Somerset LMC Newsletter Special Edition

Oct 2010

GP Commissioning in Somerset: What Sort of Consortium?

Outcomes from the LMC Conference

Summary

Delegates left Taunton Racecourse both shaken and stirred – shaken by the size of the task, but stirred by a glimpse at the potential opportunities to effect real and rapid change once GP Commissioning consortia (GPCCs) are established.

The central theme of the meeting was that GP practices and existing commissioners in Wyvern and the PCT need to start to prepare for a transformation process that will move very quickly once it starts. Although we must await the conclusions from the national consultation and the consequent enactment of primary legislation, primary care needs to have a very clear vision of where we are going and just what we want the GPCCs to achieve.

Managing change on this scale needs a lot of support. Once a clear goal is set, we will need committed co-operation from all involved parties to bring together the skills and resources to make an effective organisation. Evidence from the history of the NHS (1) suggests that the risk of failure is considerable and we must guard against the cultural and organisational flaws that make this more likely.

It is too soon to say what our GPCCs should look like. There is much to be said for putting formal structure at a high level, but when tough financial decisions have to be made practices and individual GPs are likely to listen to and engage with their local colleagues more readily than with a distant organisation (2)

GPC Presentation (Dr Chaand Nagpaul)

The Government transformation agenda is very long, and although subject to consultation it is unlikely that the central tenets, including GP commissioning, will alter substantially. As statutory bodies GPCCs will have a specified structure – including an Accountable Officer – and responsibility for real budgets. GPCCs that fail to keep to budget will presumably be put into "special measures" and ultimately taken over by more successful ones. Consideration should be given to appointing Skilled and experienced former PCT managers to deal with some of these tasks and close working with secondary care colleagues is essential. A series of guidance's for GPs and practices is published on the BMA website. (3) There are risks in the proposals – overspends, conflict between practices, loss of key staff as PCTs shrink and the conflict between choice and rationing. But at the same time there are opportunities in developing clinical leadership, developing practices, reducing bureaucracy and improving care pathways. He concluded that "rules matter"-GPCC governance arrangements must be adaptable-and "size matters" – we must carefully balance risk management and practice engagement when determining the size of GPCCs.

LMC Presentation

GPCCs face a large task in maintaining and improving current services whilst increasing efficiency and undertaking an uncertain range of non-commissioning functions. Partner organisations are configured in many different ways across the county – there is no "perfect fit" so the GPCCs must be flexible in configuration to meet different needs.

Effective change in organisation requires four things

Pressure for change. This we have in the white paper.

A clear shared vision. Which is what this conference is about.

Capacity for change. Organising the people and resources needed.

Actionable fist steps. Agreeing a project plan and time line.

We must beware jumping to conclusions about form until the functions are understood, and the whole range of tasks the GPCCs are expected to perform are known. The McKinsey "7S" analysis tool helps here – we need to look at strategy, style, systems, skills, staff, structures and shared values in determining the shape of a new organisation

BMA Law Presentation (Tim Merritt)

Although the White Paper focuses on commissioning, GPs also need to organise themselves to be able to provide services under the "any willing provider" regime . Not only will this make it easier to bring care closer to patients, it will help secure the financial future of participating practices. GPCCs will have their structure determined centrally, but provider groups can configure as they wish. A company limited by shares is likely to be the best model but take advice about this and before signing any contracts. Questions will include TUPE liabilities for staff of existing providers and access to NHS pensions. Meanwhile, GPCCs and practices will need to think about what happens if a practice fails to achieve a consortium's goals and the legal consequences for everyone if they are expelled.

Discussion Groups Session 1 (Delegates divided into old PCG areas)

The groups considered two questions:

1 ***How do we hard wire the values of general practice into the GPCCs****?*

A synopsis of replies suggested that the GP values that need to be transferred were:

- Responsiveness
- Collaboration and mutual risk sharing
- Part of the real world community
- Empowering
- Financially conservative
- Communicative
- Ethical and patient centred
- Peer reviewed and not bureaucratically directed
- Simplicity

This would be achieved by:

"ensuring sufficient GP involvement and representation in GPCC governance structures to maintain a balance between patient advocacy, and public health needs and financial accountability *<u>and</u>* *designing a structure that hears and responds to local needs"*

2 What will success look like?

- Practices still talking to one another
- Patient services available and waiting lists controlled
- PROMS confirm needs (not wants) are met
- Within budget
- Developing practices skills and engagement
- Balances centralism and localism
- Co-operating with partners and other consortia
- Rapidly assesses and implements new plans
- Forward looking and not wedded to old solutions
- Copied by other GPCCs
- Happy patients and practices.

PCT Presentation (Ian Tipney)

Although it seems a long time until April 2013 the transition task is substantial so there are significant time pressures. The HSJ has identified approximately 300 statutory duties for PCTs other than commissioning, many of which will come the GPCCs and there must be an orderly and managed transition to maintain public confidence in the local NHS. GPCCs, whatever their size, must be able to look upwards to consider regional and supra-regional services as well as downward to individual practices. Size is an advantage for much commissioning, particularly if capital investment is needed. QIPP remains the key area of work to maintain financial stability, and management of long term conditions is central to this. A 20-30% reduction in admissions in this group saves £13-15M and this should be achievable for an investment of perhaps £2M. Financial management is crucial to the transition and risks here include not only NHS inflation but the rising costs of continuing care, budgeted at £25M for 2010/11. Somerset starts from a sound base of financial balance, service delivery and good relationships but really joined up working between the PCT and the GPCC(s) is vital to success.

DISCUSSION GROUPS SESSION 2

3 What capabilities do we need to start this process?

Strategic Leadership to identify the things that need doing, and management capacity to go ahead and do them. We must make best use of the capacity we have in primary care, and ensure there is backfill for the practice manager time required. Skills of PEC, Wyvern and LMC GPs should be drawn upon.

A transition map and project plan, and funded time for the right people to be looking at GPCC functions.

A stocktake of existing infrastructure, (PCT, Wyvern, others) identifying key capacity and personnel that the GPCC is likely to need. Early engagement with specific people to try and prevent the loss of important local knowledge and experience.

An oversight group derived from across primary care to watch developments.

Essential things to consider include financial expertise, information systems, governance, prescribing support, clarity on access to public health resources, provision of customer service functions, a communication strategy and recognition of the need to develop the culture, ethos and identity of Somerset GPCC(s).

4 What do you want the LMC to do to support this work?

- See the process through and act as honest broker
- Help clarify the roles of GPCCs in relation to non-commissioning aspects of primary care
- Help identify new and existing talent in primary care
- Support continuity of service to patients and practices during the transition
- Encourage Wyvern to build on their commissioning success as a core function to be transferred to the GPCCs
- Help develop existing GP federations/ localities into local hubs ready to start work on QIPP and co-operative work across boundaries
- Ensure that practices, and particularly individuals, are treated fairly and considerately .

(1) www.nhsconfed.org/Publications/reports/Pages/triumph-of-hope.aspx

(2) www.somersetlmc.co.uk/

(3) www.bma.org.uk/healthcare_policy/nhs_white_paper/index.jsp

Commentary (Dr Barry Moyse)

Cynics who should have heard it all before were astonished with the speed with which the White Paper and its supporting documents were issued - and on schedule too. As we read them, it was clear that this time things were different; not least because instead of a Secretary of State parachuted in after a few years in another department, we now have a man who shadowed the job for six and a half years. Indeed, Professor Chris Ham of the King's Fund has declared that there is the potential for the greatest change to the NHS since its creation in 1948. Most commissioning is to be done by GP consortia free from top down managerial control but supported by and accountable to a supervising NHS Commissioning Board, itself accountable to (but not run by) the Department of Health. "Decision making will therefore be underpinned by clinical insight and knowledge of local health needs. Consortia are expected to work closely with secondary care, other professionals and community partners to design joined up services that make sense to patients and the wider public." But the White Paper *Liberating the NHS* only sets out the Government's plans in broad outline, there is no fine detail. Previous changes have been centrally directed, whatever the talk about "local solutions for local problems". So it may be quite unsettling to think that this Government really does mean it when it says there is no preferred model for consortia – except that existing commissioning structures cannot be replicated and simply renamed. Someone who ought to know has said that the author of the White Paper considers it to be like an impressionist painting. You have to stand far away in order to see and to understand the whole thing. Some say, however, that rather than a Monet, a Renoir or a Pissaro what we have is more like a Jackson Pollock.

Clearly GP involvement in commissioning will bring new opportunities to improve patient care as those places where there has been progress in practice based commissioning can demonstrate. We should be proud that Somerset is counted amongst these. But real budgets also present challenges and potential risks. The LMC, the only statutory and democratically elected organisation that represents GPs, is charged with assuring fair processes in the setting up of consortia or a consortium and with playing a pivotal role in the evolution and scrutiny of commissioning bodies. That process to develop a mandate from practices for the way forward in this county has started. Whether we like it or not we must face the task immediately in front of us, whatever may lie "over the hill." Involvement in a GP commissioning consortium will become a condition of holding a primary care contract.

But even if it is all such a good idea, is now the right time? The author Sebastian Junger coined the expression "The Perfect Storm" for a particular combination of weather conditions: when we see the state of the national finances, the growing burden of interest payments on an unprecedented peacetime National Debt, and growing unrest in the public sector – led, ironically, last week by senior police officers – the same analogy has been used about the economy. Brendon Barber of the TUC has warned of a future that is "dark, brutish and frightening", the United States economy teeters on the edge of a double dip recession, and they are planning to lay off 20% of the public sector workforce in that bastion of capitalism, Cuba! Given all this and adding the need for swingeing savings under QIPP, what if the NHS does not want liberating? Is this the greatest hospital pass of all time, secretly designed to bring about the denationalisation of the NHS?

Others say that it is precisely because things are so bad that these reforms offer the only way to save the best of the NHS and primary care as we know it. This is exactly what many colleagues have been asking for for years and this opportunity must be grasped with both hands.