

# COMMISSIONING FOR THE FUTURE

## Learning from a simulation of the health system in 2013/14

Candace Imison, Natasha Curry, Martin McShane

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The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

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## About the authors

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Candace holds a Master's degree in Health Economics and Health Policy from Birmingham University. Her first degree was from Cambridge University, where she read Natural Sciences. Candace is also a non-executive director of an acute trust in south-west London.

**Natasha Curry** joined The King's Fund in 2005 and has undertaken research in a number of areas, including long-term conditions, commissioning, and choice. She led The King's Fund's evaluation of practice-based commissioning in four PCTs which was published in 2008. She is currently developing a piece of work that is examining the implication of the NHS reforms for the voluntary sector in health. She also manages the Fund's work on predicting the risk of unplanned admission to hospital.

Natasha previously worked as a consultant at Matrix, a research and consultancy company, prior to which she was the evaluation officer at the Chinese National Healthy Living Centre.

**Martin McShane** qualified as a doctor in 1981. He has more than 20 years' clinical experience as a surgeon and GP. From 1992 onwards he became increasingly involved in health service management. After fundholding, he helped to establish and then chaired the North Eastern Derbyshire Primary Care Group and was Professional Executive Chair of the subsequent primary care trust until 2004. He participated in the NHS Clinical Strategist course at INSEAD in 2003, which continued his development and contributed to his decision to become Chief Executive of the PCT in 2004. After the last commissioning reorganisation he became Director of Strategic Planning and Health Outcomes for NHS Lincolnshire, the sixth largest PCT in England, working with 102 general practices and a budget in excess of £1 billion pounds. He has been a member of the National Patient Safety Forum since its inception and is Vice Chair of the East Midlands Specialised Commissioning Group.

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# Foreword

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## The primary care trust perspective

*Equity and Excellence: Liberating the NHS* (Department of Health 2010a) set out an agenda for the National Health Service (NHS) with wide ramifications. One of the most significant was the implicit need to support the development of competent and capable commissioning consortia led by general practitioners (GPs), within a very short time span. Working with senior executives and the professional executive committee, NHS Lincolnshire initiated a development programme in September 2010. This built on work undertaken since 2006 involving:

- eight practice-based commissioning clusters
- a very successful GP leadership development programme
- an MSc in commissioning, delivered in partnership with Lincoln University.

My involvement in the original ‘Rubber Windmill’ simulation in the 1990s convinced me of the benefits of a simulation. Using a simulation as a developmental tool for the NHS in Lincolnshire was a good way of helping GPs to understand the issues and behaviours that might emerge as a result of the proposed reforms. It was also expected that a simulation might be of benefit to the wider community outside the NHS, such as the local authority and the voluntary and private sectors.

Bringing together people with experience and skills pertinent to future roles in the system is a powerful way of helping people get insight into the challenges that lie ahead. This is particularly the case when the way ahead is the mere bones of new government policy, and the uncertainty within such a complex system as the NHS means that the future is impossible to predict.

A simulation is not designed to ape the mechanics of the future system but rather to bring out the sorts of behaviours the new system might generate. It helps participants scope the impact that reforms are likely to have across the whole system and the implications for their own organisation or role within that system. It puts participants under immense pressure to think and react in a way which draws upon subliminal and instinctual behaviours and therefore pulls out extremes. It is not designed to predict what will happen but can provide an indication of what might happen and offer an opportunity to consider how undesirable consequences might be anticipated and mitigated.

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This paper demonstrates that our simulation provided a great deal of food for thought. The centripetal pull of the NHS Commissioning Board, Monitor and the Care Quality Commission (CQC) was very strong as people brought behaviours from the old system into the new. GPs quickly discovered there were skills, knowledge, experience and mind-sets that they lacked and needed to understand and acquire quickly, both as individuals and as the emerging leaders of their new organisations.

The providers moved swiftly to leverage position in the new system. The private sector worked nimbly to offer innovative partnerships. Critically and worryingly the patient got lost as everyone focused on the money and the establishment of new relationships (power positioning).

None of this need necessarily happen in real life, but the lessons and messages from the simulation have already helped and will inform how NHS Lincolnshire makes the transition and transformation required truly to liberate the NHS.

### **John McIvor OBE**

Chief Executive, NHS Lincolnshire

## **The King's Fund perspective**

John McIvor approached The King's Fund to ask us to work with NHS Lincolnshire on a simulation of how the NHS might operate in 2013/14. Seeing this as an opportunity to model the whole system while it was still in early development, we readily agreed. Although simulations are necessarily an artificial construct, sensitive to local factors and players, they can provide valuable insight into how the various parts of the system may interact in the future. The complexity and scale of change envisaged across the NHS mean that it is only through exercises such as this that we can begin to explore these interactions.

As well as providing important learning for those involved, the simulation provides a lot of useful insights for NHS leaders and policy-makers. We hope they will take note of the messages about the scale of the development challenge for GP consortia and their leaders and the risk that behaviours from the current system will be transferred to the new.

GPs need the freedom to work with fellow clinicians to remodel care pathways to develop more integrated and community-based models of care. A key risk, apparent during the simulation, is that the scale of the financial challenge will mean the centre places a tight grip on those that hold the purse strings at a local level. At the same time, the new competition rules may restrict local



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commissioner freedoms to innovate and redesign services. The risk is that, far from liberating the NHS, these reforms will stifle the enthusiasm and innovation among GP consortia that we witnessed in the simulation.

**Dr Anna Dixon**

Director of Policy, The King's Fund



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# Executive summary

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This paper provides the findings of a simulation exercise run by NHS Lincolnshire with The King's Fund in November 2010. The simulation sought to model how the coalition government's proposed National Health Service (NHS) reforms would look in Lincolnshire in 2013, the date set for the implementation of many of the reforms to the NHS. It aimed to test the behaviours and dynamics that might develop under the rules of the new system and help local general practitioner (GP) consortia prepare for this new world.

In order to create a realistic scenario, participants represented organisations across the whole health system, including:

- GP consortia
- NHS and private provider organisations
- the health and wellbeing board
- HealthWatch
- the NHS Commissioning Board
- Monitor
- the Care Quality Commission (CQC).

The simulation took place over a day, representing a year of simulated time. Throughout the day, regular interventions were published and participants were required to react to them. Some interventions were applicable to the whole sector, while others were specific to one organisation or type of organisation.

One of the most striking observations of the day was the scale of the development challenge for GP consortia and their leaders. The GPs who took part in the simulation reported feeling pressurised and overwhelmed by the number of things they had to do. They found it difficult to grasp the rules of the new system and lacked an understanding of some of the basics of contracting. They struggled to take charge of the agenda and were reactive, rather than proactive.

GPs showed a preference for the transformational elements of commissioning over the transactional; that is, pathway and service redesign rather than financial planning and contracting. The consortia also showed a tendency to seek savings from the acute sector over other areas of health spend and missed productivity opportunities in primary and community care.

Cross-consortia relationships were slow to evolve and were threatened by differences in financial performance. This resulted in the best-performing consortia wanting to 'go it alone'. GPs were also unsure of the levers available to assist them in managing poor-performing practices. This became a pressing issue, because many of their savings plans relied on performance improvement within primary care.

One of the most active players in the simulation was the NHS Commissioning Board; its role was a mix of performance management and development support to consortia. Consortia failed to present plans to the board that gave it confidence. The NHS Commissioning Board was also drawn into helping to resolve disputes between consortia and providers and helping to draw up credible financial plans. Its workload became so great that by the end of the simulation it had taken on extra staff.

Monitor and CQC played a more marginal role in the simulation, with diminished roles in performance management and improvement. At the end of the simulation Monitor was considering whether a proposal from an alliance of NHS and private providers to develop an integrated care organisation complied with competition requirements.

Within the simulation, the acute provider was absorbed by financial planning and very internally focused. It used its dominant position in the local market to try to secure more resources.

The health and wellbeing board and HealthWatch both became marginalised, and the patient voice and public health perspective were largely ignored.

It is not possible to draw definitive conclusions from a simulation, which by its very nature is artificial. However, this simulation provides valuable insight into some of the potential risks and opportunities of the new regulatory and management structures being implemented.

Organisational challenges are sometimes likened to the challenge of building a plane while flying it. Observing the challenges faced by GP commissioners during the simulation, it is tempting to extend the analogy to building a plane while *learning* to fly it. GP consortia and their leaders have a demanding development path ahead. This poses significant difficulties for authorising organisations that have no demonstrable track record for the capabilities they will require in the future.

A major risk is that behaviours from the old system will simply be transferred to the new and that the iron hand of the centre will want to retain its grip and not liberate the NHS. This risk is magnified given the financial context and the significant pressures the NHS will face trying to keep within a capped budget with a prospective £20 billion gap between resources and demand.

On a more positive note, it was remarkable how dynamic play was and how quickly participants established a shared clinical vision of a more integrated model of care. If health communities can find a way through the financial challenges and be allowed to integrate service delivery, as many wish to do, the new system could be a major catalyst for positive change.



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# Commissioning for the future

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## Introduction

This paper describes a simulation exercise run by NHS Lincolnshire and The King's Fund in November 2010. The simulation aimed to model the reformed National Health Service (NHS) as it would look in 2013. Its purpose was to observe the behaviours and dynamics that could potentially arise in the new system and provide a learning and development opportunity for local general practitioner (GP) consortia. Although simulations are artificial constructs, it provided a means for people from across the health community to explore the implications for their organisations.

The paper offers observations about individual and organisational behaviours as well as about system dynamics as a whole. Appendix A provides more detail on the method and approach taken to the simulation.

## Context

Simulation participants were provided with a briefing for Bigshire (*see box, below*), a fictitious county that was not entirely dissimilar to the environment most participants were familiar with.

### Summary of the Bigshire briefing

- Bigshire is a rural county with a dispersed population of around 750,000.
- The health and social care system is facing massive challenges, largely due to the past two years of tight budgetary constraint.
- Waiting lists are starting to emerge in specialities that previously had no problem delivering to target.
- The 2010 comprehensive spending review put intense pressure on local authority budgets, and Bigshire County Council has significantly raised the threshold for means-tested social care.
- The population has significant health needs. The eastern, mostly rural, side of the county has a high proportion of older people. The western side, where the road and rail networks offer high-speed access to London, has a wealthier and more mobile population. On occasion, the different needs of these two very different population groups lead to tensions in how resources are used.

- The health and wellbeing board is well informed on health issues through the director of public health. However, the board has struggled to influence the developing GP consortia, which extend beyond the boundaries of the local authority. The ring-fenced budget of the health and wellbeing board is coming under pressure to support both health prevention and social interventions.
- Four consortia of GP practices have developed, two of which emerged from historical practice-based commissioning clusters. Some of the staff previously employed by NHS Bigshire are now directly employed by the consortia, some have taken their knowledge out of the system and a small core are working within Bigshire Commissioning Support Intelligence (Bigshire CSI).
- Bigshire has mostly monopoly provision. The key providers are outlined below.
  - Bigshire United Hospitals Foundation Trust (BUFT) recently acquired foundation trust status. The trust is looking to downsize its footprint while retaining its hold on services. Consultants are being asked to work in a flexible manner and foster relationships with specific consortia. Some suspect this is a precursor to relocating them to an out-of-hospital setting.
  - Bigshire Community Trust (BCT) was formed from the former primary care trust (PCT). BCT has a broad range of services structured around the consortia. There is concern about increasing competition from the other two foundation trusts in Bigshire, which are considering taking over traditional areas of community services.
  - Bigshire Mental Health Foundation Trust (BIGMENT) is a medium-sized mental health care provider. Part of its portfolio now lies outside of Bigshire. It is under constant threat of takeover from larger mental health foundation trusts with expansionist ambitions. The mental health trust has strong relationships with the majority of the consortia. The relationship with the local authority has been strained in recent years due to financial pressures on both sides of the partnership.
  - Health Direct is a private provider of a range of community services contracted to provide multidisciplinary, community-based musculoskeletal services. It is interested in expanding the range of services it can provide to the consortia, particularly admission avoidance and expediting discharge.



## What happened

A detailed summary of what happened in the simulation can be found in Appendix B. Despite a lot of interaction between the players there was little definitive action. At the end of the simulation – after a year of simulated time and a day of real time – the GP consortia had no signed contracts and no financial plans that were felt to be credible by the NHS Commissioning Board. Neither HealthWatch nor the local health and wellbeing board felt they had managed to influence the GP consortia's commissioning intentions.

Much of the interaction was between GP consortia and the central bodies, particularly the NHS Commissioning Board. During the simulation, the NHS Commissioning Board took on more staff to cope with the growing workload as it was not only undertaking a performance management role for the consortia but also trying to influence consortia development and arbitrating in disputes with providers. Monitor and CQC struggled to work closely with the NHS Commissioning Board, but worked increasingly closely with each other, and by the end of the simulation were almost operating as one.

At the local level, a shared clinical vision emerged among participants. This vision included a more integrated model of care with strengthened community services, which would help to avoid hospital admissions, facilitate discharge and reduce reliance on acute beds. This plan was supported by the acute trust, which estimated that it would need to reduce bed numbers dramatically in order to achieve financial balance. During the simulation, the acute trust also considered ceasing provision of older people's care and closing one of its two hospital sites as a means of bridging the financial gap.

A proposed alliance between the private sector, the local NHS community provider, the GP-led community provider and the local mental health provider was a major platform for the new community-based model of care. At the end of the simulation, a decision from Monitor was pending about whether the alliance could proceed or whether such collaboration contravened competition requirements.

## Key themes

This section discusses the behaviours and issues that emerged from the simulation. They come from observations on the day and reflections provided by participants after the simulation. The key themes were also tested with many of the participants (mainly GPs) at a follow-up meeting four weeks later.

It is important to note that these observations come from what is necessarily an artificial construct. The simulation took participants directly to 2013, without the benefit of a transition period, and the participants from the GP consortia did not

have experienced managerial support. However, the dynamics and behaviours described here are a plausible forecast of the future from the perspective of those who participated.

The observations have been broken down into the following themes:

- GP consortia – behaviours and support needs
- the role of the NHS Commissioning Board, Monitor and CQC
- the role of the NHS and private providers
- the role of the health and wellbeing board and HealthWatch.

### **GP consortia – behaviours and support needs**

The simulation involved four GP consortia, each with a different population profile and financial situation. A number of financial challenges were set as well as a variety of performance and engagement issues among their constituent practices.

We have grouped these into three key areas:

- support needs – skills and capacity
- managing external relationships
- managing internal relationships.

#### **Support needs – skills and capacity**

##### ***Personal and organisational development***

One of the most striking observations from the day was the scale of the development challenge for the consortia and their GP leaders.

The GPs who participated felt under pressure and overwhelmed by the number of different things they needed to do and understand. The simulation demonstrated that GP leaders will have complex relationships to manage, both internal and external to their organisation. Leadership skills will be of particular importance for:

- bringing together constituent practices
- brokering relationships across consortia
- negotiating with providers.

Many GPs have not yet had the opportunity to develop leadership skills. GPs will also need to understand the roles and responsibilities of the organisations they are relating to. Some GPs reported finding it difficult to grasp the rules of the new system. There was still a strong tendency to seek support and guidance from the central bodies.

**Learning points**

- Leadership skills will be essential to GPs if they are to set the agenda. Strong influencing and negotiation skills will be of particular importance where consortia are relatively small and their immediate sphere of influence therefore limited.
- GPs need to have a good understanding of the wider system and how its constituent pieces fit together.

***Developing transactional commissioning skills***

Another important observation was the degree to which GPs wanted to engage in service transformation and pathway redesign. However, they were far less interested in and/or equipped to deal with the transactional elements of commissioning, such as contracting, data analysis and financial forecasting. The interactions between the consortia and the NHS Commissioning Board showed that the consortia did not even have a basic grasp of how contract negotiations should be handled.

The simulation was limited in its ability to test financial management. However, GPs were given a clear remit to make savings and were put under immediate pressure by the NHS Commissioning Board to produce viable financial plans. GPs struggled to do so and the NHS Commissioning Board felt the plans were not credible and were based largely on identifying variations in referral patterns between practices. With respect to data analysis, the GPs focused on the opportunities to reduce activity rather than address population need. This was perhaps in response to the pressure from the NHS Commissioning Board to identify substantial savings. GPs did recognise the need for more support in this area and brought in a private organisation to provide data and information analysis during the simulation.

This suggests a need for GP consortia to understand early the full scope of their new responsibilities and their skills gaps so that they can be addressed.

**Learning points**

- Consortia should be supported to undertake a diagnostic phase during which they identify the type and scale of future support they require. GPs without commissioning experience will not necessarily be aware of the skills that they need.

### ***Focus on finding savings from the acute sector***

GPs in the simulation demonstrated a tendency to look for financial savings in the acute sector. Few attempts were made to look for savings in other areas (eg, mental health, community care and primary care). There was also little consideration of investing in upstream care in order to bring about long-term savings. The health and wellbeing board demanded more of a focus on prevention and GPs responded by suggesting bringing specialists into the community.

#### **Learning points**

- The acute sector accounts for less than half of NHS expenditure, so there is a need for GPs to be prepared to look across the wider system for savings, including their own provision, which represents at least 10 per cent of the NHS spend and impacts on spending elsewhere. This might require GPs to consider the community and mental health sectors as well as the roles of prevention and health promotion.

### ***Dealing with conflicts of interest***

Conflicts of interest were raised as a point of concern among some GPs. The issue arose following an approach by a GP provider who offered to deliver whole pathways as well as assistance with business cases and the management of outlying GP providers. One consortium felt that a conflict of interest arose from GPs being both providers and commissioners, and called for a total separation of the roles. The issue remained unresolved at the end of the simulation.

#### **Learning points**

- Conflicts of interest will inevitably arise and will need to be tackled transparently. Experience from practice-based commissioning suggests that where conflicts of interest were not effectively and directly dealt with, progress stagnated and relationships stalled. Consortia will need to develop clear governance to ensure that this does not arise in the new system.

### **Managing external relationships**

#### ***Cross-consortia collaboration***

A number of factors drove the consortia to work more closely together. In particular, the acute trust demanded that the GP consortia identify a lead consortium for contract negotiations. While some GPs recognised the need for collaboration between consortia at some level (eg, in order to share risks around the intensive care unit (ICU)), it took five simulated months for this collaboration

to take shape. GPs reported feeling overwhelmed at the outset by the number of things they needed to do. Although they recognised the need for some collaboration with other consortia, they did not feel they had the time to invest in identifying and building up the necessary relationships.

Good relationships between GP consortia were important to the development of collaboration. However, despite many established relationships, it still took time for them to adapt to the new system. There was uncertainty among GPs about whether consortia were primarily meant to be competing or collaborating. This manifested itself, for example, in different levels of willingness to share data.

GPs debated which form collaboration should take and considered whether the formation of a single consortium would be beneficial in some instances; for example, when consultation of constituent practices at the cross-consortia level was likely to hamper the pace of decision-making. As there were mixed views about the benefits of a single consortium, it was agreed that arrangements would be reviewed after a year.

It was interesting that enthusiasm for collaboration waned once consortia began to diverge in terms of financial performance. One consortium made a profit in the first year and began to disengage from cross-consortia activities. It was accused of exhibiting protectionist behaviour by other GPs. In contrast, those consortia that were struggling with overspends were keen to stick together and support each other. Risk-sharing agreements across consortia were eventually reached after much negotiation, highlighting the need for trust and clear governance.

### Learning points

- Relationships between practices will need time to develop. Even where existing relationships are strong, there will be a period of upheaval when the terms of collaboration will need to be explored and agreed. The time required for this to happen should not be underestimated.
- Good governance arrangements need to be in place to facilitate cross-consortia risk-sharing.
- Consortia will need to balance the need to engage constituent practices with the need for effective decision-making at the cross-consortia level.

### *Working with the health and wellbeing board*

GPs paid little attention to population need and the potential for preventive work until the health and wellbeing board put it on the agenda. Little effort was put into proactively forging links with the local health and wellbeing board in order to

understand what needs and priorities it had identified. Financial considerations appeared to take precedence over need and quality of care.

#### **Learning points**

- Consortia will need to forge close links with other local consortia and with health and wellbeing boards to ensure that population health needs and priorities are clearly identified.
- Consortia should consider undertaking an early mapping exercise of potential stakeholders and partners.

#### **Managing internal relationships**

Although the simulation did not fully explore intra-consortia dynamics, there was much debate about how consortia should engage with constituent practices. GPs recognised the importance of engaging with constituent practices, but being required to consult with practices slowed the pace of decision-making at a cross-consortia level.

Consortia struggled to know how to deal with underperforming practices and frequently sought advice from the NHS Commissioning Board. Consortia were unsure what levers and sanctions were in the GP contract and could be used to reward good performance or penalise poor performance. Questions were also raised about whether overspend by a single practice would be absorbed across a consortium or impact solely on the poor-performing practice. One consortium struggled with the management of a poor-performing practice and discussed whether it had the powers to expel the practice. The issue remained unresolved at the end of the simulation.

#### **Learning points**

- It will be essential that intra-consortia relationships develop effectively. Organisational development theory suggests that the development of a shared vision is critical in creating an organisation and maintaining engagement. This suggests time will be required for a period of organisational development and strategic thinking.
- Clarity is required over the sanctions that consortia have to manage financial underperformance and poor-quality care among constituent practices.

## The role of the NHS Commissioning Board, Monitor and CQC

This section examines the role of the NHS Commissioning Board, Monitor and CQC. These three central organisations, in particular the NHS Commissioning Board, turned out to be extremely active in the simulated system, with most contact made between the NHS Commissioning Board and the GP consortia. There was also significant interaction between these bodies and the providers, as well as with each other. There was also some limited contact with HealthWatch and the health and wellbeing board. The key features of the interactions between the players are summarised below.

### System rules

During the course of the day, participants looked frequently to these central organisations for clarification on a number of system rules, such as:

- uncertainty over whether ‘any willing provider’ agreements could be below tariff
- whether private providers could access NHS pensions
- whether an alliance of providers currently registered with CQC or Monitor requires new registration.

Such issues remained unanswered during the simulation.

### Learning point

- Clarity is required at a national level on a number of contractual and regulatory details if organisations are to operate effectively.

### The role of the NHS Commissioning Board

The NHS Commissioning Board rapidly took on the role of performance manager. This led some participants to question whether it would be a repackaged strategic health authority (SHA). In the absence of a PCT or SHA, the NHS Commissioning Board also had a developmental role, and much time was spent guiding, and almost coaching, consortia on their commissioning function.

The participants playing the role of the NHS Commissioning Board commented on how difficult they found tracking the progress of the four GP consortia in the simulation and developing a relationship with them. With no early warning system, they felt they were continually ‘fire fighting’. The NHS Commissioning Board became overloaded and by the end of the simulation had recruited more staff to cope with its growing workload. One participant suggested having some sort of account manager to help provide continuity in the relationship with the consortia.

A key driver of central intervention was the financial stress on the Bigshire economy. Although this was an artificial construct, the financial challenges ahead mean this will be the environment in which the new NHS structures and organisations will start to operate. The financial interdependence between GP consortia and providers also meant that the NHS Commissioning Board frequently had to engage with providers as well as consortia to help develop sustainable financial positions for both parties.

### **Learning point**

- Consideration needs to be given to how to establish effective communication and working relationships between the NHS Commissioning Board, its regional outposts and GP consortia, including an early warning system for significant performance issues and continuing support for consortia development.

### **The role of Monitor**

The participants representing Monitor noted how ineffective they were in influencing the acute provider – their only sanction was removing the acute provider's licence.

### **Communication challenges between the NHS Commissioning Board, Monitor and CQC**

Despite sitting at the same table for the duration of the simulation, the participants representing the NHS Commissioning Board described difficulties in communicating with Monitor and CQC. For example, there were some issues surrounding the degree to which they were drawn into extensive local discussions. To avoid communication problems, Monitor and CQC ended up working together on most issues.

### **Learning point**

- Clear and effective communication mechanisms need to be established between the NHS Commissioning Board, Monitor and CQC.

### **The role of the NHS and private providers**

Although the Bigshire provider landscape closely reflects the reality of Lincolnshire, domination by one acute trust is relatively extreme. The simulation also provided a relatively unusual scenario where a large GP-led provider organisation delivered community-based services, including sustaining a small



local hospital. This is important context for any learning taken from the behaviour of the provider market in the simulation.

### **Acute provider**

The financial position constructed for the acute provider within the simulation, although in line with national planning assumptions, required significant year-on-year savings/productivity improvements and meant that the acute provider was very absorbed by financial planning and gave little attention to quality or broader service development. When compared with the community and mental health providers, the acute provider was very internally focused.

As mentioned earlier, the acute provider within the simulation had a dominant market share of the local health economy. This dominance was used to secure more resources. At the same time, the acute provider was enthusiastic about the new model of care proposed in the community, because the financial savings programme included a 40 per cent reduction in beds and relied on effective demand management within the community; this would enable them to release resources. The acute trust contemplated closing a hospital site, but felt public opposition would make this impossible.

### **Learning point**

- Commissioners will need to place a strong emphasis on quality of care as well as improvements in productivity to avoid financial concerns overriding all other issues.

### **Mental health provider**

The mental health provider fared very well in the simulation. It bought in the expertise of a former PCT staff member to help build relationships with the GP consortia. This proved to be very helpful to the trust. The mental health provider also formed effective strategic partnerships with other providers.

### **Community provider**

The community provider felt that the block contract held with the GP consortia left it at a financial disadvantage when it came to absorbing growing demand. As financial pressures grew, the negotiations between the community provider and the GP consortia revolved around what the community provider would stop delivering rather than how it could innovate.

### **Private sector behaviour**

It may have been a construct of the simulation, but the private sector providers were noticeably more proactive and strategic than their NHS counterparts. They seemed more willing to take on risk and were less concerned about 'playing

by the rules'. This more aggressive behaviour left some wondering whether the private sector would rapidly dominate the local market.

### **Alliances between providers of private and NHS community services**

During the simulation, the providers of private community services and commissioners rapidly formed strategic alliances with other players as the private providers sought to secure their position in the local market and support the development of innovative models. By the end of the simulation an alliance was proposed between the private providers, the GP provider company, the NHS community provider and the mental health provider to develop an integrated care organisation to provide a comprehensive community care offer that would reduce the use of acute hospital beds. This proposal removed all competition between community providers, but delivered a model of care that the consortia wanted to buy. It was also supported by the local health and wellbeing board. The proposal went to Monitor for approval and a decision was pending on completion of the simulation.

#### **Learning point**

- Providers will benefit from investing in developing strong strategic relationships with GP consortia and other providers.
- Community service provision is likely to be an area which will offer some of the greatest opportunity for market entry and provider competition. At the same time it may also be an area where anti-competitive behaviour may flourish and competition law may be seen to be in conflict with preferred service models.

### **The role of the health and wellbeing board and HealthWatch**

The simulation called for a strong health and wellbeing board that was well supported by public health needs analysis. The board began the simulation with some enthusiasm and sought to develop a strategy for the local area. HealthWatch was less enthusiastic because of uncertainties about roles and resourcing. As the simulation progressed, the health and wellbeing board and local HealthWatch felt marginalised, so enthusiasm was dampened.

#### **Learning point**

- There is a need for greater clarity over the role and resourcing of HealthWatch.

Interestingly, HealthWatch made most of its approaches to the acute trust rather than the consortia about quality of care issues. When asked about this later, the representatives said they didn't want to go to multiple consortia and saw the local acute hospital as responsible for patient care.

### **Lack of authority**

The health and wellbeing board and HealthWatch suffered from a lack of authority. For example, when the health and wellbeing board asked the GP consortia to place greater focus on prevention it got little response. The inequalities and public health agenda also had little traction as financial problems dominated the local commissioning agenda.

### **Patient and public perspective ignored**

By the end of the simulation the participants for HealthWatch were very frustrated. Despite their best attempts to put patient issues on the agenda, including approaching the NHS Commissioning Board, they felt that the patient perspective was ignored. For example, the foundation trust developed plans to reduce its bed base by 40 per cent without consulting HealthWatch.

### **Learning point**

- In the absence of clear lines of accountability to the health and wellbeing board there is a risk that both the patient voice and the public health agenda could be marginalised.

## **Discussion and conclusions**

It would be wrong to draw definitive conclusions from an artificial process with all the challenges and flaws already outlined. However, this simulation gives NHS Lincolnshire and other observers important insight into the risks and opportunities associated with the new NHS regulatory and management structures.

### **The scale of the GP consortia development challenge**

GP consortia have a challenging developmental path ahead. This is true for the:

- individuals who will lead them
- organisations themselves
- internal and external relationships.

Mature organisations and leaders can look outwards and develop strong external relationships that enable them to achieve their vision and goals. Immature organisations and leaders may find themselves distracted by their internal

challenges and have difficulties managing relationships in a highly complex health and social care system that is itself in flux.

GPs and consortia should be aware that they may not necessarily know what skills and development they need, so may be unable to identify and fill the gaps. This was certainly observed in the simulation when consortia opted to buy the data-analysis services they wanted rather than the wider commissioning support they needed. These blind spots or gaps in understanding can impede effective joint working (Luft 1970). The greater the awareness an individual or group has about its behaviours and skills, the greater the capacity for joint and constructive working. Team building and other personal development activities, including personal feedback, can help improve awareness but require trust and time. Those observing the consortia during the simulation felt that participants had a number of blind spots, which would need to be addressed with support.

The absence of a body to support the organisational development of the consortia saw this work fall to the NHS Commissioning Board in the simulation. If this situation is mirrored in reality, there is a risk that consortia development will simply go the same way as world class commissioning development, which became a bureaucratic exercise rather than a developmental tool.

Finally, there must be major questions about an authorisation process that, unlike the process developed for foundation trusts, authorises organisations with no demonstrable track record for the capabilities they will require in the future.

### Risk of behaviours from the old system being transferred to the new

A critique that could be made of many NHS reorganisations is that policy ambitions are thwarted because, despite structures and systems changing, organisational behaviours stay the same. The simulation would suggest that there is a risk of this pattern repeating itself. This was particularly noticeable in the way the national organisations related to the local organisations. The policy aims to reduce the central power and influence and give a greater degree of autonomy to the organisations within the NHS.

*The government is replacing the current system of top down control. Instead of hierarchical management by the Department of Health and strategic health authorities (SHAs), improvement will come from devolving power to professionals, patients and carers.*

(Department of Health 2010b)

However, within the simulation, organisations continually looked to central bodies for guidance and help to resolve local disputes and the central bodies actively tried to manage the local position. The risk of the ‘top’, in the guise of

the NHS Commissioning Board, retaining a strong degree of control is surely magnified by the financial pressures ahead. David Nicholson, future chief executive of the NHS Commissioning Board, has already given the following response when questioned by the Public Accounts Committee about the risks of financial failure with GP consortia.

*Then finally we have the ability to intervene ... you could see us putting people in there, supporting them, moving the management of the consortium to another consortium which is more successful at managing, bringing in people from outside, the kind of things you would expect an intervention regime for [sic]...*

(Nicholson 2011)

## Uncertainty about system rules and leadership

Despite attempts by central bodies to keep control, the system felt chaotic. It was not clear who was in charge and participants were unsure about the rules they were expected to play by. In part, this was a construct of the simulation, because participants were thrown into new roles and a new system without the advantage of two years' preparation. However, the uncertainty about who was in charge seemed real. The legislation appears to give equal weight to the NHS Commissioning Board, Monitor and CQC – all of which have to be notified of any significant issue or change of service. It is not clear how significant service change would be driven forward and disputes resolved.

Private and NHS providers put forward a joint proposal for an integrated care organisation to help deliver this model of care. As the simulation came to an end Monitor was reviewing the proposal to assess whether it complied with competition law. A number of GPs commented that they found the ambiguity about whether providers and consortia should be collaborating or competing paradoxical and difficult to understand.

## The patient gets lost

The financial pressures faced by the GP consortia and providers prompted many of the conversations to be about money, not quality of care. Many of the GPs present commented on how quickly the focus on the patient was lost, even with clinicians in charge. In this system, the local democratic voice was weak and did not counter the central pull.

## Dynamism and energy

The discussion so far has exposed many more risks than opportunities. There is, however, a very important positive finding from the simulation. In contrast to the uncertainty about the rules, a striking feature of the simulation was how quickly

participants established a shared clinical vision across all the health care providers and the consortia to deliver a more integrated model of care. There was also considerable dynamism and energy among those participating – particularly the private sector and the GP consortia. If health communities can find a way through the financial challenges, and are allowed to integrate service delivery as many wish to do, the new system could be a major catalyst for positive change.

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## Appendix A

# Method

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This section describes the approach taken to this simulation and identifies the limitations of the construct. At the end of this appendix is a list of reflections and tips provided for those considering running their own simulation.

### Timeframe

The simulation took place over the course of one day. The day represented the period from June 2013 to June 2014. Each simulated month was a 20-minute period during the day.

### Location context

The Bigshire context was based on Lincolnshire, and some familiar providers and problems were adopted. Further information on the context is provided in the Introduction (pp 1–2).

### Participants

The preparation of the background materials for the simulation involved scoping which organisations needed to be included and which individuals would be best suited to the roles, particularly those in organisations that do not yet exist.

Invited participants were representative of the whole health system. Where possible, participants represented the organisations in which they currently worked and adopted roles with which they were familiar. In the case of new organisations, such as the NHS Commissioning Board, individuals were chosen based on their skills and experience. Some of these roles were taken on by participants from outside Lincolnshire, who were able to bring a national perspective. This introduced an element of reality to the simulation – the new people were unfamiliar with local issues and GPs and others had to forge new relationships with them.

### Pre-simulation briefing

Participants were provided with a briefing pack ahead of the simulation. A background briefing set out the context and issues that existed across the Bigshire health and social care system. Each participant was also provided with

information specific to his or her role. For instance, all the GPs were provided with detailed information relating to the health needs, financial situation and referral activity of their consortia.

### Interventions and scenarios

At the beginning of the day, each participating organisation was given a position statement. In addition, a pre-recorded news film was played to set the scene for the day. The short film involved interviews with:

- a political reporter
- the new director of the commissioning support unit
- a GP consortium chair
- the local authority's director of public health.

Throughout the day, regular interventions were published and participants were required to react to them. Some scenarios were published across the whole sector. Others were specific to one organisation or group of organisations.

### Facilitation and moderation

Facilitation and moderation are important components for the success of a simulation. Independent observers are vital to capture the learning for feedback and analysis. NHS Lincolnshire sought skills and additional capacity from The King's Fund to support the development of the simulation and ensure rigorous feedback and analysis. The observers worked hard to capture conversations and observations on the day.

### Feedback and analysis

It is essential to allow time for feedback and to capture people's experiences, perceptions and interpretations of a simulation. In a complex adaptive system such as health and social care, it is enormously valuable to capture, analyse and try to understand the:

- way people behave in response to the rules
- feelings generated
- resultant actions they take or decide not to take.

A feedback session was held at the end of the simulation day. Participants were invited to reflect on their experiences and understanding of the day. In addition, participants were invited to send feedback via email up to a week after the event.



Notes taken by the observers were analysed alongside feedback from participants. A timeline of events was constructed to provide a narrative of proceedings (see Appendix B). Themes and key observations were identified and the discussion in this document is structured around these themes. The key themes were validated at a professional executive committee meeting, which was held a month after the simulation day. Representatives from The King's Fund presented their observations and interpretation to the committee members and asked them to comment on whether it resonated with participants' own experiences. This provided the opportunity for any necessary clarification and discussion where opinions diverged.

## Limitations

A few limitations need to be acknowledged.

- Some parts of the system were not represented in the simulation, principally social care provision. This exclusion was deliberate and the decision was made because of logistics. Ideally, every part of the system would have been represented.
- The new GP commissioning consortia were populated solely with GPs. Quite quickly they realised they needed significant experienced management support to discharge their role. Although this was a weakness in design, it proved to be a positive part of the feedback because it exposed the need for such support.

## Tips for running a simulation

The success of a simulation relies largely on effective preparation and logistics. We have reflected on our experience and compiled this list of tips and learning points to help others who are considering running a similar exercise.

- Securing the right attendees is essential. People don't necessarily have to adopt their own roles – indeed, the creation of new bodies necessarily means that people will need to take on new and unfamiliar roles. Senior and experienced people from across the system are required, but their diaries are usually difficult to clear for a whole day, so plenty of notice is essential.
- The materials required for a simulation can be based on existing information. A background briefing is required to set out the context and issues across the health and social care system. Additional materials are also required for each organisation in the system. This information does not have to be extensive, however it is important that the information given to each organisation does not conflict with the information given to another.

- It is important to give participants the right level of information. As the simulation progressed, it was clear that the population commissioning information provided to GP consortia was far too detailed and this hampered the GPs' ability to take a strategic view. There is a need for information that is strategic but easy to digest.
- Good administrative support is required to run a successful simulation, as well as plenty of laptops, printers, projectors and screens. Simple logistics such as the room, layout, beverages and a good lunch should never be overlooked. The pace is fast and furious and quickly tiring – in this instance each hour involved three simulated months of work. Do not try to do too much in one day.
- The timetable was expanded to allow time for feedback. This provided an opportunity for valuable reflection. Participants were also invited to email further reflections over the following week to capture the key bits of learning that occurred to participants after the event.
- The validation event was a useful forum for testing the interpretation of events and behaviours with some of those who took part. Reflections from this event were used to inform and expand the paper, rather than change it – differences of opinions between those involved in the exercise and those observing it are inevitable. The subsequent publication was written from the point of view of the observers, informed by the reflections of the participants.

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## Appendix B

# Bigshire timeline

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### June 2013

- **GP consortia** have difficulties processing data – start to identify information needs; concern over engagement with constituent practices; identify emergency admissions as an area to target.
- **HealthWatch** is concerned about its role and how it would be resourced.
- **The health and wellbeing board** wants to see a single overall strategic plan for the whole area.
- **Monitor** check out problems identified by the foundation trust. Monitor was keen to talk to the NHS Commissioning Board regarding price setting.
- **The NHS Commissioning Board** spent time setting out behaviours expected from the system. It starts to plan performance review and talks about going to Monitor regarding pricing.
- **The foundation trust** immediately set about putting together a financial strategy – based on diversion from A&E and redesigning unscheduled care. The trust responds to Monitor and starts to focus on consortia.
- **The commissioning support unit** tries to sell services to private providers and consortia with limited success.

### July 2013

- **Private providers** rapidly form an alliance between a GP provider (Louth and District Medical Services; LADMS), PriceWaterhouseCoopers (PWC) and Cuddles UK. Private providers want a joint venture with an integrated care pathway.
- **The community provider** offers a more innovative model of admission avoidance. The main concern was that the block contract was not covering the increased demand.
- **GP consortia** demand more information from the community provider. Some consortia ask the NHS Commissioning Board for support in developing plans.

- **The health and wellbeing board** calls the first meeting to establish a whole-system view and to focus on longer-term health issues and health inequalities.
- **The NHS Commissioning Board** approaches consortia and asks for their plans.
- **HealthWatch** questions the foundation trust about why an elderly patient has been on a trolley for 24 hours.
- **Monitor** turns to the Department of Health for advice. Private providers want an 'even playing field' with NHS providers; that is, to be value-added tax (VAT) exempt and able to offer NHS pensions. Can they do this?
- **The mental health trust** buys in the expertise of a former primary care trust (PCT) staff member to help build relationships with consortia.

### August-September 2013

- **GP consortia** start discussion around developing an integrated emergency service with the foundation trust. GP consortia begin to talk to each other about the approaches by the commissioning support unit. GPs begin to question what powers/sanctions they have in relation to constituent practices. GPs agree the need to collaborate.
- **The foundation trust** is absorbed with financial planning and not focused on quality. The trust is planning to reduce beds by 40 per cent and HealthWatch is raising concerns. The trust is internally focused and does not share the recovery plans with consortia or HealthWatch and this causes problems. HealthWatch feels it hasn't been involved in any decisions over beds. A high-cost drug was announced. The trust agrees it won't be prescribed without agreement from the relevant GP consortia. The trust wants to communicate with one commissioner, not four.
- **The NHS Commissioning Board** is putting pressure on consortia to produce a credible recovery plan. A risk summit is held with CQC, Monitor, HealthWatch and the consortia. There is concern that no lead commissioner has been identified for Bigshire. At the summit, only two of the four consortia turn up. It is noticeable that quality concerns are not addressed. HealthWatch is concerned by this. The consortia are challenged by CQC over quality, but the consortia have no evidence. The NHS Commissioning Board suggests a need for a lead commissioner. The GP consortia suggest they have a lead commissioner at each hospital site within the acute trust, but the NHS Commissioning Board says they need one commissioner for the whole trust.
- **Monitor** is reviewing the new private provider alliance plans and is concerned about the implications for competition and conflicts of interest.

- **The community provider** is concerned that the health and wellbeing board is focused on inputs and not outcomes.
- **The health and wellbeing board** seems happy with the new private provider model, which aims to provide a whole pathway and blur health and social care.
- **The mental health trust** starts discussions with the private provider. Active engagement with consortia over admissions avoidance and high cost drugs – they agree a shared-risk deal.
- **The commissioning support unit** talks again to consortia representatives who are beginning to realise the need for data and to question the accuracy of what they have. Some consortia are keener than others. The commissioning support unit comes back at the end of September assuming that it has agreed to work with GPs, but the GPs say no such agreement was made. The unit comments that it does not know who it is working with as there is no lead contracts person.

## October-November 2013

- **GP consortia:** first meeting of all consortia. Agree lead commissioners for the foundation trust, mental health trust, community providers and private providers. Also agree lead links with CQC, Monitor, the health and wellbeing board and the NHS Commissioning Board. GPs recognise they have been reactive so far and need to be more proactive. Some GPs identify a need for management support. One consortium suggests forming a single GP cluster but agrees to keep four consortia with lead commissioner arrangements. Forming a single consortium in future was not ruled out. Decision-making is hampered by the need for GPs to go back and consult with constituent practices. A single GP says decisions should be based on clinical evidence not finances. GPs agree the need to be proactive and approach the foundation trust about what procedures they wanted it to stop. There are some communication issues among GPs. At the meeting of the health and wellbeing board, the GP response was to bring specialists into the community. GPs recognise that they are struggling with informatics and start talks with PWC, having rejected the commissioning support unit offers.
- **The NHS Commissioning Board** is still chasing GPs for recovery plans.
- **The health and wellbeing board** hears GP plans and wants greater focus on prevention, but gets little response to this.
- **The commissioning support unit** is offering services to the health and wellbeing board around strategic planning.

- **The regulators** (CQC and Monitor) meet with the foundation trust and lead commissioner and want to see improvement in quality.
- **The foundation trust** meets with the consortia about an integrated A&E. Consortia to provide a plan by December. The body language of the foundation trust with the GP commissioner suggests the trust feels it is more powerful and more knowledgeable.
- **The community trust** starts discussions with private providers about developing an integrated care organisation.
- **The private provider** signs the first contract as a new joint group with one of the GP consortia – 50/50 risk sharing is agreed.

## December-January 2014

- **GP consortia** agree a deal with the private provider (which has undercut the offer from the commissioning support unit) for analytical support. Until this point there has been no evidence of analysis of population need – everything has focused on activity. GPs start to look at population and identify priorities but there is no attempt to share this with other consortia or to do it jointly. Public relations work is undertaken in response to civil unrest – there is some consideration of what it might mean but it is not really taken seriously. GPs hold their second area meeting in January 2014. At the meeting, they start to identify some common priorities, thresholds and ceilings. Lead commissioners report back. Cuddle UK and the partnership trust have agreed a joint venture across health and social care and this is to be rolled out across the four consortia. Contracts remain unsigned – this is a priority for next month.
- **The NHS Commissioning Board** challenges the GPs' plans, which are not thought to be credible. The NHS Commissioning Board felt the plans did not link to the population need and there was little specificity about what they planned to do. On a prospective gap of £30 million, only £7 million was identified. Consortia pinned a lot on variation. GPs said that £24 million could be saved by managing variations between practices, but it was not clear how they were going to pull the money out. The NHS Commissioning Board notes that it took a 2 per cent top slice and that the consortia had the option to go back to get some money back if in difficulty, but they did not do so.
- **Monitor** is frustrated by the lack of responsiveness from the foundation trust. Monitor feels it has few sanctions in the new world, other than the ultimate one of withdrawing the licence. The foundation trust is blaming the consortia for the lack of a robust recovery plan.

- **The foundation trust** agrees an admission avoidance scheme with one consortium. The foundation trust is thinking through how it can deliver the scale of savings required (gap of £100 million on £700 million turnover). The current plan rests on closing 40 per cent of beds. The trust contemplates closing a site (but there is too much public opposition) or selling it to a GP consortium, but where would it get the capital from? The trust feels it cannot get its recovery plan properly buttoned down because it is 'waiting on primary care'. One consortium continues to struggle to cope with underperforming practices, and it is still not clear what sanctions the consortia can utilise as it is not the practices' employer.
- **The mental health trust** has gone into risk-sharing agreements with the foundation trust – eg, A&E diversion.

## February-March 2014

- **The private provider** systematically approaches stakeholder management and is gaining business. Currently engaging the mental health trust in a partnership.
- **The foundation trust** is unhappy with the revised financial position as outlined in the simulation. The proposed consortia schemes will require investment and time before they can release capacity – they present great risk to the organisation. The foundation trust considers giving up the provision of services for older people as a means of bridging the budget gap.
- **The community provider:** the block contract sum is protected but it is agreed to refocus the work delivered for the contract – the primary focus is admission avoidance and early discharge. The GP consortia approach the provider to see whether they can deliver the care for older people that the foundation trust no longer wishes to provide.
- **GP consortia:** one consortium is still struggling with underperforming practices. It decides to expel the practices from the consortium, but is not sure if it can, so seeks advice from the NHS Commissioning Board. The GPs are told they have control over locally enhanced services and directed enhanced services and could use them as a way to reward high performance – the GPs had not realised this. Other consortia start to worry that the poor performing consortium will drag them all down. Two consortia consider a merger. One consortium decides to support the poorest performer: 'If you go down, we all go down.' They agree to create a risk pool among consortia, but there is some uncertainty over how it should be regulated. The greatest resistance came from the consortium with the biggest surplus.

- **The NHS Commissioning Board** wants to see GP plans for the next financial year.
- **GP providers** approach GP consortia regarding a possible agreement offer to help deliver whole pathways, help with business cases and manage outliers. The conflict-of-interest issue arises. One consortium wants total separation of provision and commissioning.

## April-May 2014

- **The NHS Commissioning Board** convenes a meeting of four consortia and questions the degree to which the contracts reflect the joint strategic needs assessment, but the consortia are unable to demonstrate this. The NHS Commissioning Board asks the lead commissioner, 'Do you have a signed contract?' The commissioner replies, 'I didn't know I was supposed to'. The consortia still fail to bid to the NHS Commissioning Board for transitional funding, despite financial pressures. The Commissioning Board tells GPs it wants to see public health priorities in their plans and advises GPs to challenge the community trust regarding its costs. The GPs appear surprised that they can do this.
- **The community trust** tells GPs it cannot increase service provision without putting up the cost.
- **Monitor** meets with the foundation trust and challenges its plan as 'heroic, with huge risks'. Still no signed contract. Monitor feels it has limited leverage over the trust.
- **The foundation trust** is working jointly with the consortia to identify potential bed reductions.
- **The private providers** are questioning the tariff rules – can they undercut the foundation trust?
- **The GP consortia** continue to struggle with problem practices and ask the NHS Commissioning Board if they are able to fine practices at a reasonable rate. The GPs comment that the health and wellbeing board does not seem to know what it is doing. One consortium asks the foundation trust whether it will do work at below tariff rates in community hospitals in order to close its finance gap. One consortium appoints a director of development (formerly a commissioning support unit employee). There is confusion about the arrangement – the consortium is under the impression that the director of development is its employee, but the NHS Commissioning Board says he should also support other consortia. There is an assumption that other consortia will contribute financially, but the other consortia say they did not



agree to this. A dispute arises and the NHS Commissioning Board is brought in to mediate.

## June 2014

- **An alliance of private and GP providers** proposes an integrated care organisation to Monitor and CQC. Despite each provider being registered individually, can they provide joint services under their legal agreement?
- **Monitor:** before allowing the alliance to deliver its integrated care proposal, competition issues need to be investigated and assessed. The alliance may be able to go forward subject to special conditions, but this needs clarification.
- **The NHS Commissioning Board** continues to challenge consortia plans. The consortia question why they were not told they were overspent.
- **GP consortia** hold a meeting to cover the following: the foundation trust contract is signed; one consortium is still trying to reject two underperformers; the lead consortium for the NHS Commissioning Board reports that a meeting with it was 'bruising'; the community contract with the private provider is signed; the mental health contract is signed; there is still disagreement over the appointment of the director of development.



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