

# The White Paper and GP Commissioning Consortia

***LMC Information Bulletin***  
**No. 1**



# LMC Information Bulletin No. 1: The White Paper and GP Consortia

*This is the first of what we anticipate will be a series of information bulletins offering up to date and readable summaries of changes flowing from the government's White Paper and what they will mean for GPs.*

## **Equity and Excellence: A Summary of Main Proposals**

The government published its NHS White Paper - [Equity and Excellence: Liberating the NHS](#) on 12 July 2010. The key highlights of the document are:

- The government will devolve power and responsibility for commissioning services to GPs and practice teams working in consortia.
- Every GP will be a member of a 'shadow' consortium by 2011/12.
- Consortia will start taking on duties from 2012/13 and full financial responsibility from April 2013.
- Management allowances will be available to help fund commissioning.
- An independent and accountable NHS commissioning board will allocate and account for NHS resources.
- NHS commissioning board will calculate practice-level budgets and allocate these directly to consortia and will hold practices to account.
- GP consortia will include an accountable officer.
- Each consortium will hold its constituent practices to account.
- GP consortia will agree local priorities each year, taking account of the NHS Outcomes Framework.
- GPs will need to engage patients and the public in the commissioning process.
- Over time the DoH will seek to establish a single GP contract and funding model.
- PCTs and SHAs will be phased out.
- Patients will be able to choose which GP practice they register with regardless of where they live.
- The current performance regime will be replaced with separate frameworks for public health and social care.
- A new NHS Outcomes Framework will provide the direction for the NHS.
- The government will incentivise ways of improving access to primary care in disadvantaged areas.
- The public health function will be transferred to local authorities
- A new patient representative structure will be established (called Health Watch) supported by local authorities.

## **Filling in the gaps: continuing consultation**

Following the publication of the White Paper, the government released a series of documents which were subject to a consultation from 22 July until 11 October 2010:

- **Transparency in outcomes: a framework for the NHS:** The White Paper sets out how the Secretary of State for Health will hold the NHS Commissioning Board to account for delivering better health outcomes through a national NHS Outcomes Framework. This consultation was about how the NHS Outcomes Framework should be developed.
- **Increasing democratic legitimacy in health:** This consultation builds on the proposals in the White Paper to increase local democratic legitimacy in health. This will be achieved through local authorities: being given a stronger role in supporting patient choice and ensuring effective local voice; taking on local public health improvement functions, and promoting more effective NHS, social care and public health commissioning arrangements.
- **Liberating the NHS: commissioning for patients:** The White Paper sets out proposals for putting local consortia of GP practices in charge of commissioning services to best meet the needs of local people, supported by an independent NHS Commissioning Board. This consultation was about how these proposals should be implemented.
- **Liberating the NHS: regulating healthcare providers:** This document is part of a public consultation on implementation of proposals in the White Paper and supporting papers. It further outlines proposals on foundation trusts and the establishment of Monitor as an independent economic regulator for health and adult social care. The document sought views on specific consultation questions.

In addition, the **Report of the arm's length bodies review**, which followed the publication of the White Paper, sets out the proposals for arm's length bodies (ALBs) in the health and social care sector. These proposals form part of the cross-Government strategy to increase accountability and transparency, and to reduce the number and cost of quangos.

The consultation period has now closed but the documents are still available to view on the LMC's website: [www.nottinghamshirelmc.co.uk](http://www.nottinghamshirelmc.co.uk). The health secretary has said 'concrete' details of the duties and resources available to consortia would be published before Christmas 2010.

The government has now launched a further two public consultations linked to the White Paper:

- **Liberating the NHS: greater choice and control:** This consultation explains the proposals in more details and seeks the views on proposals for offering more choice for patients and service users, how shared decision making can become the norm, and how it can happen (information, 'any willing provider' and other tools and making safe and sustainable choices)
- **An Information Revolution:** These proposals are part of the Government's agenda to create a revolution for patients - "putting patients first" - giving people more information and control and greater choice about their care. The information revolution is about transforming the way information is accessed, collected, analysed and used so that people are at the heart of health and adult social care services.

These consultations close on 14 January 2011. Once all the consultations on the White Paper have been completed then the government may amend their draft bill (i.e. the White Paper) then introduce the new bill to the House of Commons.

## **The legislative timetable: From a Bill to an Act of Parliament**

*First reading* is the first stage of a Bill's passage through the House of Commons - usually a formality, it takes place without debate. First reading of a Bill can take place at any time in a parliamentary session. The short title of the Bill is read out and is followed by an order for the Bill to be printed. The Bill is published as a House of Commons paper for the first time.

*Second reading* is the first opportunity for MPs to debate the main principles of the Bill. It usually takes place no sooner than two weekends after first reading. The Government minister, spokesperson or MP responsible for the Bill opens the second reading debate. The official Opposition spokesperson responds with their views on the Bill. The debate continues with other Opposition parties and backbench MPs giving their opinions. At the end of the debate, the Commons decides whether the Bill should be given its second reading by voting, meaning it can proceed to the next stage. It is possible for a Bill to have a second reading with no debate - as long as MPs agree to its progress. Once second reading is complete the Bill proceeds to committee stage - where each clause (part) and any amendments (proposals for change) to the Bill may be debated.

*Committee stage* is where detailed examination of the Bill takes place. It usually starts within a couple of weeks of a Bill's second reading, although this is not guaranteed. Government Bills are usually formally timetabled after they have received a second reading.

*Report stage* gives MPs an opportunity, on the floor of the House, to consider further amendments (proposals for change) to a Bill which has been examined in committee. There is no set time period between the end of committee stage and the start of the report stage.

*Third reading* is the final chance for the Commons to debate the contents of a Bill. It usually takes place immediately after report stage as the next item of business on the same day. If the Bill started in the Commons it then goes to the House of Lords for its first reading.

The *House of Lords* will then go through the same process. When a Bill has passed through third reading in both Houses it is returned to the first House (where it started) for the second House's amendments (proposals for change) to be considered. Both Houses must agree on the exact wording of the Bill. When a Bill has completed all its parliamentary stages in both Houses, it must have *Royal Assent* before it can become an Act of Parliament (law). Royal Assent is the Monarch's agreement to make the Bill into an Act and is a formality.

## **What do the changes mean for GPs and practices?**

Every GP practice in England will have to be a member of a commissioning consortium by 2011/12. **This is not optional.** These consortia will shadow PCTs until they are formally established in 2012/13 but if PCTs disband earlier than expected some consortia may become operational sooner. However until new legislation has been passed by Parliament and regulations have been published following negotiation with the GPC, there will be no legal change in statutory function or responsibility.

*So how will these consortiums be formed?*

It is unlikely that the Department of Health will provide specific guidance on the formation of consortia, or interim shadow consortia. Consortia will be able to decide locally how they are formed, but the GPC

has advised that this process is flexible, to account for the interim nature of the shadow consortia and the lack of information regarding their responsibilities.

The leaders of these consortia must have good leadership skills with well-developed commissioning capabilities and be competent managers who genuinely understand the needs of local patients and also have the respect of, and a mandate from, the consortium members.

However before a consortium can agree a mandate for its leaders, it will be necessary to determine the extent of the consortium so that all practices within its boundaries have an opportunity to express their preferences. To achieve this objective, the BMA suggests practices within an agreed consortium area could elect a 'board of appointment'. The board, which some prefer to call a 'transitional' board, would need to have a definite mandate from all the GPs within the consortium and would be empowered to recruit and appoint the key executive positions within the consortium (such as the accountable officer and chief financial officer, etc.) by assessing the abilities of potential candidates against required competencies.

This process would avoid the difficulty of having popular elected leaders who were not sufficiently competent, or appointed leaders with no mandate from the practices within the consortium. Whilst recruiting, the board of appointment should consider whether they would want to see the consortium leaders retain their practical experience of general practice, and thus offer positions that allowed the post-holders to continue to work in their practice for a session or two each week. Where all consortia are in agreement, it may be possible for a chief financial officer to perform the same role for a number of consortia.

*Is there an ideal size for a GP consortium?*

The Department of Health will not be prescriptive about the size of consortia. However, getting the size of the commissioning population right will be essential for effective commissioning. It is likely that an individual community-facing consortium would serve a population in the range of 100,000 to 750,000 people, which reflects the size of most large cities in England.

All consortia should consider the benefits of working in partnership with their neighbouring groups, but where practices choose to form a consortium that is at the lower end of the suggested population range, they should consider joining with other consortia and either appoint a lead consortium for their federation, or develop a shared service agency that works on behalf of all members of the federation.

There is a concern that consortia with populations of less than 500,000 may not find it easy to manage financial risk, and they may not have sufficient management resources to function effectively nor take advantage of the economies of scale necessary to ensure that commissioning is efficient. Some argue that larger consortia (or a lead consortium) will find it easier to engage in credible interaction with acute care trusts and local authorities and to attract high calibre medical and managerial leaders. There are various ways by which these problems can be overcome. The important thing at this stage is to ensure the consortium can assure its practice members of how it proposes to overcome these concerns.

*Which services will consortia be responsible for commissioning?*

Consortia will be able to decide whether they commission a service themselves by employing existing

NHS managers, by engaging support from an external organisation or by making arrangements for a neighbouring consortium or lead consortium to do it. Subject to the consultation process, consortia will be responsible for commissioning all services except primary medical care services, other family health services, national and regional specialised services, maternity services and health services for those in custody.

The role of consortia is also likely to involve the determining of local health care needs and what services are required to meet those needs, the entering into and management of contracts with providers and the monitoring and improvement of the care provided under those contracts.

To do this, a consortium will require a governance structure that makes decisions in line with its responsibilities, aims and objectives, and on the basis of clear evidence and advice; that implements the decisions that are made; where the decision-making process is transparent; and that has internal controls to direct and account for the use of resources in implementing these decisions. Consortia will also need to consider the implications of managing their own staff. Beyond these local governance mechanisms, the new National Commissioning Board will hold all consortia to final account.

It is quite likely that some consortia, particularly smaller groups, will not wish (or not have the capability) to carry out all of these functions themselves. Instead, they may choose to subcontract some of the specific tasks such as strategic planning, contracting, HR, etc., to a lead consortium, or shared agency working on behalf of a federation of consortia. Nonetheless, where this is done, the responsibility for these functions, where they are tied to the responsibility to commission services for their registered list of patients, will ultimately fall to the original consortium.

#### *How will consortia be funded?*

Commissioning consortia will receive the full budget for all of the health care services which they are to commission. It is also likely that consortia will receive a management allowance that will be capped in reference to the size of the consortium. This will fund the actual process of commissioning: redesigning and procuring services, as well as key roles such as the accountable officer and chief financial officer.

The actual management budget allocated to consortia will be much less than that currently given to PCTs (perhaps only a third) and this will reflect the understanding that consortia are to have fewer responsibilities than PCTs, as well as the coalition government's desire to reduce health care bureaucracy.

Consortia should be aware that while it is expected that they will shadow PCTs until 2012/13, it is not clear whether they will be given a management allowance during this period. Until the transition arrangements between consortia and PCTs have been determined, consortia should avoid making plans for the management of the consortium which they are unable to fund.

Consortia will have the freedom to decide how their management allowance is spent, and may choose to employ experienced NHS managers rather than buy in external commissioning support.

#### *What about budget setting for consortia?*

Developing a commissioning budget that realistically reflects the existing and likely health needs of a local population and enables consortia to commission all of their patients' care will be very difficult. Any

budget formula must be highly sensitive, or else consortia could be held responsible for overspends which have more to do with an inadequate budget than ineffective commissioning.

Accurate commissioning budgets will also require accurate and timely data and analysis: information on expenditure, referrals, prescribing and clinical performance across secondary and community care. Commissioning groups will only be able to commission effectively when the relevant information is to hand. It is therefore likely that practices will be expected to provide detailed activity data to assist with this process.

Further to the commissioning budget allocation, there should be a risk pooling and insurance mechanism to ensure the stability and viability of these budgets against planned and unplanned debt. For example, unexpected major incidents may consume considerable healthcare resources and set a well-planned commissioning framework into financial turmoil.

Whatever accounting period is eventually agreed, practices should be aware that the White Paper states that the Department of Health will not 'bail out' those consortia that fall into significant deficit.

#### *What about working with colleagues in secondary care?*

Commissioning must be founded on the principle of meaningful collaboration between primary and secondary care clinicians. The relationship between these groups has long been considered an obstacle to commissioning in the past. It is important that these commissioning proposals seek to remove the barriers between primary care and secondary care in the NHS (however much this goes against the competitive instincts of foundation trusts).

Clinicians from both sectors are expected to work together to develop and commission integrated care services that provide the best services for patients. To achieve this, it is likely that secondary care clinicians will need to work closely with commissioning consortia and consortia must seek to build these relationships from an early stage. This applies equally to public health clinicians and social care workers.

Individual consortia should consider how best to achieve collaboration. It may be appropriate to co-opt secondary care clinicians onto specific subgroups of the consortium when exploring service redesign. However it is achieved, consortia should have in place a collaborative framework to promote multi-professional involvement in commissioning.

#### *How can we maintain patient confidence?*

Patients will need reassurance that when in the consulting room, GPs remain their independent advocate and organise their care with appropriate regard to the conditions with which each patient presents. There must be no conflict with the role of GPs as commissioners making clinical decisions with regard to the local health economy. In particular, GPs should not personally profit from any surplus in a commissioning budget – this must be reinvested in patient services. It is also important that patients do not perceive that their GP or practice has any vested financial motive for making rationing decisions.

Practices may feel it is appropriate to engage with their Patient Participation Group, where these exist, to ensure that practices are aware of patient views, and that patients have confidence in their GPs. Consortia may wish to consider holding open commissioning meetings so that patients and members of

the public can observe the work of the consortium, with perhaps a facility for patients to submit their views on the commissioning process.

Another key aspect of the changes involves giving patients more information and choice. To achieve this, a new body, *HealthWatch England*, will be set up to compile data on performance. HealthWatch England would be an independent, national body with the power to monitor the NHS and to refer patients' concerns to a wide range of authorities.

Overall, its role would be to promote the interests of all NHS patients by:

- Being a voice for patients on all NHS issues
- Investigating and reporting on the effective delivery of NHS services
- Providing a mechanism through which informed public opinion influences the regulation of healthcare

However there will also be a local HealthWatch. This organisation will retain LINKs' existing responsibilities to promote patient and public involvement, and to seek views on services which can be fed back into local commissioning, they will have continued rights to enter and view provider services and continue to be able to comment on changes to local services.

The White Paper proposes giving Local HealthWatch additional functions and funding for:

- providing complaints advocacy services and for supporting individuals to exercise choice, in particular, they will support people who lack the means or capacity to make choices
- local HealthWatch will be able to report concerns about the quality of local health and social care services to HealthWatch England independently of their host authority, to inform the need for potential regulatory action

Local authorities will have a vital role in commissioning HealthWatch arrangements. They will continue to fund Local HealthWatch and contract for their services. They will have an important responsibility, set out in statute, for discharging these duties and holding Local HealthWatch to account for delivering services that are effective and value for money. In the event of under-performance, they will intervene and, if necessary and when in the best interests of the local population, will be able to retender the contract. Local authorities will ensure that the focus of Local HealthWatch activities is representative of the local community and they will also assume responsibility for NHS complaints advocacy.

*Will there be a new GP Contract to reflect these changes?*

A new (uniform) GP contract is set to be introduced in 2012 following negotiation with the BMA and the profession. However it is highly unlikely that consortia will commission GP or other contractor profession core contracts. They will be held by NHS Commissioning Board. Essential services and QOF will be determined nationally but all enhanced services are likely to fall within the ambit of local commissioning and QOF will be more focused on outcomes (with help from NICE) and provide incentives for continuous improvements in quality of care.

Commissioning budgets will be separate from GP income but GPs will have a duty to ensure expenditure does not exceed allocated resources. Subject to discussion with BMA and the profession, a proportion of

GPs' income will be linked to their consortium's achievements in commissioning and use of resources. This is likely to be a discrete part of future QOF payments so will not involve 'new money'.

#### *What about performance management?*

According to the White Paper, consortia should play a key role in working with practices to drive up quality and improve utilisation of resources. The commissioning Board can "ask the consortia to carry out on its behalf some work involved in managing primary care medical contracts...promoting quality...benchmarking practice performance...ensuring clinical governance requirements are met and...challenging any behaviours that are inappropriate both for good clinical care and for efficient use of resources" (Commissioning for patients , 3.20)

LMCs are anxious to find out what this means in practice as it could impact significantly on our relationship with consortia.

#### *What will be the role of the LMC in the 'New Order'?*

In previous reorganisations involving GPs the LMC organised elections; advised on structures/governance; offered to mediate in disputes (we can do this again).

In previous reorganisations we were clear that we did not get involved in commissioning as our job was to represent GPs as providers (and we didn't have the resources). Now the distinction between commissioning responsibility and GPs' contracts and remuneration has been blurred and GPs need all the help they can get, we cannot expect to remain aloof. It will be for GPs to decide how much of the potential assistance we can offer they wish to take up.

Possible new functions:

- Manage elections of new GP leaders?
- Facilitate debate and source legal advice on structures?
- Help vetting of prospective commissioning support?
- Coordinate pan-consortia and Notts wide commissioning and interface with NHCT, Health & Wellbeing Boards etc?
- Coordinate commissioning intelligence and tie in with national bodies?
- Offer conflict resolution (while still supporting individuals who fall foul of performance regime)?

The LMC could also provide a range of complimentary services:

- Sourcing legal, HR, banking and accountancy services
- Managing (under the direction of the new GP education board) the education and training needs of GPs and their staff
- Managing (through expanded Comms team) the communications needs of the consortia and profession, i.e. interface with media, public, MPs etc.

#### **Conclusion**

The GPC has said that LMCs should ensure that all GPs are fully engaged in and consulted about the establishment of commissioning consortia. We are sending you this bulletin to ensure you know what is expected of you and what to expect by way of consultation by PCTs and local colleagues leading this debate. We would be grateful to receive your comments and questions and in particular your thoughts on the role of the LMC might play in helping you manage the challenges of the next 18 months.