GP commissioning: implications for the third sector

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The reforms proposed in the 2010 UK National Health Service (NHS) White Paper hold the potential for major changes to the landscape of the NHS. Although the third sector is not mentioned very much in this document, the implications for the sector are significant. This paper sets out the recent history of NHS reform and the detail of the changes before outlining some of the potential implications of these changes for the third sector.

Introduction

The publication of the White Paper *Equity and excellence: Liberating the NHS* (Secretary of State for Health, 2010) heralded reforms described as the 'biggest upheaval of the NHS [National Health Service] in its 63 year history' (Delamothe and Godlee, 2011: 237) and a 'huge untried experiment with profound equity risks' (Whitehead et al, 2010: 1373). Despite having promised to 'stop the top-down reorganisations of the NHS that have got in the way of patient care' (HM Government, 2010: 24), the coalition government announced radical plans in which 'little of the current architecture of the NHS will survive … unscathed' (Walshe, 2010: 160). Although the intentions of the White Paper may be attractive to the third sector (more information for patients, more patient voice in decisions about care, increased outcome focus, extended choice etc), recent reform processes have shown that during implementation, intentions are not always realised. After setting out the policy drivers and current proposals for general practitioner (GP) commissioning, this paper considers what the implications of these changes might be for the third sector.

NHS reform and policy drivers

To some extent, the recently proposed reforms are an extension of those started by the 1997-2010 New Labour administrations and may be more 'evolution' than 'revolution' (Cooper, 2010). New Labour was elected under a mandate to 'save the NHS' and subsequently embarked on three phases of health investment and reform. The first phase saw a focus on reform by performance management with a series of top-down targets that were primarily intended to tackle long waiting times for elective care, referred to by Bevan (2009) as 'targets and terror'. The second phase focused on strengthening provider bodies, again with the aim of tackling deficits in elective care (supply-side reform). This phase included the introduction of foundation trusts (FTs), whose operational and financial freedoms (relative to other NHS trusts) and

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new governance arrangements (in which they were accountable to local community 'members' rather than the Department of Health) were intended to lead to improved performance in terms of financial management, quality, responsiveness and innovation (Audit Commission and Healthcare Commission, 2008).

Although these initial two phases of reform did result in improvements, this was not sufficient for either national government or public expectations. Central government viewed the commissioning function as responsible for these shortcomings (DH, 2005), and the third phase of reform sought to reorient the NHS from being provider- to commissioner-driven (Stevens, 2004). It was argued that what mattered was not who provides health services, but how these are commissioned by the NHS. This phase included attempts to engage GPs with the commissioning process through the creation of primary care groups (PCGs) and subsequently primary care trusts (PCTs), and more latterly through practice-based commissioning (PBC) (DH, 2009) in which GPs hold 'indicative' budgets, which they spend on secondary services (Kay, 2002). The other core component of the third phase was the World Class Commissioning programme (DH, 2007b). This was devised to improve the capacity and expertise of PCTs in relation to commissioning. Finally, a 'level playing field' in the provision of healthcare services was to be introduced – this was accompanied by increasing interest in social enterprises delivering direct healthcare either through the 'spin-out' of NHS services or through existing enterprises.

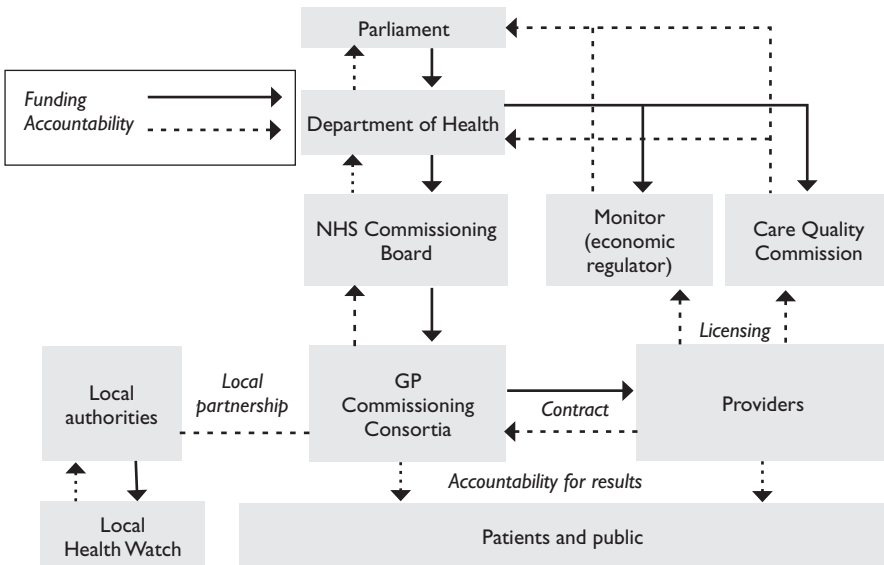
Yet, a strong demand-side was not produced within these short timeframes. A Health Committee (2010) report concluded that commissioning was largely ineffective; 'weaknesses are due in large part to PCTs' lack of skills, notably poor analysis of data, lack of clinical knowledge and the poor quality of much PCT management. The situation has been made worse by the constant re-organisations and high turnover of staff' (2010: 3). This damning report about the state of commissioning reinforced the 'widespread view' that PBC had not lived up to its potential (Secretary of State for Health, 2008). Although reform policies achieved a 'step change' with more and better services (King's Fund, 2005), the improvements made did not seem to be accompanied by enhancements in public or user optimism (Ipsos Mori, 2007). The weak incentives across demand and supply to engage and break historical patterns meant that the reforms did not bring about all the benefits that market reform was expected to deliver (Exworthy and Frosini, 2008; Brereton and Vasoodaven, 2010). In the light of this, the newly formed coalition government seems convinced that the NHS is in need of another set of reforms. The changes set out in the White Paper *Equity and excellence: Liberating the NHS* (Secretary of State for Health, 2010: 1) propose a way of breaking down these old patterns, making the NHS more accountable to patients and 'freeing staff from excessive bureaucracy and top-down control' (2010: 1).[2]

One of the main components of the reforms is the devolution of commissioning power to GP consortia. PCTs will be dissolved and the new consortia (which will be statutory bodies) will take responsibility for commissioning approximately 80% of services for their patients. These consortia will be overseen by the national NHS Commissioning Board (NCB), which will also be responsible for allocating resources to the consortia and directly commissioning primary care and specialist services. Local authorities will lead on the public health function and be responsible for

commissioning HealthWatch and patient advocacy services. HealthWatch (which will replace the current Local Involvement Networks) will ensure that views and feedback from patients and carers are an integral part of local commissioning across health and social care and will also have a role in promoting patient choice. A new Public Health England service will be responsible for allocating funding to local authorities and the NCB, and directly providing and commissioning services itself.

In terms of provision, the White Paper announces that 'our ambition is to create the largest and most vibrant social enterprise sector in the world' (Secretary of State for Health, 2010: 36). All NHS trusts will either become FTs or 'merged' with existing FTs and so will be freed from some of their existing constraints. A free market will be formed where patients can choose the provider they think best and FTs and private and voluntary sector providers will all be regulated in the same way by Monitor (currently the FT regulator) and the Care Quality Commission (CQC). The relationships between the various components of the NHS as envisaged in the future are set out in Figure 1.

Figure 1: Proposed future structure for the NHS



Emerging implications

There is some debate over whether these new reforms are revolutionary in the sense that they are entirely new and different, or whether they simply extend the themes of New Labour through the notions of demand-side reform, 'any willing provider' and clinical engagement. Nevertheless, it is clear that the NHS is about to enter a period of significant change and one in which it is intended that savings in the region of about £20 billion will be made between 2011 and 2014. A mapping exercise commissioned by the Department of Health (DH, 2007a) indicated that, in

England, approximately 35,000 third sector organisations (TSOs) delivered health and/or social care services. Of these, 14% delivered exclusively healthcare and 23% delivered health and social care, with an aggregated expenditure of £4.7 billion on healthcare services being delivered through the third sector. This section considers what some of the emerging issues might be for the third sector. With reforms as significant as those proposed, we have had to be selective in our focus and will not dwell on the social enterprise agenda, which would merit a paper in itself. In this paper, we concentrate particularly on issues relating to *demand*; *democratic voice and community engagement*; and *skills and capacity*.

Demand

Relationships between PCT commissioners and TSOs have not always felt as though they are as effective and as easy as they might be and only 36% of the healthcare services delivered in 2007 by TSOs were publically funded (DH, 2007a). However, several third sector agencies have recently worked to build up relationships with their local healthcare commissioners and are involved in the activities of local healthcare communities in a variety of ways (eg Dickinson and Neal, 2011). The abolition of PCTs significantly changes the nature of the health commissioning landscape and risks putting these existing relationships in jeopardy. At its most basic, the reforms will lead to very different geographies of care, which is important given that many TSOs are based around specific locations. The new consortia will be free to arrange their commissioning support as they see fit, so this could be from private consultancy employing their own staff or contracting with the local authority or social enterprise developed by previous PCT commissioners. Therefore, there is the potential for the introduction of consortia arrangements to disrupt existing patterns of commissioning and we will see some PCT commissioners move out of their current roles and perhaps out of the health sector entirely.

Relationships are not easy to establish and it takes time to make links and develop trust and understanding. There is a danger that in the move to consortia arrangements, TSOs lose contracts as links with existing commissioners are broken and the newly established organisations choose to commission different types of organisations to deliver services. This is also taking place against a background of increasingly constrained finances, with PCTs having to make significant savings and local authorities cutting back on the grants they give to TSOs, some of which are also being hit by the changes surrounding the personalisation agenda (Dickinson and Glasby, 2010; Harlock, 2010).

In some ways, these changes might well be perceived as a threat, particularly given that GPs have often been criticised as operating within a predominantly biomedical model of care that views individuals and their lives in a narrow way, which is at odds with the ethos of the third sector. There is a danger, therefore, not just that existing and established relationships are disrupted in this process, but also that whoever ends up leading on these new commissioning arrangements takes a very different view of service arrangements, and those TSOs with existing contracts lose these in the process of change.

Of course, there is also another reading of this situation and one that is potentially more positive for the third sector. The range of functions and responsibilities being transferred to GP consortia are vast. Although GPs have taken on aspects of commissioning functions previously through initiatives such as fundholding and PBC, the scale of their new tasks is of a different magnitude. One of the main areas in which GP consortia will need to concentrate their efforts is in reducing the resources that are spent on secondary care. PCTs have largely been unsuccessful in achieving substantial changes in such activity (Smith et al, 2010), but this will be vital if GPs are going to achieve the required efficiency savings. There may, therefore, be a gap for third sector providers in this agenda. Given the wide range of tasks that consortia will be charged with, there may be some scope for those third sector providers with experience in either particular geographical or client areas to take on responsibilities for delivering services within those areas. So, for example, providers may be contracted to take responsibility for those registered with a consortium that have Type II diabetes and are of South Asian ethnicity. This provider would treat these individuals in the local community and work to prevent them from being admitted to hospital. Given the extent of the reforms that are expected, and the short timescales in which these need to be delivered, it might be that consortia are looking for this very sort of arrangement in order to take responsibility for some of the areas where they will find themselves in need of assistance. Regardless of which scenarios play out at a local level, the implications of these reforms are that it will be crucial for third sector agencies to get in touch with GP consortia and explain to their members the type of roles that they can and do play in their local health economies.

Democratic voice and community engagement

Other than requiring GP consortia to be statutory bodies with 'accountable officers' (who will have responsibility to ensure that the new organisations 'continuously improve' and are 'proper' stewards of public money) ,the government is not at present recommending how the consortia should be structured (DH, 2011). This differs from PCTs, which are required to have a board that includes 'non-executive directors', and FTs, whose boards are accountable to local members and governors that include patient, community and staff representatives. The new consortia will be required to 'involve patients and the public in developing, considering and making decisions on proposals that would have a significant impact on service delivery and the range of services available' (DH, 2011: 7). This duty, combined with the flexibility of structure, potentially opens the door for a variety of mechanisms through which consortia engage with their local patients and communities. TSOs, with their strong roots in local communities and/or with groups to which the statutory sector traditionally find it hard to connect, could assist GP consortia to develop their engagement processes. For GP consortia this will provide potential gains from understanding and responding better to the health needs of different community groups and by legitimising decisions regarding service reconfiguration. For the TSOs concerned, this will ensure that the needs of their clients are considered by the consortia, which in turn may lead to commissioning of services to respond to these communities' needs.

Local democratic influence over the work of the consortia will be achieved through the continuation of the local authority scrutiny role (which will be extended to include health commissioners as well as providers) and through new health and well-being boards (HWBB) (DH, 2010b). Led by local authorities, these will have responsibility to ensure that commissioning and provision of services are integrated between health and social care,[3] to undertake a Joint Strategic Needs Assessment (JSNA) and to develop a Joint Health and Wellbeing Strategy (JHWS) to respond to the identified needs. Consortia are required to be members of the HWBBs and have regard to the JSNA (and corresponding strategy) when developing their commissioning plans. HWBBs cannot *direct* the consortia (or indeed social care commissioners) as the government has made it clear that they will not be 'approving' these plans. However, consortia will have to confirm (when they submit their commissioning plans to the national NHS Commissioning Board) whether their local board(s) agrees that the plan has 'adequate regard' to the JSNA and JHWS (DH, 2010b). The new HealthWatch groups will be members of HWBBs along with at least one elected member from the local authority and the director(s) of adult and children's services. There is no requirement for wider third sector involvement but it is likely that boards will want to engage the sector to gather information on local needs and consult on new models of service. It is therefore vital for the third sector to keep abreast of local developments regarding these boards, with Early Implementer sites starting in 2011/12.

Skills and capacity

Along with the personalisation programme in social care (Harlock, 2010), the changes in the health service are seeking to move the current system to a model in which the individual patient/service user has more choice over what is provided and who by (Dickinson and Glasby, 2010). Individual health budgets are being piloted, but in the short term the main approach is to enable patients to have the right to choose a provider from any sector (ie NHS, voluntary or private) who is licensed by the CQC to provide the necessary 'intervention', and for the provider to be paid according to a nationally set tariff. This system ('payment by results' – PBR) is already in place for elective surgery but will be extended to mental health, community health and diagnostic services and then subsequently to all NHS services (DH, 2010a).

For TSOs, this opens up the possibility of competing for work traditionally provided by the NHS, but will require a business model based on individual rather than grant-based funding and for which demand will be unpredictable. Sharing backroom functions with other TSOs may provide efficiencies in scale and also help to share the financial risk of fluctuations in demand. PBR also requires an information technology infrastructure, which may be difficult for smaller providers to introduce and implement in isolation. Partnerships with existing health providers from any sector may also be worth considering for TSOs that wish to deliver an element of a care pathway but do not have the expertise or clinical governance arrangements in place to provide a clinical intervention. For example, a pathway to support people with long-term conditions from minority ethnic communities may require an element of nursing and medical support alongside advice and support on health promotion, coping with

disability and managing the symptoms. A TSO not registered to provide nursing and medical services but able to work with the other issues could deliver the pathway in partnership with a local acute trust – this will play to each organisation's strengths and enable both partners to access new 'markets'.

Marketing to patients will be a vital component of any provider seeking to compete for this activity, and convincing GPs of the benefits of a not-for-profit provider is also likely to pay dividends (as GPs are the professionals who many patients will rely on for advice on the merits of different providers). While many GPs are comfortable with the private sector (as can be evidenced by a number of the pathfinder consortia developing close partnerships with consultancy firms), the concerns of many members of medical representative bodies such as the British Medical Association (Quinn, 2010) regarding the involvement of profit-making companies suggest that they will warm to the social value and reinvestment of surplus of the third sector. The Right to Request scheme, in which NHS staff could apply to 'spin out' services into social enterprises, will lead to up to 10% of community health services being delivered by social enterprises. This shows that NHS commissioners are willing to trust alternative providers, although this does vary between regions (Miller and Millar, 2011).

It is also worth noting the local authority role in commissioning public health services. The likelihood is that these will not be included in the national PBR schemes and local authorities will determine how this funding is best used. Some elements may be on an individual patient basis but there will also be broader health promotion programmes that will be commissioned on a community or locality basis.

Conclusions

If the reforms set out in the White Paper *Equity and excellence: Liberating the NHS* are fully implemented, then this will mean a great many changes for statutory and non-statutory bodies alike in the design and delivery of health services. Although there are few mentions of the third sector in the White Paper, it is clear that these reforms will result in several changes for the sector and it would not seem sensible to wait for full details of how these reforms will be implemented in practice. Whether providers or not, TSOs need to engage in discussions about how these reform processes will take shape in their locality. Given the lack of detail, the third sector may be able to influence how some of these reforms will play out in practice. One thing is for sure, GP consortia are being handed a massive task and one that they will not be able to undertake alone. Third sector organisations need to start making links with GPs and consortia to discuss their potential roles in future arrangements.

Notes

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[2] Following concerns from a number of key stakeholders, the coalition government announced on 7 April 2011 a 'pause' in the legislative progress of the Health and Social Care Bill to enable the government to 'listen' to the views of clinicians and patients. This process is expected to be completed by June 2011 and will be led by a panel of health

professionals. At time of writing, the government is indicating that the principles of the reform will remain and it is the detail about which they are consulting (Lansley, 2011).

[3] In England, the commissioning of social care services for adults and children is the responsibility of local authorities rather the NHS.

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