

LMC Discussion Paper on the Commissioner/Provider Split in Primary Care

Introduction

For reasons of politics and probity the current Government remains committed to the principle of a separation between commissioners and providers of services. Yet in primary care this distinction is neither practical nor useful: a GP crosses the nominal barrier between the two roles frequently during the working day and the anticipated new contract will formalise the requirement to fulfill both roles

Localities

This has led to an inevitable confusion about the function of GP groups across the county. When GPs meet to discuss NHS services are they speaking as commissioners, providers or both ?

The current “official” position is that if GPs meet as a Wyvern locality group they are commissioners, and if as a federation they are providers. But where separate meetings are held the same people may attend both, and in some places a single meeting considers business in both categories.

It is not realistic to expect GP groups to observe a strict distinction between the two functions as the two are, of course, mutually dependent. However, we do need to be able to show that the processes are open and fair. Providers clearly cannot be allowed to commission services directly from themselves.

“Natural communities” of GPs

All Somerset practices are members of one of the nine federations in the county. The federations vary in size, but are self selecting depending on geography, existing relationships between practices, referral pathways, community hospital access and other factors. The federations broadly fall into the boundaries of the old GP out of hours co-operatives in which GPs had an established pattern of joint working.

It therefore seems logical to use these federations as the basic unit for GP commissioning consortia.

Commissioning First

There is obviously no opportunity to provide services unless these have been commissioned and procured first, so the first priority of the consortium group must be to continue to work with Wyvern on PBC and to evolve the skills needed to become active in GP commissioning. Commissioning ideas and proposals will doubtless be generated within the group which will be passed on up to Wyvern or the new formal GPCC. (It seems increasingly likely that this will be structured at county level.) The commissioners will then evolve a commissioning plan and start a procurement process, probably offering it to “Any Willing Provider”

Obtaining Provider Contracts

In future it is likely that the bulk of contract offers will not be for services that can be provided by the generality of practices, although we should perhaps anticipate new contracting arrangements for Enhanced Services, especially those offered as LES.

More frequently the specification will be for services to be provided in a limited number of localities, say, for example, four across the county. Whilst it would be perfectly possible for a practice or group of practices to bid to provide these, we see that there may be a role here for the county GP Provider Confederation in co-ordinating and supporting bids from federations, thereby developing particular expertise in the field over time. For contracting purposes, and once again to ensure probity, federations are likely to need a suitable vehicle submit their bids, probably in the form of a limited company.

Conclusion

The LMC believes that this model allows practices to continue to work as providers of primary and intermediate care services as well as commissioners of intermediate and secondary care. Taking procurement and contracting decisions at an organisational level above day to day GP activity helps ensure that the *process* remains untainted and therefore much less likely to be open to any legal challenge if a practice, federation, or group of federations is awarded a contract.

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