"GP-led commissioning will only succeed if the new consortia learn the lessons of NHS Cumbria..."

PRACTICE MAKES PERFECT

Paul Corrigan

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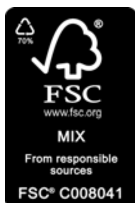

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Paul Corrigan
September 2010

Introduction

This pamphlet is based around a single case study. It argues that creating general practitioners (GP) commissioning consortia will only take place if time and effort are given to the development of GPs as leaders and members of these consortia. If this policy is simply seen as a change in organisational structure, it cannot be put into effect. The case study of Cumbria is described in some detail as the experience of the GPs in developing GP commissioning consortia there is very pertinent to the coalition government's proposals.

Chapter 1 covers the wider historical and organisational factors that led up to GP commissioning within the National Health Service (NHS). This draws on an understanding of health and social policy in the UK since the Second World War. Chapter 2 describes how GP commissioning consortia developed in Cumbria, and demonstrates that professionals need to be given time and leadership if they are to take on a very new activity. Chapter 3 considers questions that those implementing the coalition government's policy of GP commissioning need to answer if they are to succeed.

The government proposals for GP-led commissioning consortia will make substantial changes to the NHS. For this to happen new organisations will be created that will spend hundreds of millions of pounds each year. The key area of concern is to show how a group of GPs can create a set of organisations that take on the power to commission NHS care when they have no experience of carrying out that leadership task.

Background

NHS Cumbria, the local PCT, and GPs in Cumbria have created new organisations that are already commissioning care for NHS

patients. From April 2011 they will play an even bigger role in commissioning their NHS patients' care. In July 2010 the government white paper *Equity and Excellence: Liberating the NHS*[1] argued that GP-led commissioning should be developed throughout the English NHS, so a description of the experience of GPs who have taken over commissioning services from the PCT in Cumbria is of particular interest and importance for many in the NHS.

The white paper states, 'The Government will devolve power and responsibility for commissioning services to health care professionals closest to patients: GPs and their practice teams.'[2] For most GPs this is a completely new responsibility and they recognise that they will need new organisational forms to carry it out. This pamphlet describes how and why many GPs in Cumbria became persuaded that this was an important new task they should take on and how they created new and bigger organisations to enable them to do so.

The 25,000 GPs in England have always jealously guarded their ability to run their own organisations and to practise primary care medicine inside small practices that they run themselves. For 60 years they have been allowed to practise as a part of the NHS in small businesses, which they run themselves or they work with another single GP in what are referred to as 'single handers' or 'double handers'. Their organisational and professional autonomy has always been very important to them. Compared with NHS hospitals these are very small organisations, which could not possibly be the basic structure that commissioned or bought NHS health care from hospitals.

Yet some GPs want to add to their ability to develop health care for their patients by being responsible for commissioning all the health care for them. They can only really do this effectively if they are a part of a much wider organisation. This tension for GPs between enjoying running their own small business as provider of GP services yet wanting to be more powerful organisations, which can buy all the health care for their patients, drives the story of how GP commissioning consortia in Cumbria has developed. That same tension will drive the development of GP commissioning across England, if such a development is to occur at all.

Some GPs will be prepared to trade a loss of some autonomy for the ability to have a greater impact on patient care. They recognise that if they are to have a bigger impact on the development of patient care they need to be organised in bigger organisations than they are at the moment, and there will be a complex trade off between a potential loss of autonomy and a potential increase in effectiveness.

NHS health policy has traditionally been written about from the perspective of politics or policy ideas, and as GPs have until now been working as small businesses, a description of the way that they develop their organisations would normally be covered by writers interested in small business development. Thus in outlining new forms of GP-led commissioning consortia, this pamphlet brings together strands of thinking that have historically been kept separate.

Four topics covered by this pamphlet

There are four strands of thinking in this pamphlet. The first covers the separation that currently exists between those parts of the NHS that buy (commission) health care for patients and those that make decisions about medical referral; these functions can only be combined by GPs. In most consultations that a patient has with their GPs the GP recommends that some form of NHS resource should be spent on the patient's health care. The GP might:

- recommend a drug for the patient, which will lead to NHS money being spent on drugs.
- recommend that the patient needs to attend a clinic in the local health centre, which will again involve spending NHS resources.
- refer a patient to their local hospital to see a consultant who may go on to recommend that the patient needs an operation or further activity, again involving spending NHS resources.

The argument in favour of GPs being more involved in the real commissioning of NHS care is based on the assumption that as they make the medical decisions about patient care they are in

the best position also to make the financial decisions about NHS spending.

Second, this pamphlet explores what organisations GPs need to develop to become commissioners. This may appear arcane and unimportant, but it has proved to be very important in the experience of Cumbrian GPs.

The third strand of this pamphlet deals with a rather different debate about the politics of how public services are organised. The NHS is a publicly funded organisation, so the public expects it to be accountable for the money that is taken from them in taxation. Changes in the way in which the NHS is organised thus have political as well as business implications, especially when there is anxiety about moving from public to private organisation provision.

There is a range of small and large public, state and private organisations within the NHS. In recent years in general practice there has been an argument against creating larger organisations because they are seen as a new form of privatisation. This is an odd argument because most GPs already work within private sector organisations as small businesses. The innovations being discussed in this pamphlet, relating to the coalition government's proposals, all argue for a larger organisation – whether single, networked, public or private.

The fourth strand of thinking in this pamphlet concerns the relationship between primary and secondary care within the NHS. For many decades the NHS has had a policy of moving more secondary activity into the primary sector. This policy intention has not worked, and there have been many cases where activities that could have been developed in primary care have been carried out in hospitals. The current policy is even more ambitious. If the NHS cannot succeed in moving millions of care episodes outside hospitals, it will not be able to meet the increasing demands for health services within its budget.

If GPs are in charge of buying the health care for their patients then it is likely that one of the benefits of GP-led commissioning will be that some of the health care currently being provided by the hospital sector will be undertaken within GP surgeries.

The aim of this pamphlet is to blend these four strands of thinking into a single history about the development of new, larger public and private organisations to deliver GP-led commissioning in the NHS in England.

1 The policy context of the NHS and its reform programme

Why GPs are so important in the NHS

Doctors called general practitioners (GPs) were the very first part of the NHS to be created in 1948, and people were encouraged to choose their GP. Over the last 60 years nearly every patient who uses the NHS does so initially through their GP, which is why GPs are referred to as the 'gatekeepers of the NHS'. They are the entry point for all NHS services, with the exception of the Accident and Emergency Department of hospitals.

Gatekeepers for all services are very important – and how any service organises its gatekeeper function matters enormously to those that want to access the service. Within the health services in England it is possible for a small group of people to gain access to health care outside the state system. Those with either private health insurance or sufficient disposable income to buy their way into health care do not need to go through a GP to access secondary care.

Most of the population use the NHS, and GPs provide the main point of access to that health service. GPs are highly qualified professionals, not administrators, and their role as gatekeepers to the NHS is crucial. (It is true that to get to the GP patients need to get past the receptionist, who is the gatekeeper to the gatekeeper, and GPs are increasingly aware of the importance of this post.) This point is important because it is precisely the fact that GPs are highly qualified and actually making the decision that a patient should have access to the NHS that is the basis for the policy direction outlined in this pamphlet.

It is being proposed that the medical decision to give a patient a prescription or to refer them on to a clinic or hospital should be combined with the financial decision to buy those resources that are required for the patient's care, so the responsibility lies with the same individuals and organisations.

It may appear odd ever to have separated the medical and the financial roles of providing health care, but there were good social and health policy reasons for doing this in the past. One of the core reasons is the way that GPs are employed and organised. As mentioned in the introduction, for various historic reasons, when the NHS was created hospital doctors were employed under contract by NHS hospitals as staff and GPs were self-employed as small businesses. Therefore the small private business organisation that has been at the heart of the GP sector within the NHS has not been seen to have the size or public accountability to carry financial responsibility for the NHS. Different categories of medical staff work in very different organisations. Running a small business is a very different activity from working for a large organisation such as a hospital trust. Doctors running small businesses are responsible for the organisation, including its budget. Doctors in large organisations traditionally feel less responsibility for the budget; there are financial managers who deal with it.

In the next part of this pamphlet we will consider why the small business form of organisation matters, and crucially what its advantages and disadvantages are for the process of commissioning.

GP practices are small businesses

Small businesses can achieve a lot, but on their own they cannot achieve everything that larger organisations are capable of. Why therefore is most primary care in this country still provided by small businesses called general practices?

For a variety of reasons, many of them correct for the Britain of 1948, the NHS outsourced most of its primary care from its inception. GPs were not salaried employees in a nationalised primary care service. Across most of the country this model has been maintained for the 60 years of the NHS with GP surgeries continuing to be run as small businesses, with the state paying for the patients who are registered with the GP. A GP works for a partnership as a salaried doctor and hopes for

and may well attain a junior partnership in the practice after time. Partners run and own the GP practice.

In locations that have maintained a traditional community – for example much of Cumbria – the combination of being a professional and running your own business gives one high status locally. Thus GPs have an important position in these communities, especially when they live locally.

In some areas of the country this model has provided the population with much of the quality primary care that they have needed, creating and developing a close relationship of trust between a high status local professional and the people they serve. People feel safe with their GP and trust their ability not only to provide health services themselves but also to act as a gatekeeper when they need referral to secondary hospital care. Locality and smallness have been, and continue to be, important parts of building a beneficial relationship between patient and doctor.

Small businesses provide GPs with the opportunity to work directly for themselves. The incentives for working in a small business include having a role in the way in which you work and run the business. GPs manage it directly and are autonomous, which is one of the hallmarks of professional people. Patients benefit from dealing with a single professional in a small organisation who directly manages their health care.

The small business model that GPs work in has great strengths, and has facilitated strong loyalty to the profession among many patients, but there are real problems with the small business model for the rest of the NHS. The NHS now comprises many large organisations to cater for all the services that patients need. GPs, working in small organisations, need to have good relations with and understanding of some of the largest organisations in the country. The small business model is useful, but GPs operating within small businesses can provide only a fraction of the necessary health care.

Why a reformed NHS has stressed the importance of commissioning

Although every health service depends on its staff to be successful, and despite their very considerable vocations, money that pays for health care is the most important resource for health systems in developed countries. In the last few years all reforms in health systems in developed countries have involved improvements to the way that money flows around the system.

Between 1997 and 2010 in England the government has considerably increased the amount of money it spends on the NHS, at the same time as the financial arrangements within the NHS have been restructured.

The NHS is a unusual in being a health service paid for out of central taxation, providing equal access for all at the point of need.

This arrangement is strongly supported by 85 per cent of people in the country (and by a higher proportion of those who work in the NHS). One of the reasons for the reform of the architecture of the NHS that has taken place since the 1990s is to make the way in which the resources are spent on health care more transparent.

The primacy of money at the heart of modern health services may explain why the language we will use in this pamphlet to describe the new architecture of the NHS is one usually seen in economic textbooks.

A key concept of economic relationships is demand. How are goods or services demanded? How are variations in demand dealt with? Patients within the NHS do not directly buy the health care they need, as the basic principle of the NHS is that health care is provided free at the point of need. However, most people pay indirectly for the treatment they receive (as it is funded through taxation) and those managing state funded systems of health care need to ensure that the public who pay for the system have some say over the way it is spent.

At present geographically based commissioning bodies called primary care trusts (PCTs) manage demand for health care and ensure that the money spent on the NHS is used effectively.

The Cumbria PCT called NHS Cumbria covers the whole county and is responsible for commissioning health care for everyone in the county – nearly 500,000 people.

Commissioning is the method of organising demand in the NHS. The definition of commissioning for NHS Cumbria describes the activity that is at the core of these changes:

What Commissioning Means

While there are many definitions of commissioning, for the purpose of NHS Cumbria it is taken to mean the system by which the very best of health care and health improvement can be procured within available resources for the people of Cumbria. Commissioning is an iterative cycle of activity and includes:

- *Assessment of population needs and trends*
- *Assessment of government targets and guidance*
- *Agreeing priorities for health and health care*
- *Resource allocation to localities*
- *The development of models of care*
- *The development of service specifications including quality and quantity outcomes*
- *The placing of service contracts with providers*
- *Performance management of contracts*
- *Engaging with external partners, patients and the public and obtaining feedback*
- *Reviewing priorities, models and health gain*
- *Re-engineering models of care*
- *Continual reassessment*

The commissioning framework is designed to ensure that all members of the population are able to access services on an equitable basis including citizens who are hard to reach. In addition the framework will ensure action in accordance with the Sex Discrimination Act 1975, the Disability Discrimination Act 1995 and 2005 and the Race Relations Act 1976 (as amended 2000).[3]

Another concept of economic relationships is supply. How are the goods or services that are demanded supplied to meet that demand? What sort of organisation or set of organisations

meets it? How is the market for providers developed and how is that market managed? Usually there are competing organisations trying to meet any particular demand. Recent governments tried to develop a market in health care services and the present coalition government has outlined its plans to speed up this process, but there is a long way to go before there will be such a market.

When supply meets demand there is usually a transaction between the people demanding a service and those supplying it. This third concept of economic relationships concentrates on what form that transaction takes. In most cases it involves money and in many cases there is a price – an amount of money involved. Prices have been developed for some aspects of health care; for example, most aspects of hospital services now have tariffs (prices) that are set by government as the form of transaction for those services. The coalition government wants many more of the health care transactions in the NHS to be developed through specific prices.

Finally, the national framework within which demand meets supply is important – national taxation.[4] A major part of the reforms proposed by the coalition government is that a stronger national framework should be developed for the NHS.

Improving value for money in the NHS

In the past the way in which the money moved round the NHS was opaque. Some was given out locally through health boards and some was given out nationally through the Department of Health (DoH), not in return for a specific amount of health care that the organisation produced but as grants to keep organisations going. This is an inefficient way of running a large organisation: if a hospital ran out of money in February then they were usually given some more to see them through the year. This system did not encourage organisations to keep within their budgets and it was never really clear what the health board or the DoH were buying with this money from NHS providers.

It is true that there was product. Health care was delivered. Ambulances turned up, and people were made better, but it was

not clear what the relationship between the product and the money was. Before the last Labour government came to power in 1997 the demand by patients who required hospital care was not equal to the supply of care provided by hospitals, so there were very long waiting lists. For example the demand for a hospital operation could lead to a year-long wait until there was a supply of that service. The money provided in the NHS did not seem to incentivise health organisations to improve the patients' access to care.

The situation now is different. The Treasury disburses the money collected in taxation to the Department of Health, which passes it on to PCTs and they use the money to obtain health care through their strategic commissioning of health and health care for their population. The commissioners buy the health care for the local population, and the process of commissioning is the subject of this pamphlet.

The money given to PCTs is formally agreed by Parliament and worked out on a weighted capitation formula, which provides for every person living within the boundary of the PCT allocated every year. That sum is varied by means of complex calculations that take into account various aspects of the population, such as their level of deprivation and propensity to illness. Generally this means that those localities with more older and poorer people get more money per head of the population to commission health care than those with populations that are younger and better off. These sorts of formulae have been used in education and local government for years and every year there is serious contention about what goes into it. Change the formulae a little bit and a PCT can get less or more than before.

The health and health care of everyone who lives within the geographical boundary of the PCT is the responsibility of PCTs. If someone moves into Cumbria, NHS Cumbria is responsible for their health and health care. If they move across the border into North Lancashire, Cumbria loses that responsibility and the PCT in North Lancashire takes it on. We are used to this method of organising public services through local government, and the development of PCTs around geographies follows this historic model for other services.

How good the PCT is at strategic commissioning is a matter of great importance. In 2008/9 the DoH started to carry out an annual assurance programme, which looked at how well each PCT was carrying out its commissioning responsibilities against a set of competencies, criteria around their governance and outcome. In February 2009 every PCT was given an overall score on how well they had done. The median score was between weak and adequate and there was clearly some way to go. The assessment carried out again in 2010 found that PCTs had improved considerably. In local government this system of external assessment followed by internal improvement has led to systemic improvement in most local authorities. The expectation is that year on year the natural distribution of PCTs' skills and competencies will improve.

One of the main activities assessed is each PCT's commissioning strategy plan. This three- to five-year strategic plan outlines the way in which the PCT will improve the health and health care of its local population. There is a legal requirement that every PCT should carry out a joint strategic needs assessment (JSNA) with its local authority to identify the needs of the population. This demonstrates how the local authority and PCT jointly understand what the health and health care of needs of their local population are and how they are going to work together to improve the services they provide.

This understanding is only a basis for action. The commissioning of health and health care for the local population should be described in the strategic plan, which should also explain the financial activity of the PCT, and show clearly how commissioning is linked to these needs. The best strategic plans demonstrate this clear link. Others provide a good analysis of what local people need to improve their health and health care but then fail adequately to show how health care is commissioned and to describe changes made since the last plan. Too many PCTs see their main role as passing the money that they get from the DoH on to the local NHS hospital rather than changing the way in which health and health care is provided for their local people. The world class commissioning assurance mechanism has helped many PCTs to move to a much more

proactive use of commissioning and has begun to change the way in which health care is delivered.

The NHS has clear principles governing how it wants PCTs to commission health care, one of which is equality. This is why the formulae used to distribute money to PCTs are calculated in such a way as to provide more resources to poor areas than to wealthy ones, and each PCT has to carry out a local analysis to ensure that it is improving equality of access and outcomes.

Although commissioning is carried out by PCTs, and PCTs receive the money from the DoH, it is GPs who actually spend this money by referring patients to have treatment. As outlined above, clinical tests, prescription drugs, visits to see specialists in hospitals and stays in hospital for an operation or other reason all have a financial cost for the NHS.

There are 1 million consultations every 36 hours in the NHS. The crux of the argument for GP-led commissioning is that since they spend the money in any case through their referrals it makes sense for them to bring their financial responsibility in line with their medical responsibility. Health care systems are in peril if there is no link between the understanding of medical staff of the medical decisions that they make: and the financial outcomes of those decisions. That is why the creation of clinically-led commissioning is important to the sustainability of the NHS.

If GPs as gatekeepers of the system do not understand the financial implications of the medical decisions they make, they may bankrupt any system.

The proposal to develop GP commissioning consortia in England is intended to improve the relationship between the medical process of referral and the financial process of spending the money. There is a 20-year history of attempting to involve GPs in the commissioning of health care. In the 1990s under a previous Conservative government GP fundholding allowed GPs to have a budget of real money that would buy inpatient, outpatient and community health care for patients. Some pilots went further and allowed GPs to hold the budget for a wider range of services.

Those GPs who took part in fundholding were able to improve some aspects of services and were incentivised by holding the budgets to make savings through more efficient prescribing. They also developed some alternatives to hospital care. The political problem, which has a significant impact on the proposed system of GP-led commissioning consortia, is that only a minority of commissioning was carried out through fundholding.

Most GPs were not fundholders and therefore a two tier system emerged over which patients and the public had no real control. The services of patients of GPs who were fundholders were better organised than those of patients of GPs who were not fundholders. Given the importance of the principle of equality of access for the NHS, this disparity was a very big problem and explained the Labour government's commitment to abolish fundholding in 1997.

The Conservatives have learnt from this and in 2010 are committed to introducing GP-led commissioning consortia across the country at roughly the same time. Although this will be a very difficult task, they see it as preferable to being charged with building inequality into a system by only partial implementation.

Since 2005 commissioning has been developed by PCTs and GPs who have been organised into practice-based commissioning (PBC) consortia. These consortia are groups of practices that hold 'indicative' budgets for some services delegated from the PCT. However, most GPs involved have not felt that PBC consortia have sufficient power or control to make transformations in the health service. There are various explanations for this. Probably the most important is that however indicative budgets are, unless they are real incentives to carry out the hard work of commissioning different value for money services then the incentives do not work well.

One of the big problems for this halfway house is that PCTs still considered the money to be 'theirs'. After all they were legally responsible for its disbursement and felt that they should not let it be spent elsewhere. As a consequence GPs sometimes worked hard at constructing a business case for commissioning a

new service, but it would take the PCT far too long to decide whether to implement it, or they would decide not to do so. Sometimes there was a real transfer of power among GPs through PBC, but because there was no transfer of real money this happened rarely.

The coalition government in 2010 developed a much fuller and more powerful policy proposal: they want GPs to have complete charge of the commissioning process in a set of consortia. Then money will be given straight to GPs, who will commission health care.

Interestingly, the work in Cumbria predates this new government policy. As we shall see in chapter 2, in Cumbria the PCT and GPs decided in 2009 that they wanted to give GP commissioners the real budget for commissioning ('hard budgets'). The PCT fully agrees with the devolution of real commissioning budgets to consortia of local GPs, so as long as they act within the current law they can devolve power and budgets to these consortia.

However, it is far from straightforward to implement this policy. Although it may make sense for GPs to run the commissioning budgets for the NHS they have no experience of running such a large budget and it may be that few have any wish to do so. No GPs have been given any training in the management of large budgets. No GP comes into medicine in order to learn how to buy better health care. They train as GPs because they want to provide health care not to buy health care from providers.

This leads to a very important clash of motivations, which is one of the biggest problems for the development of commissioning. If GPs are going to be given most of the money in the NHS to buy health care, and their main interest in health care is providing health care, they may consider commissioning from themselves. They might do this not because they are corrupt, but because they are essentially interested in providing better health care, and they could see commissioning as another vehicle for providing the resources to ensure they can develop better provision.

So many GPs feel – with justice – that the best health care they can offer is that provided in their own practices. This could

lead to patients having no choice about where they have diagnostic tests carried out because their GP would decide to provide them in their local practice.

In nearly every case the decisions to provide patients with health care within their own practice will have been taken in the best medical interest of the patient, but the system must be transparent to ensure patient confidence.

It is essential that public funds are distributed in a transparent manner, otherwise the system could be corrupted, and without a transparent tender process there would be no competition for services, which is why an independent panel on competition and co-operation has been set up. This has the power to make judgements on anti-competitive behaviour which could be to the detriment of the patient. A patient or a competitor could decide to take a case of a GP commissioning services from themselves to the panel, which would be responsible for ensuring that there was at least the possibility of competition for the patient. If a GP is using the public's commissioning budget to buy services from themselves and not going out to compete for these services then there should be a good medical reason for this.

The importance of patient choice

One of the main ways of ensuring there is competitive transparency in the system is by developing clear choices for the public about who delivers their health care to them and where it is delivered. Many commentators believe that patient choice is new to the NHS, only introduced by the New Labour government, but in fact the first experience that the British public had of the NHS when it was created in 1948 was the leaflet inviting people to choose their doctor, and the public still have the fundamental right to choose their GP, the gatekeeper to the rest of the system.

To this basic right have now been added others, which the NHS constitution recognises. Patients can now choose their GP, which hospital to go to and when they want procedures carried out. Obviously it is important to make those choices on the basis

of good information, which is why one of the most important aspects of the proposed reforms is that GPs should give patients up-to-date information about doctors and hospitals to enable them to make proper choices.

The coalition government is putting very great weight on the development of a much better information base for patients, with the hope that highly informed patients will drive change in the system as they select GPs. Better informed patients will work with better GP commissioners to ensure that better health care becomes the norm. The theory is that if patients and GPs are put in charge they will drive out bad practice through their medical decisions and their choices.

Conclusion

To understand how GP commissioning is going to be brought into the NHS one needs to understand not just the complexity of NHS policy, but also the way in which large or small businesses have developed. We need to appreciate how GPs have successfully developed their work as a part of the small business sector and fully appreciate how hard it is going to be to move to become part of a much larger organisation that commissions health care. They will gain influence within the NHS but lose some autonomy.

2 Developing GP commissioning in Cumbria

Cumbria has many differences from other counties. There are less than 500,000 people in the county, so it has one of the largest populations of the larger local authorities and PCTs in England. But it is a large county of 2,500 square miles and an average of 73 people per square mile. Compared with most places in England this is a very sparse population. However, some towns in Cumbria – the city of Carlisle and the working-class ship building town of Barrow – have a very dense population indeed, and there is considerable inequality within the county.

As in any PCT, the health care needs of the population vary considerably and public services require careful planning and delivery. Cumbria PCT was formed on 1 October 2006, when the three PCTs that served north Cumbria joined with the Cumbria part of Morecambe Bay PCT to form what is geographically the biggest PCT in the north west. In August 2008 the PCT changed its operating title to NHS Cumbria, though its full legal title remains Cumbria Teaching PCT. NHS Cumbria is the channel for NHS funding into Cumbria and it has the responsibility to improve the health of the population.

NHS Cumbria has a leadership role in developing approaches to health and health care in the NHS and across public services by

- assessing the health of people in Cumbria and working with partners such as Cumbria County Council to develop strategies and plans to improve health and wellbeing
- steering the NHS work of family health services, including GP practices, dentists, pharmacists and opticians in Cumbria
- commissioning health services from a range of providers, particularly North Cumbria University Hospitals NHS Trust,

university hospitals of Morecambe Bay NHS Trust, Cumbria Partnership NHS Foundation Trust and North West Ambulance Service NHS Trust

- directly providing services such as health visiting, district nursing and occupational therapy; NHS Cumbria has a population of just under half a million, which is ageing faster than the national average

Size really matters

Most administrative boundaries mean that organisations within them are at the same time too big for some things and too small for others. The size of the population is very important to whoever is commissioning and providing health care for a population.

GP practices have historically been small organisations, which have built very close personal relationships with their patients and for many these relationships are an important part of their experience of the NHS. So being small has been very good, but because they are such small organisations GP practices have not been able to take on and develop a number of services that would fit much more securely in primary care than in secondary care. To develop a blood testing or a glucose testing service you need to have a sufficiently large population to make it economically worthwhile. That is why so many diagnostic tests have been carried out in large organisations such as hospitals.

The coalition government's proposals will require GP practices still to work as very small organisations, but be part of a much bigger network to carry out an activity like commissioning.

If an organisation is to assess and plan for the health and health care needs of a small population, there are difficulties that come from the nature of some health risks. It may at first sight appear to be a good idea if the commissioning organisation in a county like Cumbria is based on natural-sized organisations such as villages. Then those who are planning health care can get to know the individuals and their families and ensure that their health care needs are individually met. Such attention to

individual detail appears to be useful, but in order to meet many health care needs in an economically viable way it is necessary to plan and commission care for large numbers.

In a village the number of babies born every year may be very small indeed so it is not feasible to plan and commission effective maternity services for such small numbers. The same would be true for the serious diseases such as coronary heart disease and cancer. Each of those with diseases has some straightforward and some specialist needs. A GP in a small community may not need to commission cancer surgery more than once every ten years, and over that decade the nature of surgery for health care will have changed dramatically.

This is not just a matter of the numbers needed to assess or plan for but also a matter of risk. Health care risks of different individuals have different costs. Expenditure on health care by the provider will increase significantly if people with complex long term conditions or paediatric health care needs move into a village.

Health care commissioners and insurers need to cover large numbers of people to pool that risk. In the NHS, the risk assessment for the population is based on it being a *national* health service. Over time and over millions of people the risks even out. The NHS is one of the biggest risk pooling organisations in the world and its success depends on the size of that pool.

But although commissioning health care is much more cost effective when risks are pooled, it is also important that there is some understanding of the needs of local people. One of the problems for the NHS is that it can feel impersonal, so an increasing understanding of locality really matters. In England PCTs were initially based on small localities but later became amalgamated into larger organisations to provide a higher level of skills and pool risks.

NHS Cumbria was created by bringing two and a half PCTs together. This makes it the right size to assess large scale health needs and commission secondary care from hospitals, but too big to understand the variety of different local communities.

There are two administrative structures that provide local government services in Cumbria – the county council and the

(six) district councils. These are the three key questions to be considered by those organising GP commissioning there:

- What needs to be done at a Cumbria-wide level and how do the six localities relate to the Cumbria-wide organisation?
- What needs to be done at a local level six times?
- How do the localities relate to the size of GP practices where the real GP work is done?

Why localities in Cumbria were developed around GPs

The PCT was formed in 2006 and at first had very poor relationships with GPs. They felt that the PCT was uninterested in primary care.

PCTs commission health care from a number of sources. In Cumbria around 45 per cent of the expenditure in 2006 was on buying health care from the three NHS trusts in the region, most significantly from the hospital trusts of North Cumbria and Morecambe Bay. The GPs felt that the PCT was primarily concentrating on its relationship with these organisations and giving less money and thought to providing local care in the community.

The main argument behind putting GPs in charge of commissioning is that they do in fact spend the resources of the NHS through the medical decisions that they take every day on behalf of their patients. The relationship between GPs and PCTs was distant and mistrustful in Cumbria in 2006, so the relationship between the GPs who spend the resource through their referrals and the managers in the PCT who were in charge of that resource was distant. This made it difficult for the PCT managers to control the resource.

The outcome of this lack of control by the PCT was that it was not able to manage its budget. By April 2007 the cumulative deficit for the PCT from its first year as a Cumbria-wide organisation and its previous years as separate organisations was £36.7 million. This is about 3–4 per cent of the budget.

There are a number of ways of dealing with a deficit of this size. The new chief executive of the PCT, Sue Page, recognised

that the deficit was caused by the broken relationship between the PCT and the local GPs rather than being an accountancy problem, and from the beginning of her tenure started to change this relationship. Although the strength of the GP leadership in Cumbria has enabled GP commissioning consortia to be developed successfully, it has done so alongside the PCT rather than in conflict with it as a result of the leadership of Sue Page.

Materially Sue Page recognised that if GPs were not more involved in the way in which decisions were made about the commissioning of NHS services in Cumbria then resources would continue not to be well spent. She therefore spent much of the first two years at the PCT working with GPs in their localities. The GPs worked within the six localities that made up the six districts of Cumbria County and over this period Sue Page put in place within the PCT locality teams to cover the six areas led by a GP. Although they were developed to face outward into the six very different communities they served, they were also encouraged to work in line with a countywide framework of standards and protocols, in order to ensure that quality and safety standards continued to be met. This framework was developed by clinically led 'care stream boards' covering five areas:

- emergency care
- scheduled or planned care
- long-term conditions
- children and families
- mental health

Alongside the development of these six localities the PCT and its GPs developed an overall strategic approach called Care Closer to Home to develop health and health care around individuals and their communities. This strategy placed local primary care at the core of the NHS relationship with local people. The medical idea behind the strategy is that much more effective and active primary care will stop people having to go into hospital, and it is not new to the NHS. Indeed in January 2006 an entire white paper was based on the idea of developing care closer to home.

Although the idea of moving care closer to home has been a national policy for some time, the NHS in Cumbria was searching for an organisational mechanism to make what has only been an aspiration actually happen, and between 2007 and 2009 the PCT built up the six localities as a key mechanism for implementing Care Closer to Home. These localities looked at the local provision of primary care – in particular the community hospitals – and organized all of the medical assets into a system that would keep people out of hospital. GPs worked with clinically-led care stream boards to ensure that as many as possible patient pathways could be developed outside the hospital sector.

During this period the GPs' learned to manage provision in the six localities more collectively. They no longer provided only the limited amount of medical care, which they could carry out within their practices, and referred many patients on to the hospital. As groups of GPs localities were large enough to develop their own referral pathways and recognised that they could only keep people out of hospital collectively rather than as individuals.

In June 2009 the GPs met the leaders of the PCT to discuss what the next step could be in developing mutual relationships. At that time the money for the commissioning care was still owned completely by the PCT. Provided the PCT agreed with what the GPs were doing they would agree to finance that care; the GPs were simply providing care that the PCT bought. The money stayed with the PCT. The GPs were still not in a position to commission the care that they thought was best for their patients independently. Those at the meeting decided that the logical next step would be to provide the six GP localities directly with real money in a real organisation in order formally and legally to commission the health care that they thought best for their patients.

The following principles were agreed. It was vital:

- to develop GP leaders
- that the GP leaders spend time and effort getting a mandate from some local GPs
- that the organisations learn to work together as well as separately

- that the new organisations (GP consortia) develop some trust in the old organisation – the PCT
- that not all the organisations have to be the same

Implications of the meeting in June 2009

1. *The GPs who were leading the six localities had begun to develop the capacity to lead their colleagues in their localities. In June 2009 GPs in the locality organisations did not commission care, but were thinking through some new forms of provision and the use of community hospitals in their localities. Some of them were also involved in much tighter management of the prescribing budget. Historically across England only a very few GPs have provided this sort of leadership because to do so involves leading GPs taking on the task of performance managing their colleagues. It is important when developing GP commissioning consortia that leading GPs recognise that they will be responsible for performance management otherwise very little will change. At the end of 2009 one of the GP leads summed this up in a letter to GPs in the locality:*

I started my role as GP commissioning lead three years ago and it took me a while to understand what my function is... I think it is to maximise health spend. This encompasses everything to do with getting best care for our patients, value for money, improved morale amongst staff etc. 'Closer To Home' embraces much of this as does 'World Class commissioning' (words to describe a way of ensuring quality services) – there is nothing clever in these and I am sure they cover everything you would want for yourself, your patients, friends and family.

This paragraph expresses three important things about GP leadership:

- *It takes some time to find out what it is.*
- *If it is to be effective, leadership has to cover some very big issues that affect every patient.*

- *It may be a very big thing but it is also an everyday matter – 'there is nothing clever in it'.*

2 *By summer 2009 sufficient GPs in these localities had given sufficient authority to each of these leaders for them to be able to move on to the next step. This is vital. As a result of the way in which GPs in England have organised their work in small businesses they do not easily recognise the right of others to lead them. The whole point of GP-led commissioning is to have GPs leading GPs, but it is important not to underestimate how hard that leadership relationship is to develop. Each of the leaders has to explore the different motivations of their colleagues and find ways of encouraging more GP involvement. One of the GP leaders puts this simply: they want 'to have real influence on decisions', which was not possible through their own organisations. By June 2009 sufficient GPs in Cumbria had given sufficient credibility to the GP leaders over enough issues for the organisations to move forward.*

3 *Although the bulk of the organisational development work had been carried out by the GP leaders in the six localities, the six leaders recognised that they needed a seventh organisation covering the whole of Cumbria that brought them together. They were beginning to appreciate that there were a number of issues that could only be dealt with once across the county. Although each GP needed some sort of relationship with the hospitals in their local area, they probably only needed to negotiate a contract with those hospitals once. Although each GP needed to be able to develop a better patient pathway for their diabetes patients, they probably only needed to develop that pathway once across the whole of Cumbria. Thus they began to confront one of the problems raised at the beginning of this section – all administrative organisations are both too big and too small. There needs to be sufficient flexibility to recognise that some things are done once across Cumbria, some things are done six times across each locality and sometimes hundreds of times within each GP practice. At the very beginning of this process it is not clear what should be carried*

out locally and what centrally, but the legitimacy of local and central organisations must be recognised.

4 *The June 2009 meeting was a joint one between PCT and GP leaders. From then on they all recognised that the only way to transfer power successfully would be by the PCT and GPs working together. This may appear very obvious but because of the very bad relationships between PCT and GPs in the past, some time and effort had to go into mending that relationship. Across England building GP commissioning consortia will be a joint enterprise between GPs who will receive power and responsibility and PCTs who will have to transfer it. As a GP manager said about the GPs in the local area, 'There was widespread ambivalence but broad support for change. There was concern that we were working for the PCT and lack of trust that this organisation would change as promised, leading to lack of sign up and active involvement among GPs.' Unless concerns are properly addressed as a major part of this process it is very difficult for GP commissioning consortia to be introduced.*

5 *If there is a nationally led policy change those in charge of the process want there to be the same size and type of organisation created everywhere. This often means that the organisational form is completely wrong for some places. In Cumbria the idea of there being six localities fits in well with the district council boundaries in the county and although the GP localities agreed to those overall boundaries, one of the localities – Allerdale – wanted to organise itself with five sub-localities. In administrative terms this is a messy outcome, but there are distinct communities within Allerdale that are much better reflected by this model. If these organisations are going to have real allegiance then it is vital that they are organised in a way that reflects real communities and not just an administrative shape.*

Following all of the developments in leadership and organisation that had taken place those at the June 2009 meeting

agreed to begin to transfer financial responsibility power for commissioning from the PCT to the localities. By this time each locality had created a stable organisation that could take responsibility for buying tens of millions of pounds of health care. It seemed logical that the next step would be to create an organisation that could take the full legal responsibility to commission NHS health care

Over the rest of 2009 the PCT and the GP leaders looked at the implications of the decision to transfer commissioning budgets and in December 2009 had another milestone meeting that agreed that the PCT and the GP leads would transfer power and money from April 2010.

There are several wider developmental issues that came out of the meeting in December 2009:

- It is vital to set a deadline where some real transfer of power and finance will take place.
- The organisations receiving that power must feel capable of managing it.
- As the law governing the NHS still recognised the PCT as the accountable and legal body for the NHS, the PCT had to be in complete agreement with these changes and to formally devolve some of its power.

Implications of the meeting in December 2009

1. *By December 2009 the GPs and the PCT leaders had been discussing transferring power and finance to GPs for some time. Across the country GPs had been offered influence on budgets for four or five years through practice-based commissioning, but, still the real transfer of legal power had not taken place. Agreeing and believing in the change to come about by April 2010 was vital. Over the recent period there had been a number of false starts of power and finance being devolved to GPs and there was considerable cynicism among the body of GPs about whether the transfer would go ahead. Everyone recognised that the goodwill among GPs would*

evaporate unless something significant happened in April 2009.

2 *The PCT in Cumbria still had the legal responsibility to provide health care in the county, so it had to check what it was and was not allowed to do. For example, it could not abolish itself. It had to exist as a formal board with an accountable officer in order to receive the resources the DH provided. All of these changes then had to be agreed by the PCT board, which had to recognise that their role was changing dramatically. Executive and non executive members of the board who had agreed to one set of duties had to recognise that they would change considerably. The new government plans to change the law to ensure that money can go straight to GP commissioning consortia, but until that time PCTs will have to agree that although the law sees them as the legal body responsible for managing the money provided by the DoH, they will legally devolve their powers and finances to the GP consortia.*

At the end of 2009 one GP locality lead wanted to demonstrate what the locality had achieved and listed the 17 changes to health care that had been created through their work. What is important about this list is the detail and scale of some of the changes. Mostly these are not changes involving millions of pounds but they are small concrete changes, which local GPs could recognise. At a national scale it will mean little to GPs to be told that they will commission £60 billion of health care, but it will mean a great deal to know that they can develop a new small part of a patient pathway in their locality, for example mental health services.

These are some of the changes that had been made:

- There had been an increase in the number of community therapies in community hospitals, enabling them to take a more complex type of patient and ensure credibility with the hospital.
- All sub-localities have a short term intervention (STINT) resource. They have been split by sub-locality to encourage staff to work as integrated services rather than as separate teams.

- All community hospitals have benefited from embracing the GP clinical leadership and medical model. Community hospitals are now enabled to manage more complex patients and reduce the average length of stay.
- GPs with special interest ophthalmology (GPSI) in one location started in August 2009 with two sessions a week, operating at 50–65 per cent of the amount that had previously been paid to the hospital, thereby providing much better value for money.
- GPSI carpal tunnel surgery at one location started in November 2009. There are fortnightly sessions costing less than 80 per cent of the acute tariff.
- GPSI dermatology operates at a much reduced tariff, again providing better value for money; it started in May 2008 and has increased capacity to a weekly session of 24 slots.
- Two ten-week pulmonary rehab classes were organised over the summer. This was the first community pulmonary rehab service available in Keswick. This teaches patients with chronic obstructive pulmonary disease mechanisms to cope with their condition, thus avoiding unnecessary emergency admissions. Further classes were scheduled for 2010.
- There was new equipment bought by the sub-locality for community equipment costing £40,209, of which £25,180 was spent on refurbishment, flooring and redecorating of community hospitals.
- Training funds for practice staff and nurses were allocated at £1 per patient for all the registered patients on the GP list size.
- Dental funding was £26,000, spent on targeting high risk vulnerable patients with mental health problems, alcoholism, drug misuse and hepatitis C.
- There was an enhanced service for sexual health based in one locality, costing £18,500.
- Local community services involving other agencies such as Fit4Life, the MS Society and Age Concern have all worked with the practice in 2009 to support patients in the community.
- Smaller projects such as case management of vulnerable adults were set up and evaluated.
- One community hospital has reduced capacity to nine beds, two of which are virtual, in line with Care Closer to Home plans.

- One locality project came to the end of its 12 month pilot (whereby the GP commissioning board commissioned an integrated rapid response service to work alongside mainstream community services). Some £160,000 of efficiency savings were identified from the project. The sub-locality was able to invest in homecare practitioners as a result of the success of the pilot. There is nothing to stop all areas achieving this sort of success.
- Challenges for the future will include further developing community skills and close links with acute clinicians to manage patients with long term conditions in the community.

This list of achievements was expressed concisely and explicitly. Anything longer, with abstract policy goals, might have been seen by GPs as bureaucratic.

From April 2010 the PCT and GPs were ready to develop further by shifting the centre of gravity of commissioning NHS health care from the PCT into localities. In order to do this a new agreement was signed between each locality and the PCT. This formally devolved key responsibilities from the corporate PCT and gave key resources to GPs with local populations. With this formal devolution of power the GPs became the local leaders of the NHS for their district and had explicit responsibility for ensuring that the commissioning resource previously run from the centre was now spent through their much closer understanding of their local communities.

It is important to recognise that these changes took place in Cumbria within existing legislation. Locality arrangements will be put in place for the transition year and until the coalition government changes the law they will continue to operate within the framework of the PCT as a public body accountable to the secretary of state. Arrangements will be put in place across a comprehensive range of governance issues in line with national and local requirements, to ensure:

- the organisation is operating within current legislation
- patient safety, improving quality and standards
- effective regulation

During the transition year to the new system new governance systems will be implemented in a staged and planned way to ensure that the PCT continues to fulfil its legal obligations at all times. The chief executive officer will remain the accountable officer, through which the responsibilities will be discharged via the chief operating officer to the locality lead GPs in line with current standing orders, standing financial instructions and a scheme of delegation.

From April 2010 these localities had the duty to create new forms of partnerships with local people and agencies ensuring the assets of their area are used to deliver key health outcomes. Crucially the GP consortia have the responsibility to develop new levels of local reporting and accountability, engage representatives of the community and be transparent to the community. Since April 2009 they have had direct control of and accountability for budgets.

This new formality and clarity starts to diminish the PCT. As the GP-led localities take on their enhanced role encompassing more of the duties and responsibilities of the PCT, more of the PCT staffing resources have been devolved and processes have been adapted to support the localities as the heart of the PCT.

Even this devolution was recognised as incomplete. Developing GP-led localities in this way makes decision making more local but needs to be taken further. The next step is to develop even more local approaches where community and primary care services are integrated for particular identifiable communities. By April 2011 it is expected that there will be more communities creating new ways of working within the framework of a locality. These subsequent developments which the localities will introduce during the next year create the opportunity to test out new organisational models which can develop increased local ownership and engagement as part of the NHS, embedded in and accountable to its local population.

Although some aspects of PCT power can be devolved to localities, these locality organisations recognised that there needed to be a Cumbria-wide system management to set countywide standards and specify affordable best practice. As

part of empowering the localities the development of Cumbria-wide care streams ensures that the commissioning organisations in Cumbria have a legitimate and effective place in setting the context for local decision making and performance management of local services.

For this devolution of power to work without endless conflicts, everyone concerned – all six localities and the PCT – had to agree a statement of principles. These provided the framework for a constitution:

Cumbria's agreed statement of principles

This Statement of Principles sets the foundation for how our localities, sub localities and practices will work together. As we develop our organisational relationships, roles, and responsibilities our Operating Framework will develop to reflect these changes; however, our Statement of Principles will remain the same. It will be the foundation upon which we build our reference point, to make sure that 'what we do and how we do it' remains true to our vision and beliefs. The Clinical Senate will hold these principles and be the body through which they are reviewed.

Together this Statement of Principles and our Operating Framework make a local constitution for the development of localities and integrated care within NHS Cumbria.

Statement of Principles

The following is an agreement between leading clinicians in Cumbria. It spells out the guiding principles by which they will collectively improve the health and well being of people living in Cumbria and the health services that they receive. These principles will be binding on all those practices, sub-localities and localities which collaborate to provide and commission primary care services.

Collectively, we will

1. *Strive to provide the best possible health and health services for the people and patients of Cumbria.*
2. *Work to address health inequalities across Cumbria and ensure resources are directed to where they are most needed to address inequalities in health*

3. *Seek evidenced based, best practice and share knowledge to ensure that we deliver that best practice, for individual care and across care pathways.*
4. *Respect Localities' individuality and the different needs of localities and their communities.*
5. *Work together to ensure the integrity of our local and collective decisions and decision making processes.*
6. *Engage staff, patients and the public in devising our best practice.*
7. *Engage with our local communities to ensure shared approaches to local needs and concerns.*
8. *Fully support our colleagues to innovate, challenge and shape services at all levels.*
9. *Ensure the highest performance standards are maintained by all practitioners within our collaboratives and through the use of reliable and timely data we will performance manage those who do not perform to agreed standards.*
10. *Be sound custodians of Cumbria's health and social care budget, ensuring we achieve a balanced outcome at the end of each year.*[5]

The pan Cumbria organisation

The PCT and the GP organisation made it clear that the six localities could not – each one differently – develop their approaches to health care. There will need to be pan Cumbria organisations:

Collaborative working in primary and community care

The devolution to Localities is a key step towards the development of more locally integrated services, better reflecting individual patient need. It also supports the development of more collaborative working at Locality and County level. This will support more efficient and effective use of resources in delivering clinical care. Experience may suggest that it can be further progressed in new organisational forms, such as the development of integrated care organisations.

Collaboration across Cumbria

Localities recognise the need to collaborate across Cumbria; for strategic planning, health improvement, consistent excellence in standards, mutual support, sharing of best practice and to ensure the best use is made of all

resources on behalf of Cumbrians, ensuring the integrity of the whole health system and tackling entrenched health inequalities.[6]

To ensure that the cross locality working would have as much credibility with stakeholders as possible it will need to be backed up by an organisation. Most crucially the six GP leads agreed that they would form a clinical senate, which would be the key decision-making body. This body would be constituted by the six locality lead GPs and the executive directors of the PCTs, even though the PCT was still existent.

The clinical senate

The clinical senate will be responsible for the effective engagement of a wide range of clinicians (nurses and allied health professionals). As the collective organisation of the six localities the Clinical Senate has to determine those issues which cannot be taken individually by a locality. In these situations the localities will need the strength of the joint organisation and will require joint action.

Key decisions will be needed in those areas of strategy that have been the clear responsibility of the PCT, such as the creation of the commissioning strategy plan. This is the five-year strategic plan, which sets the vision and aims of the NHS in Cumbria with the key goals and outcomes to be achieved and the associated targets for improving health and wellbeing across the county and in each locality. It explains how these aims and outcomes will be achieved within the resources available. Setting strategy and implementing it is a key process for any large organisation with a budget of £800 million. Over the last few years large public sector organisations have become used to doing this, but even though they have business plans, GP practices are not used to developing strategy at this scale.

Having set an overall strategy the senate will be responsible for working out how much resource should be distributed to the locality consortium. It will allocate resources in accordance with an agreed resource allocation model. This is a very large change for GPs and transfers their responsibilities into a new and very

difficult area. In the past, within practice-based commissioning the PCTs would work out how much indicative budget would go to each practice-based commissioning consortium. To place GPs in charge of the process of allocating resource and for them to accept that role gives them a new responsibility, with all of the disagreements that can cause.

Once the senate became responsible for allocating the budget the only organisation that a GP could blame if they did not get enough resource is the one run by their colleague GPs. This changes not just the abstract power dynamic about resource allocation but also GPs' feelings about allocation. As a small business GP practices could always blame 'NHS bosses' if they felt they were being unfairly treated. They could feel that 'the bureaucrats' were to blame. Now the decision is made by their own colleagues. Although GPs may still feel frustrated about lack of resources, in future that frustration will be directed at their fellow GPs.

The senate will agree the core service standards which will apply to services across the county. Although the public want to have local services, they also are very keen that there should not be a postcode lottery in Cumbria. They want a consistency of approach, which will be provided by the senate. To put this into operation the senate will agree the core service models and pathways framework. This will include clarity where appropriate about those mandatory aspects that must be applied in localities and the flexibility to adapt to local circumstances.

As with resources, in the past, if a GP was told that there would be a Cumbria-wide standard for a particular disease pattern, they might interpret this as an intervention that interfered with their autonomy. Now the GPs may still feel that their autonomy is being limited by the creation of a Cumbria wide pathway, but that limitation of their autonomy is coming from a fellow GP.

Currently PCTs negotiate and monitor the overall contracts of GPs with hospitals and other NHS providers. However, much of the daily frustration felt by GPs takes place over these contracts with hospitals. A GP refers a patient to a hospital for an outpatient appointment and it may be the case that the next

time they know anything about that referral is when the patient comes back to see them, instead of being copied in to all the information that goes to the patient. Without being informed about what is happening to the patient, the GP feels that they cannot really develop an overall and up-to-date plan for the patient.

In Cumbria it has been the frustration about obtaining timely information that has been one of the main motivations GPs have for engaging in commissioning at all. They want to be involved in their patients' care once they have been referred to a hospital for a test. However, hospital staff may feel that they should be in charge of the patient once they enter the hospital.

One of the main motivations for GPs becoming involved with commissioning is their wish to retain responsibility for the overall care of their patients. Although they recognise that the hospital needs to take control of the clinical governance of patients when they are in their buildings, when they leave hospital their whole care is the responsibility of the GP.

Therefore in order to develop GP-led commissioning consortia it is important to ensure that contracts with the hospital are fulfilled. One way to do this would be to set up a system whereby hospitals were only paid once GPs received information from them about what has happened to a patient; this would give GPs a considerable lever of power.

To play this key role in taking the responsibility of negotiating and managing contracts, the clinical senate in Cumbria recognised that it would need some organisational backup. There are twin pressures that will be reflected in the discussion and apprehensions of GPs across the country. On the one hand nearly all GPs have experienced the PCT as a large and unresponsive bureaucracy. Many feel pushed around by non-clinical staff and believe this is the problem with all bureaucracy. On the other hand GPs who are thinking about taking over commissioning know that they will not be able to carry out all the organisation themselves. They need some administrative skills and support. The anxiety of GPs about recreating a bureaucracy that will oppress them is mirrored by their anxiety

that although they have trained as medics they will have to spend too much of their time looking at balance sheets and chasing up contracts.

In Cumbria the clinical senate had to find its way through these twin pressures. Developing what skills GPs need and don't need to support commissioning is one of the main issues of discussion. GPs recognise that they will need a support office that will service the clinical senate and provide the functional tasks to enable localities to improve their ability to act locally. The senate knows that it will be led by a chief operating officer that will have an important operational support function providing support for the localities in such areas as finance, human resources and governance. However, although the senate recognises that these skills need to be deployed, it is not necessarily the case that the senate needs to employ individuals with those skills. The PCT employs a number of people to deploy these skills and although GPs recognise the importance of the skills they question whether they need to employ professionals who have them or whether they can purchase them from outside.

The senate recognises that during 2010 it will be critical for continued quality, safety and performance that staff and teams work to ensure effective performance and delivery in the commissioning and provision of services, for example in professional development and standards, pathway and service redesign, contract negotiation and care stream development must continue to be provided and managed effectively. So in 2010 existing PCT staff are continuing to be employed by the senate, but during this year of transition GPs and the PCTs will together consider how these activities and responsibilities will be undertaken in the future.

The role of the locality organisation

Having defined the role that will be played by Cumbrian-wide organisations it was important to lay out the role for the localities themselves. This is crucial for GP commissioning: if the GP-led local commissioning consortium does not have allegiance

from the majority of GPs in its area, then the locality will fail. The locality will commission and provide services that:

- improve the health and wellbeing of the local community
- are value for money
- are of the highest quality
- meet the health needs of the local population

This is the core task of commissioning and the main duty that is being transferred from PCTs to GP organisations in Cumbria.

Each locality will be governed through a locality board, with the GP commissioning lead as delegated accountable officer for the locality. It is a crucial part of the structure of public expenditure in the NHS in England that officers should be accountable. They are legally accountable for the proper use of the public money in PCTs. Before the creation of localities, the chief executive of the PCT in Cumbria was the accountable officer for the money given to the PCT by the DH. She now delegates that role to the lead GP in each locality.

Each locality will operate in its own right but may devolve responsibility to one or more sub-localities. As mentioned above, the Allerdale locality agreed to be run as five sub-localities as this fits better with the nature of its local communities. Where a locality operates as a number of sub-localities a set of collaborative rules will be agreed to manage risk across the local health system. Whether a locality chooses to operate as one or more sub-localities, it will go through a process of accreditation and performance management.

The focuses for measuring performance will be quality and outcomes. Each locality will develop services that have the patient at the heart of the decision making through prevention, enabling self care and self management and enhancing care planning through personal consultation. Localities will ensure that patient experience and outcome feedback are systematically built into their decision-making systems at all levels and will develop proactive approaches to broad community engagement.

Localities have the responsibility for commissioning care from the full range of providers and for managing community health services. It is worth listing the services they will be responsible for:

From April 2010 each locality will take responsibility for the following resources:

- *Secondary care commissioning including: All Payment By Results (PBR) activity where the PCT has a direct contract with a provider, plus non contract PBR activity and independent sector activity. This figure will be inclusive of any planned activity reductions that follow on from the Care Closer to Home that is already reflected in contracts. It will also include PBR excluded drugs and devices*
- *Practice prescribing budgets*
- *Community Services (including Care Closer to Home investments) being the direct costs of provision*

Commissioning for Children's and Mental Health Services will continue to be undertaken collectively during the transition year; however, each locality will have a stake in the service reviews and service developments.

The national contract will remain in place for GPs' contracts; however, the contract values for each locality will be included in the locality resource assessment to reflect the overall resource the locality has at its disposal. All practices will contribute to Cumbria-wide targets and aim to achieve their individual targets.

Locality responsibility will include:

- *Achieving financial balance*
- *Delivering all Operating Framework targets*
- *Cumbria Strategic Commissioning targets*
- *Local Area agreement targets*
- *Delivering quality standards in Primary Care and Community Services*
- *Meeting the requirements of the NHS Constitution*

Day to day management of Community Services will be undertaken at locality level.[7]

Conclusion

The list above demonstrates how comprehensively power is being moved to local GP-led commissioning consortia. The responsibility passes to localities with a set of duties to use this money within a framework. To get to this point many people in different organisations have to move far from their previous positions:

- PCT managers need to recognise that their previous attempts to devolve power and responsibility to GPs have been experienced by the GPs as at best insufficient and at worse a sham. They need to demonstrate clearly that they are devolving real power and responsibility to a timetable because they see it is in the best interest of patients. Over these four years PCT managers have persuaded GPs that they are really committed to this change. Only under those circumstances will GPs feel it is worth the effort to develop new approaches.
- GP leaders have to want to take on these new powers and responsibilities. They have to recognise the benefits for their fellow GPs and themselves. If they don't they will not be able to persuade their fellow GPs about the benefits.
- The majority of GPs have to believe that this big change is worthwhile and their patients will gain from it.
- All of this takes a great deal of patience and goodwill. As GPs come from small organisations and PCTs are large organisations, the possibility of misunderstanding is enormous. PCT managers need to start by recognising that localities must be built from the bottom up and not from the top down.

3 Policy lessons drawn from the experience in Cumbria

Lessons from Cumbria

National policy cannot be drawn from a single location and we are not saying that Cumbria is in any way the same as the rest of England. But there are some important issues that the Cumbrian experience of introducing GP-led commissioning raises for the rest of the country, irrespective of the national policy. However, the national context for these issues has changed significantly since the Cumbrian GPs started to develop their own commissioning organisations.

The coalition government has placed GP commissioning consortia at the core of its reforms. These changes will be developed through legislation over the parliamentary year 2010/11, so GPs' involvement in NHS commissioning will be at the core of health policy over the next year and at the core of the implementation of reform from 2011 onwards.

The government plans for GP commissioning cover the whole of England and it is therefore important to draw some wider policy issues from the Cumbrian experience, as under the proposed plans every GP will have to become a commissioner.

The tension between the experience of GPs as professionals running their own small business and the need to develop commissioning consortia that are much bigger organisations is key to whether this policy succeeds or not. Most GPs enjoy working in or running small organisations and are anxious about losing any of that autonomy. Some GPs actively want to commission all the care that their registered patients receive but recognise that to carry out that function they need to be part of a much bigger organisation than the small businesses within which they practise.

Therefore one of the most important policy issues to explore is how to persuade those GPs who are very happy working for

their own small organisations to become part of a much bigger organisation that will commission care for their patients.

How to develop GPs as commissioners

In Cumbria many GPs needed some persuasion to do this, and this is likely to be the case in the rest of England. So the first policy issue to rise from the Cumbrian experience is how to work with GPs to develop them as commissioners? Why has the government chosen compulsion? Is this the best way of getting GPs to do something so new?

As we have seen, GPs in Cumbria needed considerable time in discussion with colleagues to think through what it might mean to commission. Many GPs were more or less content with what they were achieving with their patients and did not feel that they wanted to be more involved in commissioning health care. There was and there will continue to be a process of development here.

There is an important distinction between the policy for the GPs in Cumbria and the government policy in this specific area. The GPs in Cumbria did not have the power to make other GPs commission care for patients. The government intention is to make it compulsory for all GPs to become commissioners:

> *A fundamental principle of the new arrangements is that every GP practice will be a member of the consortium, as a corollary of holding a list of patients… The Government will discuss with the BMA [British Medical Association] and the profession how primary medical care contracts can best reflect new complementary responsibilities for individual practices, including being a member of a consortium and supporting the consortium.*[8]

These are two very powerful methods of making GPs become involved in commissioning:

- to make it one of the conditions of having a registered list of patients and being able to treat them that every GP practice becomes a member of a commissioning consortium; this is a direct change to the way in which all GPs carry out their work –

they will not be able to provide GP services to patients unless they commission care
- to negotiate a change in the nature of the GP contract to include the requirement that they are part of a commissioning consortium

These are powerful methods of compulsion; it is the government's intention that GPs will not be able to practise as a GP if they do not commission. This policy will have implications in every locality, but those not involved in thinking through the implementation of any policy may find this an odd issue to raise as they consider that it is the duty of governments to enact legislation making people do what the voters have voted the government in to do.

However, passing legislation making everyone do something is only one way of making something happen, and compulsion is often an ineffective way of implementing policy and it is likely to be most counterproductive with staff who run themselves in small businesses. Although some GPs see the professional and economic point of developing their role as commissioners others are only really interested in providing health care for their patients and prefer to leave commissioning health care for their patients to their local PCT.

The experience in Cumbria (chapter 2) showed that GPs with an existing interest in commissioning were able to persuade GPs who were only interested in providing health care that the best interests of their patients would be met by recognising the importance of commissioning decisions to the interests of their patients. Nearly all GPs had experiences where they felt their patients had been let down by the work of hospitals and other providers. Although they might not have been clear about what they could do about it, they recognised that better commissioning of health care would lead to better outcomes. Those GPs who wanted to develop commissioning consortia could find examples from their colleagues' practice to demonstrate the shortcomings of the current system and patiently build an appreciation of how the commissioning of NHS health care could deliver very specific and detailed improvements if GPs were in charge of it. Persuasion and

detailed argument proved effective in bringing about active and committed change.

Some GPs are not at all interested in commissioning and do not under any circumstances want to get involved. Making it compulsory for these doctors to commission health care might have a negative effect on their practice. Each individual GP needs to have a conversation which demonstrate how they will be much better practitioners of medicine and improve patient outcomes if they are involved in commissioning, and the experience in Cumbria was that their fellow GPs can make this case best.

How to introduce GP commissioning consortia without using compulsion

Although the government has the power to compel GPs to implement GP commissioning consortia there are other ways of bringing about this change in practice.

The government could have staggered the change by first asking GPs to consider the experience of Cumbria and encouraging them to implement GP-led commissioning by April 2012. It is difficult to guess how many would have wanted to be in this first wave, but the experience in Cumbria suggests that up to one-third of GPs would have started to commission from April 2012.

The whole policy then would have depended on the success of this third of English GPs who were commissioning care in relation to the rest of the GPs in the country. The GPs who were part of these consortia would from April 2012 have had the opportunity to demonstrate how their patients were getting better service. If as seems likely one of the main things that GPs want from commissioning is to have much better and quicker information from those to whom they refer their patients, then the third who were successful volunteers could demonstrate how paying hospitals directly gives GPs the right to obtain better information about their patients more quickly.

This would have created the climate where more GPs would have been encouraged either to form their own consortia

or join the existing consortia. The number of GPs who would join in that second year would depend on the success of the first wave. And if the GPs who had volunteered to introduce the new policy were not successful it would clearly not be sensible to make that policy compulsory for all GPs.

Those GPs who do not under any circumstances want to commission care will not carry out the policy very well if they are made to do so under duress. They might be persuaded to change their minds if they can witness the benefits that commissioning care directly has brought to other GPs, or if their patients move to those GPs who provide a better service by directly commissioning care.

Compulsion is different from competition. Making it compulsory for GPs to commission care is different from bringing about change by letting patients choose GPs who commission care and reject those that don't. This uses patients' choice rather than central government power as the driver of policy. It will be interesting to see as the government policy unfolds and is implemented whether its preferred driver of compulsion works.

Patient care and patient trust comes first

Bringing together financial and medical decision making in the NHS is the purpose of GP-led commissioning, but there is a worry that patients might not like the policy of giving GPs this dual responsibility. Patients are primarily interested in one thing: they want to know that their doctor will make the best medical decisions on their behalf. They do not necessarily care whether the best clinical needs cost a lot or not very much money. Most patients trust their GPs to make the best medical decisions without any thought of their budgets.

If patients knew that GPs were in charge of spending the money for commissioning as well as making the medical decisions about their care they might be concerned in case the GPs' medical decisions were influenced by potential cost factors, and that their professional judgement might be diminished in the long term.

This is a serious concern for the NHS, and within a month of the government's white paper being published[9] the British Medical Association's (BMA's) General Practice Committee issued a statement on the principles of commissioning:

This GPC statement enshrined a set of fundamental principles with regard to GPC commissioning which will define policy, inform debate and negotiations and ensure that good medical practice is enshrined within these enhanced responsibilities… This statement makes clear that GPs are, first and foremost, responsible for their patients. It sets out what the expectations of GPs should be – how GPs should expect to be treated by their consortia, while reassuring those who may face scrutiny that they will be defended and empowered in their appropriate treatment of patients.[10]

The first section of this document tries to reassure the public:

GPs must continue to make the care of their patients their first concern, in keeping with the GMC's Duties of a Doctor.

GPs must always work in partnership with patients, respecting their dignity and right to confidentiality, making good use of the resources available.

GPs must always provide patients with advice, investigations or treatment where necessary. The investigations or treatment provided or arranged must be based on the assessment of needs and priorities, and on clinical judgement about the likely effectiveness of the treatment options.

GPs must always refer a patient to another practitioner where this is in the patient's best interests.

GPs must give priority to the investigation and treatment of patients on the basis of clinical need, when such decisions are within their power. If inadequate resources, policies or systems preclude this, and patient safety is or may be seriously compromised, the matter must be drawn to the attention of the appropriate authority.

GP commissioning has the potential to increase efficient use of resource, as well as ensuring that these limited resources are used for service provision and redesign in order to best meet the needs of patients. However, it would

be absolutely unacceptable for a contract held by a GP to conflict with their professional responsibilities in providing care for patients.[11]

Although a statement of principle such as this is an important starting point for the public, the struggle to maintain and develop trust once financial and medical incentives are combined in GP commissioning will need a wider public debate.

Everyone who wants this policy to succeed, including the government, will have to engage with the public in an open debate about the need for the NHS to provide value for money as it provides the very best medical care. The debate about waste in the NHS has traditionally been a very false one. Politicians often appear to make the case that waste and inefficiency in the NHS is primarily caused by managers and bureaucracy, whereas the front line has no role to play in increasing efficiency.

Although it is true that in any organisation management and bureaucracy can be made more efficient, since the vast bulk of the resource of the NHS is spent by and with those on the front line, this is where there is most scope for providing better value for money. Indeed, this is one of the rationales behind the main policy of GP commissioning – because GPs are not financially responsible for the expenditure of NHS resources they make decisions that are not informed by financial responsibility. Bring financial and medical responsibility together and there will be greater responsibility and greater value for money.

The lesson from the Cumbrian experience is that peer pressure can be influential. The medical decisions that individual GPs make about any particular patient care vary considerably, and when GPs are provided with this data in detail and discuss them the GPs whose medical decisions are most at variance from those of their colleagues sometimes change them. As a result of introducing collective decision making in Cumbria, there is less variation between the medical decisions that different GPs make, especially in the prescribing of medicines.

This change in the behaviour of GPs is important and relates to the recognition that individual autonomy when making medical decisions is not necessarily a good thing. Like any individual who works without any peer discussion, individual

GPs can develop practices that are idiosyncratic. However, as the policy of GP-led commissioning is introduced some GPs will protest that their commissioning consortium is putting pressure on them to change their referral behaviour and that this is an attack on their autonomy. They may even appeal to politicians or the BMA to help them stand up to the pressure of the commissioning consortia to come into line with their colleagues.

How local politicians and the BMA act in those circumstances will influence the success or the failure of this whole policy. If politicians or the BMA defend the individual right of individual GPs to refer in the way that they personally want to as inalienable, then the principle behind introducing GP consortia and value of peer pressure will be undone.

In Cumbria the leaders of the consortia recognised this. They knew from the beginning that one of the main outcomes of this whole policy was to change the referral behaviour of a few GPs. They recognised that this may lead to some conflict, which could become public. At every stage the GPs leading consortia recognised that they would have to be in a position to defend their actions to patients, if necessary in public debate or in the local newspapers. They recognised that there is little point in developing this policy if all referral decisions by individual GPs remained the same as they had always been. The core of the policy was that there should be changes in the referral patterns of the GPs who had been outliers in the way that they prescribed.

Building new GP commissioning consortia

The progress made by GP localities in Cumbria was assisted by the PCT wanting to devolve power away from itself. This unusual motivation assisted GPs by providing a safety net for their development. Now that the government has decided to introduce GP-led commissioning throughout England it is to be hoped that PCTs will help GPs develop their own commissioning consortia. The PCTs will be abolished by April 2013 and the best of them will want to ensure that there is a strong legacy of GP commissioning consortia to come after them.

There will be some difficulties for the PCTs that want to do

this. The first problem is that in the past their power and duties have put PCTs in the position of making the changes in the NHS happen, but this is not appropriate in the current context as it is the task of the GPs themselves to be in charge of these changes; one of the quickest ways of alienating local GPs would be for the PCT to tell them what they have to do and how to do it.

As PCTs recognise that GPs are in charge of this process and that their job is to help them where possible there is another, more subtle problem relating to the way in which PCTs and GPs think about their world, which is very different. Most senior managers of PCTs have spent their working lives working in large organisations and tend to think strategically rather than focus on individual detail, as GPs do when treating patients. GPs have spent most of their working lives running much smaller organisations and delivering services to the public. They are interested in developing those services and want to do so quickly, with attention to detail and minimum bureaucracy.

It is important for the future of GP-led commissioning that these two ways of working meet together, although as the policy is introduced this will be hard. For example, in Cumbria the PCT clearly recognised that the size of the population covered matters enormously to the efficacy of commissioning: small commissioners who negotiate with large hospitals don't strike the best of bargains for their patients.

But GPs who are interested in commissioning are concerned about how they can use commissioning in their daily practice to improve patient outcomes. They want to use the power of commissioning to improve the way in which other providers of health care including hospitals relate to their patients. However, if the PCT tells them that the only way they can commission is by being part of a consortium with a population base of half a million, many will lose motivation. Although PCT managers are aware of the benefits in efficiency and value of running large organisations, these may not be obvious to GPs, who are used to running much smaller organisations. Because of the speed of change that is required in order to implement the government's proposals, there may not be enough time to allow GPs to come to these conclusions themselves.

The organisational form of GP commissioning matters

One of the reasons behind the policy to introduce GP-led commissioning is to unlock the potential that exists as a part of the small business ethos of GPs. The idea is that GP-led commissioning will be better than PCT commissioning because GPs are small business people who understand economics and value for money. Therefore if expertise as small business people is to continue to be valued it is important that they retain their organisations as small businesses. In Cumbria the localities have formed themselves into not-for-profit community interest companies, which can take responsibility for their success and failure.

The government white paper[12] makes some specific proposals about the nature of the organisation within which GPs will carry out commissioning, including that there needs to be a statutory organisation. This would change the dynamic of how GPs would carry out this role. They would no longer be working for themselves: when they are commissioning they would be working for the state. This would undermine the motivation of GPs, which the government is trying to unlock, and therefore undermine the new policy. It would also impose the new policy on GPs, rather than allow different organisations to emerge across the country.

The sub-title of the white paper is 'Liberating the NHS', but it is strange to believe that liberation can take place through nationalising the GP endeavour of commissioning.

Conclusion

Creating an NHS policy is hard enough – stakeholders need to be taken on board, the economics need to be worked out and a timetable of implementation needs to be brought in. However, this particular policy is totally dependent on England's GPs seeing how it will benefit their patients and wanting to implement it. Changing GPs' contracts and passing legislation through Parliament may construct a policy framework, but will not motivate 25,000 GPs to be persuaded of the value of the proposal.

Unless GPs can see the point of this change it will not happen. Thus the key question determining the success of the policy is whether enough GPs want to be involved in organising commissioning and being part of a commissioning organisation.

This is not a policy issue but a developmental issue. The experience of Cumbria is that it takes thousands of conversations, and hundreds of very small meetings to get the majority of GPs on side. This only works with very high class local GP leadership and if the time and effort goes into helping those leaders to develop.

With strong local GP motivation creating GP commissioning consortia is going to be merely very difficult. Without that motivation, it will not happen.

Notes

1. DoH, *Equity and Excellence: Liberating the NHS*, Cm 7881 (London: Department of Health, 2010) 4.
2. Ibid.
3. NHS Cumbria, 'Moving towards locality devolution and integrated care', Mar 2010.
4. Taxes are generated by the UK Parliament, but the NHS is developed and the resources distributed by the nations England, Scotland, Wales and Northern Ireland.
5. NHS Cumbria, 'Moving towards locality devolution and integrated care'.
6. Ibid.
7. Ibid.
8. DoH, *Equity and Excellence*, 28–9.
9. DoH, *Equity and Excellence*.
10. British Medical Association, General Practice Committee, statement, Aug 2010.
11. Ibid.
12. DoH, *Equity and Excellence*.

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By April 2013, Primary Care Trusts (PCTs) will no longer exist. The model of health care brought in under New Labour has had its day and is being replaced with general practitioner (GP) led consortia, putting power directly with the frontline staff to control their budgets. This is the 'liberating state' in action, devolving decision-making powers to the health care professionals closest to patients.

However, for most GPs, the power of commissioning is an entirely new responsibility: one that will require new organisational forms to be effective. This pamphlet investigates the example of NHS Cumbria, where GP-led consortia have been in development since June 2009, using it as a case study of the future of the NHS.

Paul Corrigan offers a unique perspective on the reforms, having been instrumental in the creation of PCTs as senior health policy adviser to Tony Blair. He finds that NHS Cumbria has a wealth of experience for reformers to draw upon, and argues that, in contrast to the top-down approach of the PCTs, GP-led commissioning will increase efficiency and quality of service in the NHS from the ground up.

Paul Corrigan was senior health policy adviser to Tony Blair.

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