must be found through this. At present the government has said little about how it intends to manage the problem. The Health and Social Care Bill at present says only: “Regulation ... may ...

impose requirements relating to – (a) competitive tendering for the provision of services; (b) the management of conflicts between the interests involved in commissioning services and the interests involved in providing them.”⁵⁴ GP innovation versus financial interest is clearly a complex issue and work will need to be done to ensure the right regime is in place. However, it would

seem sensible for it to include some key elements. Firstly, it needs to be entirely transparent to patients, the public, healthcare providers and regulators exactly how many patients and what value of treatment GP consortia are referring to providers in which they have an interest. This data will need to be monitored by the regulator and investigated where it shows potential cause for concern. Secondly, where there are other local providers who can offer the same service, GPs should always present a patient with the choice between the different options before making the referral, along with unbiased data on the outcomes offered by the different providers. One option would be to make it a requirement for GPs to declare to the patient any financial interests they have at the time of referral.

“Where there are other local providers who can offer the same service, GPs should always present a patient with the choice between the different options before making the referral, along with unbiased data on the outcomes offered by the different providers”

54 Paragraph 63

Whichever mechanism is chosen, there will need to be evidence available (perhaps gathered through patient surveys or random checks) that GPs are following best practice.

Recommendation

Consortia and their GPs should be required to declare publicly any hospitality or gifts they or their practice receive from providers of NHS care to ensure that public trust in their referral practices is maintained. When developing a regime to avoid conflicts of interests between GPs' provision and commissioning roles, regulators will need to ensure that transparent information is widely available on the volume and value of GP referrals to providers in which they have a stake. In turn, GPs will need to ensure that they offer patients unbiased advice on their choice of provider and that they are transparent to their patients about any financial interests they may have.

2.4 Policy tensions that need to be addressed

Many of the GPs and experts interviewed raised concern about tensions in the plans set out by the government which need to be clarified as far as possible, even if they cannot be fully resolved.

Tensions in GP-patient relationships

The relationship between patients and their GP is one of the strongest in the NHS. As mentioned at the start of this report, 94% of patients have trust and confidence in their local doctor.⁵⁵ There is a danger that this relationship could be jeopardised through GPs becoming the gatekeepers of patients' access to further care and treatment. One GP consortium manager raised concern that GPs are not used to saying no to their patients and that they would find doing so very difficult. This is a tricky issue, because the whole purpose of the government's policy is that GPs take on this rationing role. As explored in sections 1.5 and 2.1, the more individual GPs take an interest and involvement in commissioning, the more the government's plans are likely to succeed. It is therefore impossible to remove this tension altogether, but it can be mitigated.

The same practice manager mentioned above felt that the key to the issue was GPs successfully communicating with their patients. He felt that consortia need to have early examples of success to demonstrate to their population that the new system is working and to ensure that levels of patient trust and confidence do not slip. There was wide variation in the level of patient engagement amongst pathfinder groups interviewed. Some already have well established patient forums and others are making it a high priority from the outset (such as the group in Fleetwood described in section 1.2.). However, there are also groups which have not yet begun any substantial work on this issue – either because they lack the staff or because their focus is on other things. It is very important that GPs do not neglect patient engagement in the early stages of the development of their consortium. Patient trust is hard won and easily lost.

Engaging well with patients will be particularly important in cases where GPs are having to make difficult decisions. If a drug or treatment a patient wants is to be denied then patient expectations will need to be managed from the outset and

⁵⁵ Department of Health, *GP Patient Survey October 2009 to September 2010*, 16 December 2010

GPs will need to have clear evidence to back up their decision. Primary Care Trusts have generally managed this badly and in such cases they have often been seen as out-of-touch bureaucrats who care little for the needs of their patients. GPs have the potential to do this far better because they already have the trust of their patients. They know their patients full care history so they are better placed to make decisions about the benefits of a particular drug or treatment. However, GPs will still need to be intentional in the way they manage these cases if they are to succeed. This is well illustrated by an example one GP leader described. He wanted to get patient buy-in to decisions about drug prescribing – his consortia had just decided to stop prescribing a drug for which they believe there is little evidence. However, that would mean that patients across the group would then be able to receive IVF treatment when they need it. For patients to support this, however, the GP recognised that patients would need to accept the clinical evidence and the benefits and feel like they had participated in the decision. It could not be something that was imposed upon them. As set out in the discussion above on incentives, GPs will also need to demonstrate that they are above reproach in their dealings with care providers and drug companies, particularly in terms of any funding or hospitality they receive.

Recommendation

GPs will need to maintain high standards of communication with their patients to ensure that trust is maintained. They will need to be able to demonstrate strong examples of successful commissioning from an early stage, involve patients in decision-making and make sure they have very clear supporting evidence in cases where they are not providing a particular drug or treatment to a patient. Consortia need to make sure they do not make patient involvement a secondary issue, but embed it in their plans from the start.

Losing patient trust will be a particular issue in cases where GP consortia are performing poorly – and rightly so. This is why it is important that there is potential for good consortia to expand into areas where consortia are not performing well (see section on competition below), otherwise patients who are suffering at the hands of poor commissioners will be left with no alternative. In terms of competition between NHS providers (rather than commissioners), many people are worried about whether the government is planning to allow below-tariff price competition (as opposed to competition purely on the basis of quality). The government's messages over this have been confusing, although the head of the NHS has now written to the heads of all NHS trusts stating categorically that: "There is no question of introducing price competition."⁵⁶ This is welcome as there was a high risk of breakdown of trust between patients and their GPs if patients perceived their doctor was pushing them towards a particular care provider simply to save money.

Fears about whether a culture of bureaucracy is really ending

Through its plans for GP commissioning, the government aims to free local doctors from top-down micromanagement and slash bureaucracy in the NHS. However, many of the GPs interviewed are concerned about whether this rhetoric

⁵⁶ *The Daily Telegraph*, 17 February 2011

will be backed up by reality. For example, one raised the issue of service specifications and a worry that GP commissioners would have to negotiate a plethora of variations to contracts, which would be time-consuming, bureaucratic and render them inflexible to changes in patients' needs. He wanted contracting to be simple so that if a provider is licensed to offer NHS services then he can be confident in sending his patients to that provider without having to check and negotiate a huge number of issues. There is also widespread concern that the government has said very little about the size and structure of the NHS commissioning board. The legislation introduced in Parliament would give the Board wide-ranging powers to intervene in the operations of consortia and GPs are understandably concerned about how these powers might be used. Given the list of functions the Board is supposed to perform, it is unsurprising that many think a large body, with strong regional presence, is likely to be needed.

Recommendation

The government needs to clarify how it intends to implement its plans for an NHS Commissioning Board and to confirm that in abolishing Primary Care Trusts it is not simply displacing many of their bureaucratic functions to this new entity.

Several GPs also reported that they were worried that a culture change is not really taking place in the NHS and the centre is not really prepared to loosen its grip. Some Primary Care Trusts (such as NHS Cumbria) appear to be genuinely supporting GPs to take control of commissioning; others (as described in section 1.5) are unwilling to let go and are trying to push their local GPs in certain directions. A culture change takes time, but the government needs to impress more strongly on local NHS managers that GPs must be given the freedom to drive these changes in the way they see as best, without micromanagement. GPs must not be pressured into courses of action which they know will not deliver the best results for patients.

Competition versus covering a defined geographical area

We discussed the benefits of allowing some competition between consortia in section 2.2 above. The government has so far done little to indicate that it is supportive of this idea. It has emphasised the need for consortia to cover a defined geographical area, stating that consortia must “together cover the whole of England” and must not “coincide or overlap”.⁵⁷ When asked to clarify this, the Department of Health has insisted that this does not mean that a GP practice in one area could not be a member of a consortium in another, nor that two consortia might not operate in one town, with practices interspersed across the same area. The aim is instead “to ensure ... that there is no ambiguity as to which consortium is responsible for a person that is not registered with a GP practice or who needs access to emergency healthcare”.⁵⁸ While these are valid issues, which need to be addressed, the way this proviso is generally being interpreted is that consortia will not be permitted to overlap or compete and that they would have a defined and rigid geographic catchment area. It risks stifling the potential for consortia to innovate and risks giving patients little real choice. It is also likely to

⁵⁷ *Health and Social Care bill* 2010-11, Part 1, Clause 21

⁵⁸ *Explanatory notes to the Health and Social Care bill* 2010-11

be one of the factors behind a number of consortia failing to try out new configurations and instead simply continuing to cover the entire geographic area occupied by the Primary Care Trust.

Recommendation

The government should look again at its plans for GP consortia to cover a defined geographic area. There needs to be the potential for consortia to look at innovative new configurations and to provide patients within an area with real choice, driving up standards across the board.

Some of the ways of dealing with the geographical issues might be, for example, to allocate unregistered patients to the consortium of which their nearest GP practice is a member or to ensure that any emergency care accessed by patients away from home is paid for by their own consortium. There are ways in which these issues could be overcome and the benefits of increased competition could be realised. But again, this adds weight to the case for not abolishing Primary Care Trusts too quickly and providing time to get this issue right, rather than seeing many consortia simply replicating the geographic area of their local Primary Care Trust.

2.5 Areas of Deprivation

One of the concerns that the British Medical Association has raised about the government's plans is that poorer parts of the country will lose out. Laurence Buckman, chair of the organisation's GPs committee has said that GPs will have to compete to attract patients "with emotive offers of treatments ... but only the richer ones will be able to exercise real choice".⁵⁹ Encouragingly, interviews with pathfinders have provided little evidence to support this claim. Most pathfinder consortia we spoke to are covering mixed social areas and some promising groups, such as the Fleetwood case study in section 1.3, are operating almost exclusively in areas with high levels of deprivation. However, one small consortium did say that it had partly formed because it had wanted to separate off its wealthier patient population from neighbouring consortia, which cover areas of high deprivation. This was the only example uncovered of this tendency to avoid operating in areas of deprivation. It is not necessarily a problem *per se*, if there are also enthusiastic and innovative groups operating in deprived areas, but what would be worrying would be if the best consortia and GPs were tending to cluster in wealthier places.

There is the potential in the future, though, for increasing tension between the government's plans to allow patients to register with the GP of their choice and the fact that the best GPs may have full patient lists and be unable to take on any more patients. This would be particularly worrying if it meant that people in more deprived areas, who may be less likely to seek out a good doctor, might be excluded from the best practices and therefore consortia. The government has made some progress in encouraging GPs to practice in deprived areas and to some extent higher levels of funding for these places is already built into the NHS

⁵⁹ *The Guardian*, 25 January 2011

allocations formula, but there is still more that needs to be done. The Public Accounts Committee recently raised this as an urgent issue saying:

“The Department has failed adequately to address GP shortages in areas of highest need. The Department should identify, as a matter of urgency, what measures it can take to drive up the numbers of GPs in deprived areas, including using direct financial incentives to encourage GPs into areas of greatest health need. The Department should implement an action plan to deliver this objective within a defined timeframe.”⁶⁰

Although there is little evidence that emerging consortia are excluding areas of deprivation where GP practices already exist, there are still not enough good GPs operating in those areas. The Department of Health has said that it is “working with the independent Advisory Committee on Resource Allocation (ACRA), academics and relevant stakeholders to develop an appropriate methodology and formula for resource allocation at the practice level which will form the building block for consortia allocations”.⁶¹ In its report, *Which Doctor: Putting patients in control of primary care*, Policy Exchange called for these allocations to be ‘based on age, postcode and a “patient premium”’. The premium element... would act as an incentive to providers to deliver healthcare where it is needed most.”⁶² The transfer of commissioning budgets to GPs is an opportunity to provide much stronger incentives for them to work in deprived areas.

Recommendation

As it works on a formula for allocations to consortia, the government should provide a stronger incentive for GPs to work in deprived areas through giving a higher 'patient premium' to those GPs who do so.

This would not necessarily mean additional spending but instead a reallocation of existing resources.

2.6 Supporting GPs who have little enthusiasm for commissioning

This report has argued that all GPs will need to buy in to GP commissioning and get involved, to some extent at least, if the policy is to be a success. And it has found strong evidence of many GPs doing just that: creating consortia that, on the face of it at least, are strong and likely to be genuinely innovative. However, there are still large numbers of GPs who are unenthusiastic about the government’s plans. For example, a recent poll by the Royal College of General Practitioners found that over 40% disagreed that the proposed model of GP commissioning would improve health care outcomes.⁶³ The Health Secretary has said: “General practitioners and health care professionals in GP pathfinders are, in contrast to the unions, enthusiastic about what we are trying to achieve.”⁶⁴ However, this study has shown that this is also not consistently the case. One GP lead was openly negative about the plans – seeing them as another upheaval which the NHS would have no problem in dealing with because it is used to upheaval, but which would not make

60 House of Commons Committee of Public Accounts, *Tackling inequalities in life expectancy in areas with the worst health and deprivation*, Third Report of Session 2010–11, 2 November 2010

61 Department of Health, *Liberating the NHS: Legislative framework and next steps*, 15 December 2010

62 Featherstone, H. and Storey, C., 2009

63 Royal College of General Practitioners Press Release, 1 February 2011

64 *Hansard*, 31 January 2011, Col.615

any difference to patients. The manager of another consortium was also not particularly enthusiastic but said GPs needed to be pragmatic and work to deliver the programme. The GP lead of a third consortium said he was enthusiastic, but only if some very significant concerns he has, particularly around central micromanagement continuing, are addressed. Although those with concerns are in the minority, it is worrying that some of the GPs and managers leading the groups that should be paving the way for the new policy do not feel they can fully back it.

There is also evidence of a lack of enthusiasm amongst some GPs whose practices are members of pathfinders. In addition to contacting the leads of pathfinders, we also interviewed a small number of member GPs. A majority were not keen on the proposals and almost all planned to have no involvement (although the small sample means this evidence should be viewed as anecdotal rather than statistically reliable). One said that he plans to have “as little involvement as possible”. Another said that GPs need to be “involved in commissioning but are not appropriately experienced/competent to take over full responsibility”. A third said that GPs feel “not enough consultation took place regarding this and many are still very unclear about what it really means for them, their patients and their Practice. The GPs are also concerned that they will end up getting the ‘blame’ for future cuts in health services or budgets.”

GPs are professionals and it is unlikely any lack of enthusiasm they have will prove disastrous for patients as most will still do their best in the situation in which they find themselves. However, where GPs lack enthusiasm it does call into question the likelihood of them delivering real transformation in NHS care. Before pathfinder groups can become established, work needs to be done at a local level to win the support of their members – and to address the concerns of their leaders. The Department of Health is driving forward the pathfinder programme at high speed, with groups already covering half of England and three more tranches set to be announced by the summer. There is a danger that they are pushing groups together before the ground work has been done to bring the group members on board. This groundwork was crucial in Cumbria and the consortium this report studied in Kingston has also emphasised its importance. There are five key lessons from emerging consortia and from medical groups in the US which help demonstrate how it can be carried out.

- 1. GPs need to share best practice across the country.** GPs are more likely to be persuaded of the merits of the plans by other doctors than they are by NHS managers. Those GPs that are enthusiastic and have new and innovative ideas need to be sent out to inspire others. GPs have wide-ranging concerns about how the policy will work in practice and they need to see that other doctors are finding solutions to those problems and understand that the whole project is feasible.
- 2. The leaders of consortia need to be chosen in a transparent way that all members of the consortium agree is fair and so that they are felt to represent the whole group.** This is not always happening at the moment. For example, one GP we spoke to expressed concern that “self-appointed ‘leaders’ may not necessarily be those best placed to actually deliver the improvement required”. And another said that their consortium leader “seems biased and does not listen to all of the members”. There are a variety of different ways of ensuring a fair and transparent process: several consortia interviewed were

using elections in which all member GPs had a vote; another had appointed a high-level external interview panel to select the right candidate for all key positions.

3. **GPs need to be able to develop the skills that they feel they lack.** In part, this will come through knowing how to access external support services as described in section 2.3. It will also come through the leaders of emerging consortia and Primary Care Trusts (in the transition phase) providing appropriate training for GPs who need it. Kingston consortium, for example, is providing sessions specifically for newer and less experienced GPs to give them the support they need to get involved.
4. **Commissioning-related tasks must not be an 'extra-curricular' activity that GPs are forced to fit in on top of their other work.** Doctors in Medical Groups in the United States were generally compensated for the time they gave to specialist commissioning committees. It should be the same in the NHS, with GPs remunerated for the time they spend commissioning, just as they are remunerated for the time they spend with patients. The Department of Health will need to account for this factor in the management costs allowance it provides to GPs.
5. **GP consortia must be allowed to develop more slowly where more time is needed to win over local GPs.** One of the pathfinder leads interviewed said that his consortium had not wanted to be included in the first or second wave of pathfinders because they needed more time to work locally to get the governance model right. The group is now being announced in the third wave. The government's timetable is ambitious in expecting all GP consortia to be established by April 2013, with full responsibility for running budgets. Some will undoubtedly be ready for this. None of the consortia interviewed for this report expressed any significant concerns about their ability to deliver within the timescale. However, these are the groups who are ahead of the game. Just as the pathfinder group described above was not ready for the first or second wave, so when the April 2013 deadline comes around there will be groups who are not ready to take on full, statutory responsibility for commissioning. This will particularly be the case where consortia are developing from scratch rather than from successful Practice-Based Commissioning groups, which have already had years to evolve. It will be counter-productive to push these groups into taking on full commissioning responsibilities too quickly. A much better approach will be to get the foundations right so that when these groups do take on full commissioning responsibilities they can do so successfully. This adds further weight to the argument made in section 2.1 that the abolition of Primary Care Trusts needs to be slowed down, at least in some areas.

Conclusion

The GP pathfinder programme is at an early stage, but already some new and innovative proposals are emerging and many of the pathfinder groups seem extremely promising. If their plans are realised then their patients will start to see real benefits. Success will take time, though. One of the points emphasised by many GPs was that in these interim two years they need to be given the freedom to

try things out, to fail and to learn lessons. The media are likely to jump on GPs when they make mistakes and the government will need to keep calm when they do. It will need to work with consortia and allow them to change track where necessary. At the same time, the government will need to be building up solid data on what does work so that there is a reasonable body of evidence available for GPs to access once they do take on statutory responsibility for commissioning. The imperative for this is all the greater since there has been no pilot scheme of the proposals.

In recent years, GP commissioning has received widespread support in principle from politicians of all parties and across the NHS. It would be a loss to everyone if it were discredited and the emerging consensus destroyed through overly rapid implementation. The changes that are planned are a natural next step from trials in the 1990s and from Labour's Practice-Based Commissioning programme. (Indeed, many of the promising consortia interviewed have grown out of successful Practice-Based Commissioning groups.) However, the government has lost many potential supporters, both inside and outside the NHS, through pressing ahead with them so quickly. If these issues are simply swept under the carpet then there is a real danger firstly that patient care will suffer in the transfer to the new system and secondly, that it will further undermine confidence in the proposals. If this is allowed to happen then, inevitably, as with a number of previous attempts at NHS reform, it will not be long before the wind changes and the whole scheme is put into reverse. On the other hand, if the hard work is done to slow things down, to bring sceptics back on board and to lay a solid evidence base for the scheme, then its potential to deliver real and lasting transformation in the NHS is enormous.

“ One of the points emphasised by many GPs was that in these interim two years they need to be given the freedom to try things out, to fail and to learn lessons ”

Appendix 1: Interview Data

Size (number of patients): Very small = 0-49,999; Small = 50,000-99,999; Lower medium = 100,000-199,999; Upper medium = 200,000-299,999; Large = 300,000-399,999; Very large = 400,000 +

Interview	Type	Enthusiastic?	Flexing up?	Flexing down?	Patient involvement	External service providers	Role for all GPs
Interview 1	Very small	Yes	Yes (secondary care) Yes (determined that core commissioning needs to stay in house to maintain the advantages of small size but will work with other consortia/across the region to share best practice on service redesign, to contract large-scale services such as the local children's hospital, to manage relationships with local authorities and social care providers and to share back office functions such as IT)	Yes (see 'role for all GPs')	Plans for elected patient representatives who will constitute a majority on the board	Social enterprise developed from local Primary Care Trust	Responsibility for a specific commissioning area e.g. cancer
Interview 2	Very small	Yes	No plans	Yes (Want to go beyond GP engagement to GP commitment. See 'role for all GPs')	Plans to extend patient forums, hold elections for their representatives, include their representatives on the board and provide more opportunities for patient feedback.	Open minded. The key things they will be looking for are stability and consistency.	Yes. All are getting involved in specialist groups. All budgets are devolved to practice level and each practice is monitored in every commissioning area. One GP and practice manager from each practice sit on the Board.
Interview 3	Very small	Qualified yes	Yes (will need to link with a large local consortium for negotiations with the local hospital)	Yes (see 'role for all GPs')	Have not had the staff to do much yet. Want to reach out to patients who will not turn up at meetings so a lot of communication will be survey or internet based.	Still to be decided but expect to need external support	Yes. All are getting involved in specialist groups. All budgets are devolved to practice level and each practice is monitored in every commissioning area. One GP and practice manager from each practice sit on the Board.

Interview	Type	Enthusiastic?	Flexing up?	Flexing down?	Patient involvement	External service providers	Role for all GPs
Interview 4	Very small	No (neutral)	Yes (will need to link with a large local consortium for negotiations with the local hospital)	Yes (see 'role for all GPs')	Extensive programme - at least five patient reps on board. They will go to all households for the election of these reps.	Yes, working with a management consultancy firm. Will only have 2-3 permanent in house staff and will contract out for other services. There will need to be county-wide organisations to deliver services like IT to all consortia.	Yes, all must attend meetings and take responsibility for their own referral and prescribing rates
Interview 5	Small	No	Yes, joining with a much larger local consortium. Will try to commission some services locally but generally feels too small to commission	See 'role for all GPs'	Hopes to do things slightly better but does not believe the Government's plans will make much real difference to patients	Yes - will receive support from a larger consortium	Will try to get all GPs and nurse practitioners involved
Interview 6	Lower medium	Yes	Yes (working with others in the area to manage the local hospitals)	Yes (Believe leadership must be distributed and all practices must play a role. Working on how this will happen but have already started providing training for newer and less experienced GPs to give them the support they need to get involved)	Under development - working with new local Healthwatch organisations to make sure they are fully involved	Trying to use incumbent NHS staff to start with. If they refuse to cooperate (which is looking possible) then will look to the private sector	Yes in understanding population health. Monitoring of referrals will also take place at practice level as well as consortium level
Interview 7	Lower medium	Yes	Yes (working across the city with other pathfinders to engage with the council and working with seven other pathfinders to the region to manage relationships with the acute hospitals)	Yes (see 'role for all GPs')	Still progressing (although some forums already exist) but very keen to get more patient buy in to decisions such as those on service redesign and availability of drugs.	Open minded. Currently recruiting for two new posts and do not expect they will be filled by ex-PCT staff. Have worked with a private IT company to develop a city-wide referrals gateway.	Yes. All practices have representatives on the Board according to the number of patients they represent (e.g. 10,000 patients = 4 members). GPs are also getting involved in specialist committees and each practice has its own referrals monitoring system.
Interview 8	Lower medium	Yes about GP commissioning but not about the abolition of Primary Care Trusts	Under discussion (likely to share some back-office functions and commissioning processes with other consortia)	No plans at present	Under development (currently interviewing and assessing members of a patient participation group)	Still under discussion	Attendance at engagement and training events
Interview 9	Lower medium	Yes	Yes (where economies of scale are needed e.g. A&E, cancer, some tertiary care)	Yes (see 'role for all GPs')	Already using expert patient groups and wants to continue with this model as well as having co-opted patient members on the board	Has been using a private company for external support under practice based commissioning and will continue with this	Yes, GPs are involved in specialist groups and referral rates are monitored at practice level. They have instituted a peer review system to look at each GP's number and volume of referrals.
Interview 10	Upper medium	Yes	Yes (some joint working with other neighbouring consortia)	Yes (Federation model with four clusters from 30,000 to 170,000 patients)	Under development. Have patient groups but they are not representative. Interested in social marketing and citizens juries for some decisions	Working with Primary Care Trust staff where they can add value but otherwise keen to look elsewhere	Believe clinical and financial decisions should be devolved down as far as possible.

Interview	Type	Enthusiastic?	Flexing up?	Flexing down?	Patient involvement	External service providers	Role for all GPs
Interview 11	Upper medium	Yes	Yes (working across the city with other pathfinders to engage with the council and working with seven other pathfinders to the region to manage relationships with the acute hospitals)	Yes (the consortium is a federation of three groups. Some commissioning will be done at group level and some at federation level. Also see 'role for all GPs')	Some very innovative schemes and plans for patient involvement being conducted at practice level. As well as patient forums, also using extensive surveys and individual communication with patients to keep them out of hospital unnecessarily and to make sure they receive high-quality treatment	Open minded. Challenging the Primary Care Trust as to whether it can deliver. Already using some external support for the training of GP Board members	Referrals monitored at practice level and clinical audits will also be conducted at this level
Interview 12	Upper medium	Yes	Yes (Will work with other local consortia on some large-scale contracting issues)	Few formal arrangements for this although a recognition that some tasks are better performed at a lower level	Evolving from patient groups at surgeries; lay members of the board	Essential services will be kept in house – most of staff are likely to come from the PCT. They are unlikely to go private for any external support – partly it's not in their ethos, partly they don't need to because of their size and partly there is little offered because of their geographical location	Activity will be monitored at practice level but only some GP practices are represented on the Board
Interview 13	Large	Qualified yes	Yes (Some issues will need to be decided at regional level such as controversial decisions on exceptional access to treatment)	Yes (Four localities, each of whom have leaders who sit on the board)	Four lay non-executive members on the board and a business lead who will take responsibility for engaging widely with patient groups	Working with Primary Care Trust staff at the moment as do not want expertise to be lost but open to looking elsewhere in the future	Yes in managing budgets and referrals at practice level and in meeting regularly in locality groups
Interview 14	Very large	Yes	No	Yes. There are six localities which each take responsibility for commissioning in their own area and are getting involved more and more in the contracting process with larger providers. Each has a lead GP and deputy and they are working to get other GPs involved as well. A regional 'sentate' body then takes responsibility for strategy and standards across the region and for devoting budgets to the localities	Lay involvement on all 6 locality boards and plans to extend lay involvement at much more local level in co-operation with local authorities. Also looking into recruiting lay experts to put some challenge into commissioning processes	Little used at present as due to their geographical location, which has few providers	Working to get more GPs involved

Interview	Type	Enthusiastic?	Flexing up?	Flexing down?	Patient involvement	External service providers	Role for all GPs
Interview 15	Very large	Yes	No	Yes. Three localities will allow more localised population needs assessment and each GP practice will hold and manage their own commissioning budget	Under development	Too early to say Each practice will take responsibility for their own spending	Each practice will take responsibility for their own spending
Interview 16	Very large	Yes	No	Yes. The pathfinder would prefer to be six localities rather than one large group. In the long-run this will probably happen but in the short term the SHA, DH would not allow it. Core contracting and back office functions will still be done at federation level, but everything else will be done in the six localities	Developing a number of different patient involvement groups	Want to be able to use companies for back office functions if the PCT offering is poor	Yes, all practices will hold budgets and monitor their referral rates (although will not take on financial risk). All practices also send a rep to the clinical board in their locality

Appendix 2: Incentives

Profit centre	Entities causing money to flow to the profit centre	Reason for financial flow	Resulting behaviour at the profit centre
Providers of NHS	GP consortia	Holders of commissioning budgets	Marketing to GP consortia
	Patients	Right to choose any provider	Marketing to patients
	NHS Commissioning Board	Central commissioning of specialised services	Marketing to the Commissioning Board
	Monitor	Setting the NHS tariff	Pushing for as high a tariff as possible
GP consortia	NHS Commissioning Board	Allocation of funds to consortia	Lobbying Commissioning Board and the committee on resource allocation over its funding
	GP Practices	The number of patients on their lists will decide the amount of funding the consortium receives	Pushing GP practices to increase their list size
	Patients	Right to choose their GP practice	Marketing to patients
GP practices	Department of Health	Payments for the provision of primary care	Lobbying the Department over the funds received
	GP consortia	Payments for the provision of additional primary care services	Encourage consortia to refer primary care treatment to practices within the consortium
	Patients	Right to choose their GP	Marketing to patients
Other providers of NHS primary care services	GP Consortia	Holders of commissioning budgets	Forcing GP consortia to prove they are not favouring a particular provider