Consultation response

The King's Fund response to the Department of Health's public consultation on *Commissioning for Patients*

11 October 2010

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.

This paper is a formal response to the Department of Health's public consultation on *Commissioning for Patients* that sets out information on the intended arrangements for GP commissioning and the NHS Commissioning Board's role in supporting consortia and holding them to account.

Key messages

- The King's Fund is broadly supportive of giving GPs and other health professionals more power in commissioning and of using real budgets as a means of doing so. Allocating commissioning budgets to GP consortia could improve the use of clinical expertise in the planning and purchasing of health care and impose a much needed financial discipline on the way providers deliver care by making them responsible for the wider cost implications of their clinical actions.

- However, we would question whether the proposals represent the least disruptive means of achieving the desired improvements in commissioning. There are a number of significant risks associated with the coalition's proposals to devolve £80 billion of the NHS budget to GPs while also phasing out PCTs and SHAs, and the evidence base supporting some of the proposals is limited. Unresolved questions include:

    - Where will the much needed local and regional system leadership reside in the absence of PCTs and SHAs? Who will plan and oversee large-scale strategic change, eg, hospital reconfiguration?
    - Will consortia be large enough to carry the financial risks associated with random fluctuation in the health needs of the population?
    - Will organisational upheaval distract from the QIPP challenge?
    - Will the proposed constraints on management allowances make it difficult for consortia to access the professional management support systems they will need?

- The King's Fund does not endorse a single model for GP commissioning in which all consortia bear the full risk for commissioning a comprehensive range of services. The evidence suggests that clinical commissioning is most effective when the scope of services commissioned is adjusted according to the size and skills of each consortium.

- However, if the approach to be taken is that all consortia are to become fully risk-bearing (as outlined in the White Paper), we would urge the government to do this through a more flexible, stepped process in which consortia are not exposed to full risk in the first years of their existence, and take this on only as and when they are ready for it. Evidence from other countries suggests that budgetary responsibility should be

transferred gradually as GP commissioners learn how to manage budgets effectively. This refers both to (a) some consortia taking on responsibilities before others and (b) responsibilities being transferred incrementally rather than transferring full financial risk from the outset. The NHS Commissioning Board could have the power to limit windfall gains or unavoidable losses during this period or until there is general confidence in the accuracy of the resource allocation formula.

- Those consortia that are already well developed should be enabled to move more quickly – providing an opportunity for piloting the process and enabling future groups to learn from their experience. The more advanced consortia will need to support the development of others rather than compete with them or gain a monopoly over the best managers and support staff.

- If all consortia are to take on full financial risk for commissioning a comprehensive range of services, GPs should be discouraged from forming consortia covering a population of less than 100,000. Smaller consortia would not be well placed to become fully risk-bearing. However, larger consortia may need to devolve some commissioning responsibilities to local groups of practices or clusters to retain 'buy-in' and support local innovation.

- It is essential that commissioning is a multi-professional endeavour, not just the responsibility of GPs. GP commissioning should be conceptualised as commissioning for a practice's registered population rather than commissioning by GPs. Depending on the degree of multi-disciplinary involvement in consortia, GP commissioning has the potential either to be a stimulus for different professional groups to work together more closely or to be highly divisive. There needs to be a stronger focus on engaging a broad range of professionals in commissioning in order to deliver joined-up services. The NHS Commissioning Board could include measures of integration and multi-disciplinary working as part of its performance framework.

- The commissioning system needs to be multi-tiered, with different commissioning responsibilities residing at different levels. While some services could be devolved to local groups or practices, others would be commissioned more effectively at intermediate levels between GP consortia and the NHS Commissioning Board. Consortia will need to aggregate to perform certain commissioning functions collaboratively, and the NHS Commissioning Board is likely to need to have a presence at the regional level in order to perform its role effectively. It may not be sufficient to allow such collaboration to happen organically. The Department of Health should put careful thought into the question of what structures or guidance may be needed to allow commissioning between consortia to be done effectively.

- There are strong arguments for consortia retaining a geographical focus. However, GPs in consortia will need to work together closely, taking collective financial risk, and in this context trust between colleagues and a shared understanding of priorities may be at least as important as shared geography. Getting the right balance between geography and affinity will be critical. This will vary according to local characteristics, particularly population density. If some consortia are established on non-geographical lines, it will be all the more important, and all the more challenging for them to build strong relationships with local authorities.

- The King's Fund agrees that making membership of commissioning consortia mandatory for general practices may be a powerful way to guarantee clinical engagement. However, it will be essential for most GPs to feel they have ownership of these new organisations. Financial incentives linked to achievement of quality and performance criteria will be important, but other incentives and levers also need to be adopted including peer review and benchmarking of performance within and between consortia. The government will need to develop a clear operational policy on how GP consortia will work with their constituent GP practices to ensure due process and transparent decision-making and to address conflicts of interest.

- Building the necessary skills within consortia will be challenging. There will be a role for both PCTs and external organisations in this. Consortia will be inexperienced users of external support and will need to learn from PCTs' experience of working with external organisations. PCTs should help them to be aware of the challenges involved and to develop minimum commissioning competencies, including leadership skills and a clear understanding of the commissioning function. Arrangements will also need to be put in place to safeguard public accountability where consortia choose to outsource certain aspects of commissioning to private sector organisations.

- While we would not advocate the creation of an assessment process as burdensome as world class commissioning for GP consortia, we do not believe it will be adequate to assess the performance of consortia in terms of outcomes alone. The NHS Commissioning Board should complement outcomes measurement by also assessing consortia in terms of a small number of essential commissioning processes or competencies.

- The consultation document assigns a wide range of responsibilities to the NHS Commissioning Board. The Boards is likely to need a substantial workforce and regional presence in order to discharge these multiple duties effectively.

- Further work is needed to clarify how GP consortia will operate in the wider architecture of the NHS and local government, including the interface with social care and public health. Particular areas for attention are:

    - how social care commissioners and providers can help GP consortia to develop opportunities for shared or delegated commissioning, eg, of learning disability services
    - the role of the proposed local health and well-being boards and their relationship with GP consortia
    - how far the new arrangements will create new opportunities for the integration of health and social care without undermining existing achievements
    - developing a clear understanding of the respective roles of consortia, health and well-being boards and NHS Commissioning Board in terms of performance management and support.

- The proposed structural changes will need to be supported by major cultural changes in the clinical community if they are to be implemented effectively. A culture of continuous quality improvement through peer review and audit will need to be fostered within consortia, and GPs in particular will need to accept that their responsibilities extend beyond the proximal concerns of their clinical practice to the health of the population they commission services for. The challenge of building effective consortia, therefore, relates not only to addressing the skills gap, but also to changing professional cultures and values.

- An immediate priority must be to support existing commissioning and managerial talent during the transitional period, to prevent this from being lost from the NHS. PCTs have made considerable developments in recent years and it is imperative that this learning is not lost.

Response to Consultation Questions

A. Responsibilities

GP commissioning

1. In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?

In order to encourage GPs to take an interest in commissioning specialised services beyond their local area, involvement at this level may need to be formalised in contracts and properly remunerated. Under PBC many GPs have not engaged with wider commissioning activities beyond small-scale local re-provision because involvement is voluntary and they have not been directly or sufficiently remunerated for such activities (Curry *et al* 2008).

The relevant professionals from specialist services will need to be engaged in designing the commissioning framework and contracts, drawing on the appropriate NICE standards. It will also be important to harness the knowledge of GPs with a Special Interest in relevant clinical areas.

It is not clear why maternity services will be commissioned at the national level rather than by consortia. The involvement of GPs in the care of pregnant women has declined dramatically over the past 30 years, and our research suggests this may be to the detriment of patient care (Smith A *et al* 2010). Whatever level maternity services are commissioned at, it is important that GP consortia are involved in commissioning local services if the role of general practice in maternity care is not to be weakened further.

2. How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?

There will need to be clarity about the division of responsibilities between the different parties involved in commissioning low-volume services. In the case of PBC, the decision not to have prescriptive guidance specifying how roles and responsibilities should be shared between PCTs and PBC groups led to disagreements and conflict between the two groups. Considerable time and energy was spent in local health economies attempting to resolve these disputes, and this contributed to the limited progress made by PBC (Curry *et al* 2008). There is a danger that a similar situation will arise if there is a lack of clarity over who has responsibility for commissioning low-volume services.

There are particular complexities relating to the commissioning of low-volume services which are also high cost. Random fluctuation in the numbers of patients requiring such services has the potential to be highly financially destabilising for consortia, particularly for those covering a small population. Stop-loss insurance was used to protect against these risks in GP fundholding (and that for elective care only) so it will be essential that similar arrangements are developed for GP commissioning consortia (Ham 2010). Getting the right balance between giving GP commissioners responsibility for the management of risk while also protecting them from the possibility of catastrophic losses will be crucial.

3. Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?

There are a number of services which would be best commissioned at intermediate levels between individual consortia and the NHS Commissioning Board. Cancer networks, stroke care in London, trauma, and high-risk complex surgery are examples of services that fall into this category. Provision of these services needs to be concentrated for reasons of quality, safety and workforce regulations, and the commissioning of them needs to occur at a similar level.

To commission such services successfully, consortia will need to aggregate and commission collaboratively, and the NHS Commissioning Board may need to have regional offices in order to perform its role effectively. Collaboration will be needed at a number of levels to create a commissioning system with multiple tiers, with each tier being the most effective level for commissioning a different range of services. It may not be sufficient to allow such collaboration to happen organically. The Department of Health should put careful thought into the question of what structures or guidance may be needed to allow commissioning between consortia to be done effectively. Close links with local authorities and other local organisations will be essential in the new arrangements.

4. How can other primary care contractors most effectively be involved in commissioning services to which they refer patients, eg, the role of primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?

Commissioning needs to be seen as a core part of the role of other primary care contractors. There is a danger that a disproportionate focus on GPs and the term 'GP commissioning' could alienate other professionals and detract from the fact that what actually needs to happen is multi-specialty clinical commissioning (see question 26). Primary care contractors are currently involved in PCT commissioning through representation on Professional Executive Committees. A similar forum for multi-professional engagement could be created within consortia. Within these forums, there is clearly a role for specialist advice from professionals working in community, secondary and tertiary care. Hence, GP commissioning should be conceptualised as commissioning for a practice's registered population, and not as an activity led solely by GPs.

GP consortia arrangements

5. How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?

It will be important for GP consortia to take on, as a core responsibility, the role of driving up the quality of care provided by their constituent practices. Clear lines of accountability need to be established between consortia and their constituent practices (especially where they are federated). There will be a need for clarity over the levers that consortia have to hold practices to account, particularly if, as proposed, the contract is to be held nationally by the Board.

An important role of PCTs in working with general practice has been their ability to invest in local general practice services and to use enhanced services payments to establish new innovations and new ways of working. There is a danger that this ability could be lost under GP commissioning, so consideration should be given to whether and how GP commissioning consortia might take on responsibility for managing GMS and PMS contracts directly. To do so, the inherent conflicts of interest in GPs as commissioners will need to be clarified and addressed openly if the flexibility of these arrangements is to be retained.

There is a danger that the incentive to control referrals will have perverse consequences, leading to a focus solely on referral volume rather than quality. As part of their role in improving quality, consortia will need to establish a robust performance management framework, which should be underpinned by relevant and comparable data. It will be important for practices to be able to shape the rewards and incentives embedded in their performance management. Consortia may also wish to establish referral management processes to ensure that referrals are appropriate and timely. In doing so they should learn the lessons of existing referral management schemes, particularly that the use of blanket targets to control referral rates runs the risk of reducing appropriate as much as inappropriate referrals (Imison and Naylor 2010). National guidelines could help consortia to develop an appropriate performance management regime. In addition to guidance, a culture

of improvement through peer review will need to be fostered within consortia, and clarity will be needed as to what happens if a practice consistently under-performs.

In addition to benchmarking within consortia, attention should be paid to benchmarking between consortia and regionally which, again, should go beyond volume of referrals and take into account clinical outcomes and patient experience. It is essential, therefore, that datasets are standardised and comparable across the country while allowing flexibility for how they are used as improvement tools at a local level. Performance should be open to public scrutiny as international evidence suggests that regular publication of performance information in the public domain can act as an incentive for improvement and can strengthen accountability (Shih *et al* 2008).

6. What arrangements will support the most effective relationship between the NHS Commissioning Board and GP consortia in relation to monitoring and managing primary care performance?

PBC had most impact where relationships between GPs and PCTs were constructive and collaborative. The same is likely to be true of the relationship between consortia and the NHS Commissioning Board. In order to foster effective relationships, the NHS Commissioning Board is likely to need a regional presence. Without this there is a real risk that adversarial relationships will develop as the Board is unlikely to be able to understand the local and regional context within which consortia are working.

One of the most important parts of the relationship will be how the NHS Commissioning Board will hold GP consortia to account for their performance. This will in turn have an impact on the way GP consortia hold member practices to account for the cost and quality of services they provide as well as 'commission'. The NHS Commissioning Board will need to ensure that GP commissioners are held to account for the collective performance of practices, but the Board should not stipulate the terms by which GP commissioners hold their constituent practices to account. It is not clear how the primary medical services contract, if held by the Board, can be used by consortia to manage performance of member practices.

7. What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?

In order to ensure transparency and fairness, all procurement decisions undertaken by GP consortia must be open to public scrutiny. There must be in place a rules-based process for GP consortia to follow to ensure that their procurement decisions follow 'due process'. However, for many GPs, an important motivation for being involved in commissioning is the opportunity it creates to 'make' as well as 'buy' services for the benefit of patients. Rules on procurement and opening up the market to any willing provider should not create obstacles to GP commissioners doing this, provided that there is transparency in decision-making.

To facilitate choice, all patients must have the opportunity to register with the practice of their choice. Where choice is restricted (for example, due to geography or monopoly of supply) then it will be particularly important for GP consortia to facilitate effective public engagement in the commissioning process.

NHS commissioning board

8. How can the NHS Commissioning Board develop effective relationships with GP consortia, so that the national framework of quality standards, model contracts, tariffs, and commissioning networks best supports local commissioning?

While the White Paper states that the primary function of the NHS Commissioning Board will be to hold GP consortia to account, it is not clear how it will do so and what the

consequences of poor performance will be. Equally, it is not clear what would happen in a case of financial failure and whether the Board will bail out or take over the failing consortia. It is essential that there is absolute clarity around such matters.

Part of the assurance framework must include financial management and solvency of consortia. This may also require the Board to have powers to request information about third parties to whom the consortia have outsourced commissioning functions, and in the case where financial risk is transferred, may extend to information about the solvency of such organisations.

As discussed in our response to the Local Democratic Legitimacy consultation, there is also a need for clarity around the role of local authorities and the duties for partnership that will be placed on GP consortia. These arrangements will have implications for the relationships that develop between consortia and the Board.

While there is a clear need for national frameworks, model contracts, tariffs and networks, there is also a need for local flexibility in their use and implementation. The model contracts and currencies in future should not be organisational. Contracts should be based on service lines, clinical pathways and currencies that encourage care to be delivered in the most appropriate setting. The NHS Commissioning Board can then support GP consortia to adapt national frameworks for their own local needs.

9. Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?

GP consortia are likely to require a great deal of support and development, particularly in the early years. While much of this support will be provided by PCTs, there will also be a role for the Board. One area in particular where the Board might provide support and guidance is around using external support effectively. The Board could, for example, continue some of the functions currently performed by the regional Commercial Support Units.

B. Establishing GP Commissioning Consortia

Governance

10. What features should be considered essential for the governance of GP consortia?

In addition to requirements around financial governance, it will be essential that consortia include an individual with responsibility for clinical governance and patient safety. This relates primarily to consortia's responsibility for managing performance in primary care. There will need to be a system for learning from adverse incidents in primary care and putting improvement methods in place in response to them. Responsibility for clinical governance in secondary care will remain with provider trusts, but in their role as commissioners of secondary care, consortia will also need to be able to understand these governance processes and to hold providers to account for upholding them.

Organisation

11. How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?

There are strong arguments for consortia retaining a geographical focus.

- Retaining a geographical focus could help in the process of building partnerships between consortia and local authorities or other locally based organisations and mitigate some of the effects of the loss of co-terminousity between PCTs and local authorities.
- Data flows are currently organised on a geographical basis, and moving away from this would make it considerably more difficult to disaggregate public health and performance data down to the consortia level. Without this data consortia would struggle to function as effective commissioners.
- A geographical focus could better support forms of engagement and involvement from patients and the public that live in local communities.
- It may simplify the issue of who commissions services for patients not registered with any GP practice.
- It could also better enable GP commissioners to target and manage those individuals in a community who are at risk of an unscheduled hospital admission.

However, despite the challenges associated with losing a geographical focus, it is important to recognise that GPs in consortia will need to work together closely, taking collective financial risk, and in this context trust between colleagues and a shared understanding of priorities may be at least as important as shared geography. Getting the right balance between geography and affinity will be critical. This will vary according to local characteristics, particularly population density. Adhering rigidly to geographical boundaries may be less important in urban areas with a highly mobile population.

If consortia are given freedom to include some practices that are not part of a geographically discrete area, there will need to be a process for dealing with the 'cherry-picking' which could potentially occur, whereby consortia pick practices with the least complex patient populations. The use of a person-based resource allocation formula would be essential to ensure that appropriate risk adjustment could prevent this leading to inequitable allocation of funding.

Building strong relationships with local authorities will be all the more important if some consortia are established on non-geographical lines. Consortia may want to consider using a lead commissioner arrangement in which one local authority commissions health and well-being services for the population on their behalf, rather than attempting to build relationships with multiple authorities.

12. Should there be a minimum and/or maximum population size for GP consortia?

There is no 'one size fits all' solution to commissioning and the evidence suggests commissioning needs to be 'multi-tiered'. The optimal size of a GP consortium needs to take account of a range of trade-offs including: the ability to take on and manage financial risk; the ability to secure effective and professional management support with restricted funding; the need to ensure the right level of engagement from multi-speciality professionals and agencies depending on the nature of the service to be commissioned; and the need to ensure support and 'buy-in' to commissioning from local GP practices.

While many GP practices might wish to operate in small-scale consortia, the evidence suggests there are several risks associated with small consortia size:

- vulnerability to random fluctuation in patient costs (insurance risk) –this caused severe financial difficulties for several risk-bearing physician groups in the USA, including some highly competent groups
- less negotiating power with providers and leverage over the quality of services
- a greater number of (smaller) commissioners makes it difficult for providers to maintain good relationships with each, and means more time is required to come to collective decisions between consortia where that is required
- loss of economies of scale in managerial and other costs
- limited access to capital to fund innovation
- harder to perform accurate risk adjustment for smaller populations - leading to an increased risk of inequitable resource allocation.

The experience of the 303 primary care trusts before they were merged into 152 in 2006 was that having a larger number of smaller commissioning organisations made it difficult for each PCT to build up the necessary skills base to be effective commissioners. There were also major difficulties in establishing relationships with local authorities, as the areas covered by PCTs were not co-terminous with local authority boundaries (see question 19).

However, there are also disadvantages of large size:

- historically, larger groups find it harder to bring about change - there is a risk of becoming cumbersome and bureaucratic
- it is harder to create sufficiently strong incentives for each constituent practice to change their decisions/practices – vulnerability to 'free loaders'
- the larger the group, the less 'local' they will be and the greater the risk that they will feel more remote from their populations
- large groups of doctors may lack coherence, and patient satisfaction may be lower compared to smaller groups.

In summary, there are merits and risks with both small and large groups. Smaller groups are better able to make changes happen across a narrow scope of services, while larger groups are better placed to take on financial risk for a broader range of services but are less well placed to introduce change quickly (Ham 2010).

There is no definitive data on the optimum size for consortia, but there is some evidence to suggest that consortia serving a population of less than 100,000 should not take on a global budget for all services as the insurance risk would be too great and would lead to an unacceptably high bankruptcy rate (Smith 1999; Smith and Thorlby, 2010). However, some evidence suggests that smaller groupings, perhaps down to 25,000, are possible if consortia take on the risk for commissioning only a limited range of services and if over- and under-spending can be carried over from one year to the next (Ham 2010).

The overarching lesson of this evidence is that the most effective system for GP commissioning would be to allow GPs to form consortia of a variety of sizes, but then to adjust the scope of the budgets held accordingly. However, if the government adopts the system outlined in the White Paper, in which all consortia would be expected to take on responsibility for commissioning a comprehensive range of services, GPs should be discouraged from forming consortia covering a population of less than 100,000. Despite the option for smaller consortia to enter into lead or pooled commissioning activities with others in order to manage risk, the management and transaction costs involved in so doing would be restrictive.

In order not to lose the advantages of small-scale consortia under this system, we suggest that the statutory GP consortia, each serving a population of more than 100,000, should be able to devolve certain responsibilities to smaller local groupings made up from their constituent practices.

It should be noted that even consortia covering a population of 100,000 or more will not be big enough to bring about large-scale service reconfiguration, eg, changing the way in which stroke or cancer services are provided. At present, PCTs commission these services collaboratively, for example, using lead commissioner arrangements. Consortia will need to aggregate and work together at a number of levels in order to perform these roles (see question 3). There is a serious question about where the responsibility for local system leadership and strategic change (eg, hospital reconfiguration) will reside in the absence of PCTs and SHAs.

C. Freedoms, Controls and Accountability

Freedoms

13. How can GP consortia best be supported in developing their own capacity and capability in commissioning?

World class commissioning has gone some way towards articulating what skills are required for commissioning. They range from very specific, technical skills (eg, data analysis and interpretation) to more generic leadership skills (eg, influencing, negotiation and relationship management). Highly specialist skills are also needed in areas such as accountancy and contract management. Consortia will need to develop an understanding of what is required and will need to be clear about what capabilities they want to develop internally, and what they will buy in. As a minimum, consortia will need to develop strong leadership skills internally, so that they can have an effective dialogue with colleagues in primary and secondary care about quality and productivity, and so that they are able to influence secondary care clinicians who are not directly accountable to them. Other, more technical skills may be either developed internally or purchased from external providers.

A survey of practice-based commissioners suggested that there is currently a significant skills gap among GPs; 80 per cent felt they lacked some or all the necessary skills to be an effective commissioner (Wood and Curry 2009). There is a real risk that the same will be true of GP commissioning, perhaps more so as the responsibilities of GPs under the new proposals will be even greater.

To address this skills gap, consortia will be able to buy in developmental support from a range of organisations. This will require them to possess sufficient prior understanding of what commissioning is and what support they will need to become competent commissioners. Without this understanding there is a danger of external support being used ineffectively (see question 14). Supporting the development of this minimum skill- set will be a key role for PCTs and local authorities over the transition period. Consortia should work closely with existing commissioners to develop a sufficient level of understanding to allow them to then engage the services of external organisations if desired. This will include working with PCTs, local authorities and also the various commissioning support services established within the NHS, including data warehouses, business support units and commissioning support agencies such as those which already operate across London and Birmingham.

There is a danger that the cap on management costs may become a major barrier, making it difficult for GPs to either buy in or build the skills they need. This cap should remain under review and be adjusted or removed if it becomes clear that it is preventing consortia from becoming effective organisations.

It will be important that any outsourcing of commissioning responsibilities to other organisations (be they NHS or independent sector) supports rather than undermines the development of the core leadership skills and 'commissioning literacy' that need to be built within consortia.

14. What support will GP consortia need to access and evaluate external providers of commissioning support?

External support can help improve commissioning processes, but using it effectively is not a simple task. Research published by The King's Fund suggested that the least competent commissioners can also be less effective in using external support (Naylor and Goodwin 2010). In order to work effectively with external providers, GP consortia will need assistance in the following areas.

- **Clarifying their developmental needs**. Consortia will need to develop a clear vision of what high-quality commissioning would look like, and where their own

capabilities are relative to this vision. Our research suggests this is what the world class commissioning programme did for PCTs. It may not be necessary to replicate the world class commissioning assurance framework for GP commissioning, but it will be important that the WCC 'vision', encapsulated in the competency framework, is translated to the new environment.

- **Procurement processes** for buying in external support. PCTs have often struggled to use the range of procurement vehicles that exist for external support effectively. A new procurement framework aimed at GP consortia may be needed. It may also be helpful to put in place a quality assurance system for firms providing external support, to help GPs to choose between the options available.
- Guidance and support around **relationship-building** with providers of external support. The quality of working relationships between internal and external teams can be a make-or-break factor in the success of external support.

Managing financial risk

15. Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?

The criteria for risk management are broadly right but the detail needs to be established. Clarity is needed over how financial failure will be handled and what happens to consortia that have failed.

Experience from the USA shows that budget-holding introduces significant financial risks. Vulnerability to random fluctuations in patient costs (insurance risk) caused severe financial difficulties for several risk-bearing physician groups, including some highly competent groups. Forthcoming work by the Nuffield Trust indicates that in the absence of risk-sharing arrangements, one-third of practices in the UK could be predicted over- or under-spend on their commissioning budget by 10 per cent or more, due to chance alone. Detailed empirical work will be needed to establish the best arrangements for risk-sharing between consortia.

Careful thought needs to be given to what stop-loss or reinsurance arrangements need to be put in place to ensure the solvency of consortia and what assurances are needed that they will be in a position to meet their liabilities in relation to the registered population. Where third parties take on these responsibilities on behalf of consortia (eg, for low-volume services or services such as learning difficulties or mental health) the Board will need to be clear how it will assure itself of their solvency and the robustness of contracts held by the consortia.

If GP commissioners are going to be able to drive large-scale change, they may require similar financial flexibilities to foundation trusts, which are not required to break even annually. The reason for this is that essential investment in new innovations and alternatives to hospital care may take time to embed and may not provide savings in the short term. Alternatively, where budget savings are made, it was common under previous approaches to GP-led commissioning to see these held in risk pools rather than re-used to invest in patient care.

Any financial regime will need to balance the risks and benefits of giving GP commissioners flexibility around having to balance budgets annually. It might be advisable, therefore, that in their first few years GP consortia should be allowed to keep only a fixed percentage of gains and/or to take responsibility for only a fixed percentage of any losses. The NHS Commissioning Board could have the power to limit windfall gains or unavoidable losses for the first two or three years, or until there is general confidence in the accuracy of the resource allocation formula. This may be particularly relevant where GP consortia have to pick up on 'inherited debts' (for example, in the costs of a local PFI deal) that would not otherwise be accounted for in the allocation.

The balance of personal versus collective risk also needs clarification. As statutory bodies, consortia will carry collective risk but will not necessarily carry personal risk. How this impacts on financial incentives needs clarification.

Financial risk management will be a key skill that GPs will need to develop. During the transition period, appropriate skills must be transferred from PCTs where possible. On an ongoing basis, consortia will need to be supported by the NHS Commissioning Board to manage their budgets effectively.

Finally, there needs to be a clear failure regime, through which practices or groups that do not commission effectively are required to scale down their commissioning activities, retaining responsibility for a narrower range of services and carrying less financial risk.

Transparency and fairness in investment decisions

16. What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

It will be essential that GP consortia demonstrate transparency and fairness in the investment decisions they make. All procurement decisions need to be open to public scrutiny and there needs to be a process in place to ensure that all procurement rules are adhered to. The economic regulator and the NHS Commissioning Board will need to develop and maintain a framework that ensures transparency, fairness and patient choice (see our response on Regulating health care providers).

In particular, there will need to be robust arrangements for identifying and governing conflicts of interest, for example, those that may occur when a GP consortium commissions services from practices within the consortium, or from a GP provider federation with a membership that overlaps with that of the consortium. These arrangements would have to provide reassurance that any clinical referral decisions were not compromised by financial concerns.

Accountability to patients and the public

17. What are the key elements that you would expect to see reflected in a commissioning outcomes framework?

We would urge the government to consider having the NHS Commissioning Board assess the performance of commissioners more broadly than in terms of outcomes alone. As argued in our response to the *Transparency and Outcomes* consultation, outcomes measures used on their own do not give an adequate measure of quality, as they can be insensitive to difference, slow to detect change, and are influenced by multiple external factors beyond the control of the organisation being assessed.

In particular, there will need to be some assessment of the quality of commissioning processes. While we would not advocate the creation of an assessment framework as burdensome as world class commissioning (WCC) for GP consortia, the WCC competency framework provides an invaluable description of the essential features of high-quality commissioning, and this should not be lost. As consortia build their commissioning capabilities, the measurement of a small number of essential competencies would be a helpful means of monitoring and guiding the development of consortia over time. These could include, for example, patient engagement in commissioning, partnership-working with local authorities, or the use of predictive modelling tools to better understand population health needs.

In summary, the NHS Commissioning Board should assess consortia in terms of the following dimensions:

- clinical outcomes of care, including patient-reported outcome measures (PROMs)
- population health outcomes, including health inequalities
- access to care, including equity of access
- financial control and value for money
- patient experience

- core commissioning competencies.

18. Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?

The incentives used to engage GPs in commissioning activities under PBC have proved to be weak. Linking practice income to commissioning outcomes (and processes) may be the most effective way to secure wide engagement. Evidence from the USA suggests that where a team is responsible for the clinical and financial outcomes of their enrolled patients, resource use is lower and outcomes can be better because there is an incentive to provide preventive care (Ham 2010). Such gains are usually felt over a relatively long period of time and so any reward scheme would need to consider carefully the fact that the impact of an intervention this year might not be felt for a number of years. Careful risk adjustment would need to be employed to ensure that any rewards reflected the complexity of the population.

While financial incentives may play a role, reward for good performance does not need to be limited to these. There is also scope to reward higher performing consortia by granting more powers and autonomy, or providing professional development opportunities. Indeed, the use of non-financial incentives may pose less of a risk of undermining public trust in professionals. There is some danger, for example, that people will question whether GPs' referral and prescribing decisions remain in patients' best interest if GPs are financially remunerated for controlling costs in these areas.

The best approach may be to allow GP consortia to agree with their constituent practices and staff what performance incentives are provided. Some may choose financial incentives whereas others may focus on non-financial rewards. The reward schedule would also need to be flexible enough to allow it to be reviewed and updated over time, so that the right behaviours are being encouraged at each point (Smith and Thorlby 2010).

19. What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

Public health departments in PCTs have built up a detailed understanding of the needs of local communities. PCTs will need to support GPs to understand those needs and to help them to start thinking systematically about the health of the population as well as the needs of individual patients.

Consortia will need to build close relationships with local authorities and the new Public Health Service in order to work collaboratively on tackling health inequalities. Critical to this will be the new health and well-being boards to be established in local authorities, and the ability of directors of public health to establish effective relationships with consortia.

There is a danger that replacing PCTs with GP consortia will create barriers to joined-up working, as the largely co-terminous geographical boundaries that currently exist between PCTs and local authorities will be lost. Particular attention should be given to how social care commissioners and providers can develop arrangements with GP consortia for shared or delegated commissioning (eg, of learning disability services). Before the merger of PCTs in 2006, the lack of alignment between PCT and local authority boundaries was identified as a serious structural limitation to effective joint working on health inequalities (National Audit Office 2010). Much progress has been made in recent years around the integration of health and social care, and care must be taken not to undermine these existing achievements. There is also a question over whether the new health and well-being boards will have sufficient power over GP commissioners (see The King's Fund's response to the consultation paper on Local Democratic Legitimacy in Health).

It is important that the commissioning outcomes framework includes requirements for GP consortia on health improvement and the reduction of health inequalities. So far the impact of the QOF on public health and health inequalities has been limited, and GPs perceive their

role in this area to be limited (Dixon *et al* 2010). A cultural change will be required in order for consortia to be active in tackling health inequalities, and the commissioning outcomes framework will need to put strong incentives in place. Consortia will need to be held to account and rewarded for delivering on a high-level set of outcomes for the health of the population, in order to shift the focus to improving outcomes for their wider population.

There is some danger that the ringfencing of public health funding will support the view that public health is not the core business of general practice or the NHS more widely. We believe that this would be regrettable if it means that NHS professionals fail to capitalise on the many opportunities they have to play a role in health improvement and the reduction of health inequalities.

D. Partnership

Patients and the public

20. How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?

Effective public and patient involvement (PPI) will need to become embedded within GP consortia decision-making. PCTs performed relatively well on the PPI sub-competency in world class commissioning. This suggests that some PCTs will be well placed to advise GP consortia on involving patients in commissioning decisions, although the extent to which patient groups have been able to influence the scope, quality and direction of local services to date is unclear. GP consortia will need to capitalise on the progress that PCTs have made.

There is also a general need to make the commissioning function more 'visible'. To date, public awareness regarding commissioning has been low, compromising the degree of support commissioners can expect for their decisions (Smith J *et al* 2010).

21. How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?

GP consortia can ensure that commissioning decisions are equitable and reflect the public voice and local priorities by building relationships with local voluntary sector organisations and involving them in the commissioning process. These relationships are currently often brokered by the PCT, and so PCTs will need to help transfer these links during the transition period.

22. How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patient Participation Groups?

[No response]

23. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?

There needs to be close joint working across health, local authorities and wider welfare providers at a local level to ensure equity of access to health and social services and to work towards equity of health outcomes across all population sub-groups. It is not clear from the White Paper that there will be a requirement for GP consortia to address inequalities in health and care and there is a risk that, unless commissioning consortia have a duty to reduce inequalities in health care and outcomes, gaps may widen. We hope that the government will use the forthcoming public health White Paper to set out its plans for reducing inequalities in health, including creating duties beyond the legal minimum requirements to ensure that reducing inequalities in health care and outcomes is a priority for local organisations.

Under previous forms of GP budget-holding (GP fundholding and Total Purchasing Pilots), the outcomes achieved by different groups was variable. The same is likely to be true of GP consortia, and there is a strong case for national benchmarking and performance monitoring to ensure local populations are not disadvantaged by this.

It is essential that the new arrangements are seen as a multi-disciplinary approach to delivering health services and that, as such, staff from a range of professions are engaged in decision-making and needs analysis. Local organisations should all be working to common goals and priorities. By engaging with colleagues in social services, community services, housing, education and the voluntary sector, GPs will be better able to serve the most complex needs of their patients and to facilitate equal access and to provide them with truly joined-up, integrated, services.

Where consortia straddle two or more local authorities we have concerns that responsibility for services for some population groups that currently benefit from PCT/local authority joint commissioning might fall between commissioning bodies (particularly services for the most vulnerable, eg, people with mental health issues). It is essential that thorough needs assessment processes are undertaken at consortia level, using high-quality data and robust risk stratification tools and that consortia are held accountable for how effectively they are working with local partners to meet the needs identified in the Joint Strategic Needs Assessment.

Local government and public health

24. How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?

It will be critical for GPs to build on the relationships that PCTs have forged with local authorities and for PCTs to support GPs in this during the transition period. There are some examples of areas where these links have become very strong (see next answer). GPs need to start thinking and operating on a more strategic, population, level. While consortia are unlikely to be co-terminous with local authority boundaries, there might be some value in consortia joining together and developing a lead commissioner arrangement in which one consortium develops relationships with one local authority on behalf of others. In this way, a consortium will be able to concentrate on their links with one local authority rather than having to develop relationships with multiple authorities (see also Q11). Where a GP consortium straddles more than one local authority, conflicts might arise in relation to the public health objectives/priorities that GPs are expected to work towards and clarity will be needed at a local level as to how these conflicts are managed. The nature of the relationship between GP consortia and local authorities will very much depend on the powers granted to local authorities.

One potential complexity of the loss of co-terminousity of health commissioning and local authority boundaries is the misalignment of financial flows. While GPs will be allocated funding on a capitation basis, funding allocated to local authorities will still be based on a set geographical population. It is possible that the populations of GP consortia might straddle two or more local authorities, limiting the potential for pooled budgets and adding to the complexities around needs assessment, service provision and financial management.

25. Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to care trusts, children's trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to the new arrangements?

There is learning available from localities that have successfully brought health and social care together. Torbay is one example where the creation of a care trust has been successful. Ashton, Leigh and Wigan is an example of a PCT that has established a single commissioning agency in partnership with the local council. The future of care trusts as an organisational vehicle is unclear, as those who are performing PCT functions in their local area will be affected by the proposals. During transition to the new structures, there may need to be interim arrangements to protect existing agreements about pooled budgets so that important jointly funded services are not destabilised. It will be critical that, as the changes take place, strong local partnerships are protected and built upon.

As set out in our response to the democratic legitimacy consultation response, certain factors will facilitate partnership working.

- **Strong local leadership**: efforts to co-ordinate and integrate services are best led locally to ensure they are appropriate to local contexts and build on existing relationships (Ham 2009). Investment in leadership development will need to be continued throughout the reforms.
- **Regulation should support rather than inhibit integration**: the common framework for regulation of both health and social care already established by the Care Quality Commission is an important foundation. However, the current system of

regulation focuses on individual organisations and might need to shift towards a regime that focuses on care systems and pathways in order to link performance assessment more closely with patients' experiences of care (Ham and Smith 2010). Consideration also needs to be given to how to mitigate the negative consequences of a more robust competition regime for inter-organisational relationships at a local level. Policy frameworks need to support collaboration as well as competition between providers (Ham and Smith 2010). One approach might be for the NHS Commissioning Board to hold commissioners to account for outcomes associated with integrated care, eg, through developing quality indicators focused on care transitions, and for partnership working. Such a framework should ensure consistency of care quality while allowing local organisations flexibility over particular structures and functions.

- **Shared information systems**: some localities have invested heavily in improved IT systems that enable the sharing of key information between providers. This needs to be encouraged and developed, and consistent use of unique identifiers across all services (particularly social care) would enable existing data sets to be linked up.
- **Aligned funding for health and social care**: it will be important for health and social care budgets to be brought closer together. We welcome the government's proposals to work with LGA to explore the potential of place-based budgets, as experience suggests that place-based approaches to funding public services can produce more cost-efficient services. It may be necessary to review the existing powers in section 75 of the Health Act so that councils and GP consortia can legally share resources and plan together - this may need to be addressed in the government's response to the Law Commission's review of adult social care law next year.

Although there is learning to be carried forward, it should also be recognised that, so far, policy initiatives have failed to produce consistently joined-up services except in a small number of places and less than 5 per cent of total NHS and social care spend is subject to joint agreements. Therefore, we would urge the government to have local integration as a central feature of the new approach.

This autumn, The King's Fund is hosting a series of seminars to examine how to speed up progress in bringing health and social care services closer together. A policy discussion paper setting out recommendations will be published later in the year and made available to the Department of Health.

Other health and care professionals

26. How can multi-professional involvement in commissioning most effectively be promoted and sustained?

While the onus will be on GPs to lead the new commissioning arrangements, if they are to be successful, it will be essential that there is real engagement from nurses, pharmacists, allied health professionals, specialists and social care professionals. If such multi-disciplinary working is not developed, there is a danger that new arrangements will exacerbate historic divides between professions and sectors. Such a multi-disciplinary approach has the potential to provide better co-ordinated and tailored care for individuals, particularly the elderly and those with complex long-term conditions. There are some examples of effective multi-disciplinary teamworking across the country (eg, virtual wards in Croydon and diabetes network in Cambridgeshire), and learning from these successes needs to be harnessed.

Leadership skills among GPs will be essential in bringing about successful collaborative working. Organisations in the USA that are held up as high performers invest heavily in clinical leadership (eg, Mayo Clinic). Such skills should not be underestimated and it is important that appropriate training is available to GPs.

It will be particularly important to involve specialists in commissioning, for several reasons:

- without a strong role for specialists, GP budget-holding could become another factor that drives a wedge between primary and secondary care (Smith and Thorlby 2010)

- GPs will not always have the specialist knowledge needed to commission services to meet the needs of their patients and to challenge hospital coding unless they work with other professionals
- if consortia contain only GPs, they will be bearing large financial risks for aspects of performance that are not wholly within their control

Learning from the United States suggests that risk should be matched to the types of providers in the risk-bearing organisation (ie, the consortia). Groups that do not include specialists or any hospital representative should be cautious about bearing large amounts of risk for the costs of specialist/hospital services. For true multi-disciplinary commissioning to be successful, specialists will need to share in the risks and rewards of commissioning. Such risk-sharing would reduce the incentive for increasing activity and consultant-to-consultant referral, which became an issue under PBC. This may require renegotiating the consultants' contract to enable them to become part of commissioning groups.

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