Executive summary

This response details the British Medical Association’s (BMA) position on the specific areas for reform contained in this consultation, building on the views set out in our response to the White Paper ‘Equity and excellence: Liberating the NHS’. We hope all these suggestions will be considered and used to develop the proposals in a way that ensures the maximum benefit for patients and the NHS.

The BMA is interested in exploring with the Government the proposals for GP led consortia, which see GPs as an integral part of the commissioning machinery within the NHS. Successful commissioning will only be achieved with GPs, secondary and tertiary care consultants and other clinical colleagues working together. Public Health consultants will also have a significant role to play, as will clinical academics. It is absolutely essential that all these expert clinicians play a central role in commissioning decisions and, as such, consortia must include consultants and other specialists into the decision-making process.

The concept of GPs leading many of the NHS’s commissioning decisions is not widely understood. Some patients may view GP-led commissioning with suspicion, particularly when their GP refers them for treatment from another GP provider. It will be essential to develop and implement a system that maintains patient trust and protects professional values. This system should be as transparent as possible and assure patients that their doctor is referring them to a particular provider purely because it will provide the best clinical outcome.

When commissioning national and regional specialised services, the NHS Commissioning Board should actively seek the assistance of appropriate secondary and tertiary care specialists and GPs from consortia. The Board will not be able to make informed decisions without involving them.

The BMA is not convinced that maternity services should be commissioned by the NHS Commissioning Board and believes it would be better for them to be commissioned at consortium level.

When commissioning low-volume services, it would be most appropriate for consortia to join together in regional consortia federations with a single lead consortium. The lead consortium would commission low-volume services on behalf of the group, while the member consortia would share the risks associated with these services by joining together.

Local Medical Committees (LMCs) should maintain their statutory role with respect to consortia and their relationship to constituent practices. They will be able to ensure that there are fair parameters with which consortia can judge practices and represent the interests of constituent practices regarding the assessment of their performance.

For the commissioning of specialist services it may be appropriate to establish a split in the commissioning functions of the consortia between the designing of a care pathway and the contracting and procurement of services that will fulfil that care pathway. This split would ensure that clinicians involved in commissioning decisions had no influence over the actual procurement of services and as such should help to avoid conflicts of interest.

The practicalities of the relationship between the NHS Commissioning Board and consortia will need to be considered. We are concerned that the gap between a national board and locally based consortia will be too great, and there is a risk that the Board could be too remote from individual consortia for the two to be able to liaise effectively. This will become even more of a concern if many small consortia are formed. It may be appropriate for the NHS Board to have local outposts of some kind, to liaise with consortia, provided this does not compromise efficiency savings gained through the abolition of Strategic Health Authorities (SHAs) and does not replicate the bureaucratic performance management functions of SHAs.
The continued emphasis on a market approach, despite the intention to increase choice and competition, leads to increased transaction costs in commissioning, reducing the resources available to spend on patient care. The BMA is critical of the direction of travel seen in the NHS in England in recent years and we remain opposed to the commercialisation and active promotion of a market approach in the NHS. We wish to see an NHS that is a public service working cooperatively for patients.

It is essential that any commissioning performance indicators are neither directly nor indirectly detrimental to the main focus of a GP's role, which is to prioritise the care of each individual patient. Indicators should be high-level and encourage long-term patient-centred goals rather than being financially driven. Targets should be few in number and avoid focussing on organisational elements which could increase the bureaucratic burden on practices.

The focus of a commissioning consortium will be to design effective care pathways which cross between GPs, local hospitals, local authorities and community services. The commissioning population will therefore depend primarily on the natural clinical community of the local hospitals and local health economy. By involving clinicians from secondary care and other healthcare professionals, safe and effective pathways for appropriate patient management can be developed.

However, the ‘any willing provider’ policy has the potential to undermine the development of these pathways if, as a consequence and in order to promote competition, multiple providers would have to be in place for each one.
Liberating the NHS: Commissioning for patients
BMA Response

1. Introduction

1.1 The BMA is an independent trade union and voluntary professional association, which represents doctors and medical students from all branches of medicine all over the UK. We have a membership of over 140,000 worldwide. We promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

1.2 It is important to highlight that, with devolution, healthcare policy has become increasingly divergent across the four nations of the UK, and the BMA’s response to the policies and priorities set by each administration will vary according to the particular national context. The NHS in England has already moved further towards competition and marketisation in health than the devolved nations, and is now significantly different from the service in the rest of the UK. This response has been written to reflect the position of the BMA solely in the terms of the implementation of proposals in the English NHS, and should not be seen as representing the BMA’s views more generally on the way forward for the NHS across the UK.

2. GP led commissioning

2.1 High-quality commissioning is essential to improve the standard of health services available to patients and to ensure the best possible use of limited NHS resources. The BMA strongly supports greater clinician involvement in the design and management of the health service. The BMA is interested in exploring with the Government the proposals for GP-led commissioning, which see GPs as an integral part of the commissioning machinery within the NHS. Successful commissioning will only be achieved with GPs, secondary and tertiary care consultants and other clinical colleagues working together. Public Health consultants will also have a significant role to play, as will clinical academics, not least because commissioning needs to take into account education, research and training requirements. It is absolutely essential that all these expert clinicians have a role in commissioning decisions.

2.2 The concept of GPs leading many of the NHS’s commissioning decisions is not widely understood. Patients and the public may initially find it difficult to understand, particularly if an increasing number of services are to be provided in a general practice setting. One of a GP’s primary roles is to act as a patient’s independent advocate, organising patient care based on the patient’s individual needs. It is possible that some patients may view GP-led commissioning with suspicion. As such, it will be essential to develop and implement a system that maintains patient trust and protects professional values. The system should be as transparent as possible and assure patients that their doctor is referring them to a particular provider purely because it will provide the best clinical outcome. Clear probity and scrutiny rules will need to be drawn up to provide assurance and patients will need to be informed about the way that commissioning works.

3. Responsibilities

Scope of GP led commissioning

- In what practical ways can the NHS Commissioning Board most effectively engage GP-led consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?

3.1 When commissioning national and regional specialised services, the NHS Commissioning Board should actively seek the assistance of appropriate tertiary and secondary care specialists and GPs from consortia. The Board will not be able to make informed decisions without involving local consortia: a mechanism is required to enable consortia to send representatives and specialists to the Board to facilitate locally relevant decision making. The Board should also encourage coordination between consortia across areas within a region to ensure that the commissioning of specialised services fits with the commissioning plans of
other consortia. This will be dependent on the geographical level at which regional commissioning takes place. It would also make financial sense to have such cross-consortia coordination. In addition to input from local consortia, service design and commissioning decisions must be informed by extensive input from local consultants from within the speciality and from other specialties that support the service. It is not logical to deprive the commissioning and service design process of specialist advice.

3.2 The BMA is not persuaded that maternity services should be commissioned by the NHS Commissioning Board but believes they should be commissioned at consortium level. Consortia, supported by consultant advice from the specialty and from those supporting it, will have an important role to play in ensuring appropriate standards and clinical quality in maternity care, as well as improving the local coordination of maternity services in a similar way to other patient demand-led services, such as out-of-hours care. A great deal of maternity care will continue to take place in surgeries, led by midwives and GPs. To commission maternity services as a separate national contract runs counter to the underlying principles of the White Paper to devolve commissioning responsibilities to be as close to the patient as possible.

• How can the NHS Commissioning Board and GP led consortia best work together to ensure effective commissioning of low volume services?

3.3 Unless a consortium was large enough to manage the risks of commissioning for low-volume services itself, we believe it would be most appropriate for consortia to join together in regional consortia federations with a single lead consortium. The lead consortium would commission low-volume services on behalf of the group, while the member consortia would share the risks associated with these services by joining together. It may be appropriate for the lead consortium of the federation to have some form of representation at the NHS Commissioning Board. It will be essential that the process of creating a lead consortium is carefully considered and democratic, to ensure larger consortia do not simply take control. Extensive consultant advice from within the specialty is essential if a well founded system is to be created.

3.4 An alternative to creating lead consortia could be a new organisation that acted on behalf of consortia, which could also host other regional functions. This could be similar to previous health authority or primary care group arrangements but with the GP-led consortia as the leading statutory body.

• Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP led consortia?

3.5 The BMA believes it is unlikely that all consortia would have the skills, expertise and experience to commission locally those services that are currently commissioned at a regional level. However, where a consortium includes individuals with the appropriate skills and experience it may be possible for it to take the lead on commissioning these types of services within a regional consortia federation group. This will be dependent on having meaningful relationships with local specialists and proper public health support in place. Much will also depend on the size of consortia.

3.6 We would stress that wherever a lead consortium commissions services on behalf of a region, it will be important that the individual consortia remained involved in the process.

• How can other primary care contractors most effectively be involved in commissioning services to which they refer patients, e.g. the role of primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?

3.7 As stated previously, for GP-led commissioning to be effective, there will need to be sensible collaboration with appropriate clinicians for the commissioning of all services. The development of the right clinical pathways is crucial. This must be driven locally by clinicians,
who must be able to develop services that best meet the needs of their patients. This could be done in a two stage process, where the broad principles of the service were set out initially by the commissioner and then the details developed in close cooperation with potential providers. We acknowledge the issues around conflicts of interest that are inherent in this approach, but believe it is important that commissioners are able to develop the right pathways, which they cannot do in isolation.

3.8 Some Primary Care Trusts (PCTs), practice-based commissioning (PBC) groups and Local Medical Committees (LMCs) have already engaged with Local Dental Committees and Local Ophthalmic Committees in the provision of certain community services. It would make sense for consortia to consult with these groups, as well as Local Pharmaceutical Committees, and offer representatives of these groups a role in the development of appropriate clinical pathways. It is important to note that patient groups should also have extensive input into the design of clinical pathways.

Relationship between consortia and individual GP practices

- How can GP-led consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?

3.9 It is unclear whether this question relates to the quality of care provided under General Medical Services (GMS) contracts or to the quality of wider commissioning activity. Where improvement in the quality of primary medical services is sought it may be sensible for this to be done across a group of consortia with a lead consortium if required, although low level performance issues could be dealt with on a peer-to-peer level within individual consortia. Comparison and analysis of robust and trusted data in small peer groups has been known to be effective in altering behaviour¹. This has allowed practices to examine how they work and ensure they are reaching a common standard.

3.10 The BMA would be opposed to consortia having a role in setting local Quality and Outcomes Framework-style targets, as we have been in relation to PCTs². These must be set by nationally representative organisations.

3.11 For consortia to have a role in improving practice performance, they will require the right leadership, governance and culture, to endow the constituent practices with a sense of professionalism, ownership and peer involvement. To facilitate this, it is important that there is a statutory role for LMCs with respect to consortia and their relationship to constituent practices. LMCs will be able to ensure that there are fair parameters with which consortia can judge practices, to represent the interests of constituent practices regarding the assessment of their performance and help prevent the replication of the PCT patronage that currently exists in some areas.

3.12 Viewing this question in the wider sense, consortia commissioning budgets will have an effect on all constituent practices, which will need to remain aware of and vigilant about the resources available. Should the consortia commissioning budget begin to run down, the prescribing and referral activity of all practices would be affected equally and early agreed steps would need to be taken to prevent any deterioration in the financial situation of the consortium. However, we would oppose any suggestion that practice Personal Medical Services (PMS) or GMS budgets be linked to the over- or under-spends of commissioning budgets and penalised accordingly. This would place an unacceptable strain on the doctor-patient relationship and would raise serious issues of probity and ethics. This point is even more acute in a time of financial pressure, as there will be a considerable emphasis on the provision of cost-effective high quality care, and any improvements in the quality of commissioning and patient care will have to operate within a limited funding envelope. It will


be very important to consider how commissioning budgets will be set and agreed, and between whom.

- What arrangements will support the most effective relationship between the NHS Commissioning Board and GP-led consortia in relation to monitoring and managing primary care performance?

3.13 Again, it is not clear whether this question refers to the management of GMS/PMS contracts or the management of commissioning performance.

3.14 Regarding the management of primary medical services contracts, it is possible to see that in the future, consortia will adopt a role and set of responsibilities similar to that of PCTs at present, possibly by developing a position for a lead consortium or primary care group-type organisation locally. We would have significant concerns over the conflicts of interest that would arise from such a situation. Consortia should focus on managing the commissioning of secondary and community services. The management of practice contracts should be achieved through existing methods such as the Quality and Outcomes Framework (QOF), practice accreditation, quality accounts and contract mechanisms. We would not support NHS Commissioning Board targets, nor balanced scorecards for practices held at the Board level.

3.15 As highlighted previously, it will be essential that the leadership, governance and culture of consortia are developed in the right way, if they are to play a role in managing practice based commissioning performance. Commissioning performance reviews should be peer-led, with the processes owned by every practice in the consortium, as opposed to consortium-imposed processes.

3.16 Practices that are initially unwilling to engage with a consortium, to avoid excessive prescribing or referrals, should be addressed in a staged approach. This should involve peer review, analysis of variation and support from the PCT while it exists, then passing to the consortium, to change behaviour, leading to the use of an arrangement similar to Annex 8 of the GMS contract\(^3\) for excessive or inappropriate prescribing.

3.17 As well as tackling concerns at the practice level, consideration should be given to addressing individual practitioner performance issues. Commissioning performance reviews should not focus on short-term costs, but on the long-term quality and cost-effectiveness of commissioning decisions.

3.18 Throughout this process, the LMC should have a central role in ensuring that the interests of practices are represented and that practices are judged against fair commissioning parameters.

- What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?

3.19 The BMA wholly recognises the responsibility of clinicians to not abuse their dual role as commissioners and providers. The commissioning process will require appropriate clinical and corporate governance structures and there must be a proper audit process of the commissioning decisions that are made. Clinicians involved in the commissioning process should declare any conflicts of interest and remove themselves from the process where this occurs. The General Medical Council (GMC) has produced guidance\(^4\) on probity and declaring a financial interest that should be revised to account for the changes in commissioning structures. For example, Good Medical Practice, published in 2006, states that:


“5. If you have a financial interest in an institution and are working under an NHS or employers’ policy, you should satisfy yourself, or seek assurances from your employing or contracting body, that systems are in place to ensure transparency and to avoid, or minimise the effects of, conflicts of interest. You must follow the procedures governing the schemes.”

“75. If you have financial or commercial interests in organisations providing healthcare or in pharmaceutical or other biomedical companies, these interests must not affect the way you prescribe for, treat or refer patients.”

“76. If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the healthcare purchaser.”

3.20 The principles behind these statements are valid, but now need to reflect a context where GPs may be involved in commissioning decisions where they have a financial or commercial interest. Guidance will need to be updated to reflect the new arrangements.

3.21 For the commissioning of specialist services (those which not all practices will be able to offer and where a formal procurement process will be necessary), it may be appropriate to establish a split in the commissioning functions of the consortium between the designing of a care pathway and the contracting and procurement of services that will fulfil that care pathway. The design of the care pathway would naturally be clinician-led, including those in secondary care and academia. However, the procurement function could be carried out by appropriately skilled and experienced managers employed or engaged by consortia, such as former PCT or Trust managers, or external experts with capability in this field. They would procure the service from the most appropriate provider with no bias towards (or against) any members of the consortium who were also potential providers. This split would ensure that clinicians involved in commissioning decisions had no influence over the actual procurement of services and as such would help to avoid conflicts of interest.

3.22 It may be appropriate to establish a final independent arbiter to ensure that the probity of clinicians involved in the commissioning process had been maintained. This could be a function of the NHS Commissioning Board or possibly the Competition and Cooperation Panel.

3.23 Consortia must be allowed to commission local enhanced services (LESs) or equivalent from their constituent practices, otherwise the redesign of local services based on patient needs will be very difficult. Consortia also need to be able to resource all practices, which can in turn expand their practice staff accordingly, to deal with additional work that migrates from hospitals.

3.24 In general, most LESs are available to all practices in an area. A situation could arise in which several providers within a consortium wish to offer these services. This could be problematic for consortia as the provision of services would become less affordable as more activity was undertaken. Consortia will need to take into account the difference between work that can only be done with a registered practice list (for example, work that is closely related to essential primary medical services), and work that can be done by any provider to the same standard (for example, services moved from the hospital into the community). It will also be important to take into account duplication of services, geography and access to services across a whole health economy.

3.25 For the majority of LESs, the registered practice will be the preferred provider for their patients. As such, it is entirely appropriate for practice resources to increase, as a result of transferring work from secondary to primary care, in circumstances where the service can be delivered more quickly, conveniently, cheaply and to the same or higher standard than elsewhere.
3.26 Including information about all services provided by practices and other providers in leaflets and websites and on NHS Choices will help enable patients to make more informed decisions.

The role of the NHS Commissioning Board

- How can the NHS Commissioning Board develop effective relationships with GP-led consortia, so that the national framework of quality standards, model contracts, tariffs and commissioning networks best supports local commissioning?

3.27 The practicalities of the relationship between the NHS Commissioning Board and consortia will need to be considered – such a relationship must be robust. We are concerned that the gap between a national board and locally based consortia will be too great, and there is a risk that the Board could be too remote from individual consortia for the two to be able to liaise effectively. This will become even more of a concern if many small consortia are formed. It may be appropriate for the NHS Board to have local outposts of some kind, to liaise with consortia, provided this does not compromise efficiency savings gained through the abolition of SHAs and does not replicate the bureaucratic performance management functions of SHAs.

3.28 The BMA would also stress the importance of engagement between the NHS Commissioning Board and the BMA’s representatives for doctors in different practices. In particular, we would like to see the current relationship between the General Practitioners Committee and the NHS Employers primary care contracting team mirrored in their relationship with the Board, given that, in future, the Board will hold all primary medical services contracts. This would allow for formal negotiations and give confidence to the profession and commissioners that their national representative body could voice their opinions. There will also need to be engagement between LMCs and consortia or lead consortia on a regional level. It is inevitable that there will also be other national and regional networks and meetings. However, these must be more open and accountable than some of the equivalent networks at present.

3.29 The NHS Commissioning Board, while holding consortia to account, should also have a supportive role in helping local consortia commission effectively and in developing ways of enabling wider collaboration between consortia, particularly when commissioning low volume or regional specialised services. Training events for commissioners should be held on a regional and national basis, as appropriate.

- Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?

3.30 To support effective commissioning, the Board should act as a repository of information and guidance about best practice in commissioning. We would welcome the opportunity to develop some joint guidance to help the Board fulfil this role. The Board should also provide a forum for consortia to share their ideas and experiences with each other.

3.31 As suggested previously, the Board could act as an independent arbitrator when there is conflict between consortia and their constituent practices, and support consortia when dealing with conflicts between consortia and providers. This should be supportive, rather than punitive. Furthermore, a national independent dispute resolution body will be needed, which commands the confidence of the profession, to resolve local disagreements between practices and consortia.

3.32 We would also stress that the Board must be the body that undertakes national contract negotiations with the profession, as it will hold all primary medical services contracts. We would vigorously oppose any move towards local negotiations of the terms and conditions of national GMS contracts.

3.33 The Board should review local commissioning practices to ensure that consortia commissioned services are provided at an appropriate and equitable level across a region.
4. Establishment of GP led consortia

Organisational form

• What features should be considered essential for the governance of GP-led consortia?

4.1 Before it is possible to determine what governance arrangements should be in place for GP-led consortia, it is necessary to know what will be legally required of them, based on their budgets and the expectations placed upon them. Form must follow function. We would, however, recommend at this stage that governance arrangements should be light-touch, but also protect consortia from legal liability. It is important to recognise that consortia cannot be expected to have the same complex governance arrangements as PCTs when operating with a fraction of their governance budget.

4.2 What is clear is that the opportunity for GPs and other healthcare professionals to commission NHS services in consortia comes with great accountability and responsibility. The accountable officer(s) within consortia should be those that lead the group. Depending on the legal requirements of consortia, potential governance features may include:

- Patient and carer feedback and involvement in the commissioning process;
- Commissioning that parallels local needs and priorities;
- Publicly reporting spend against budgets and health outcomes;
- Having due regard to National Institute for Health and Clinical Excellence guidelines;
- Public declaration of conflicts of interests of any commissioners and providers; and
- Publication of annual quality accounts (once these have been piloted and evaluated for primary and secondary care) identifying commissioning successes and areas for improvement.

4.3 The relationship between a consortium and its members will need careful thought. If a consortium’s leadership is to be truly effective, it is vital that the consortium has not just a formal mandate from its members, but that its leaders have the respect of the consortium’s members. We would not want to see a situation where initial enthusiasts take on leadership roles almost by default, by virtue of being first movers.

4.4 Electing the leaders of consortia carries the risk that those elected may be more popular than competent. Conversely, simply appointing consortia leaders carries the risk that those appointed may be competent but lacking the respect of consortia members. One potential way of addressing this problem would be to recommend that consortia elect a Board of Appointment that is empowered to appoint to key positions within the consortia, such as accountable officers or finance officers, competitively. Alternatively, a consortium could recruit and appoint its leaders, subject to ratification by referendum of its members. Irrespective of the method of appointment it is essential that leaders of consortia retain a close association with the realities of clinical practice in primary care: to abandon this is to lose a key virtue of primary care led commissioning. Leaders and officers of consortia should all remain practicing clinicians.

4.5 It will also be important that consortia are seen to have integrity and are trusted by patients and the public.

Forming consortia

• How far should GP-led consortia have flexibility to include some practices that are not part of a geographically discrete area?

4.6 The focus of consortia will be to design effective care pathways which cross between GPs, local hospitals, local authorities and community services. The consortium commissioning population will depend on the natural clinical community of the local hospitals and local health economy, but should also be sensitive to social communities. Unusual urban boundaries and local transport problems can create groups of patients more likely to seek healthcare in an area other than that in which they live. Dispersed rural populations must
also be considered. The commissioning population must thus reflect the natural health community of the locality, both clinical and social.

4.7 Taking this into account, it does not make sense for a consortium to include a practice that is not geographically part of a discrete area or natural health community within the locality. However, practices on the boundaries between consortia should be able to decide which consortium they join. The public health function of the local authority would need to be aware of this, but should not be able to veto it.

4.8 It is critical that consortia do not undertake adverse selection to pick the ‘best’ practices and exclude practices that have naturally high referral costs because the consortium fears that the performance of these practices will damage its overall performance on paper.

4.9 It is also important to note that free choice of practice registration for patients would create immense difficulties for consortia where they are required to make commissioning decisions for a defined geographic population or natural clinical community. The BMA is opposed to the proposal to remove practice boundaries, details of which can be found in our response to the Department of Health consultation “Your choice of GP practice”.

5. Should there be a minimum and/or maximum population size for GP led consortia?

4.10 We anticipate that the majority of consortia will have a population of between 100,000 and 750,000 patients but there should be no ‘one size fits all’ solution. We do not wish to see a specified maximum or minimum size for each consortium. Consortia should be of a sufficient size to be able to deliver the core functions currently undertaken by PCTs but also to maintain their local identity. Small consortia could find it very difficult to commission successfully from the larger foundation trusts and commercial providers, while there will likely be a scarcity of clinical leaders and experienced managers of sufficient calibre to run small consortia effectively. Moreover, NHS financial pressures, the need to reduce management costs through economies of scale, greater exposure to risk and the requirement to set meaningful budgets for commissioning services across a population all mean that consortia will find it very difficult to undertake their commissioning functions effectively if their populations are too small.

5. Freedoms, controls and accountabilities

Freedoms

• How can GP led consortia best be supported in developing their own capacity and capability in commissioning?

5.1 The NHS Commissioning Board will need to make clear its expectations of consortia so they know exactly what will be required of them. Consortia should use existing expertise and experience where it is available, for example from PCT managers, SHA leaders, GP leaders, public health specialists and secondary care clinicians. Consortia will certainly require legal, financial and human resources assistance in setting up robust structures, which should come in the form of national guidance. The BMA would welcome the opportunity to play a leading role in developing this guidance. Consideration will need to be given to the most appropriate media through which to provide consortia with the high quality information and support they will need.

• What support will GP led consortia need to access and evaluate external providers of commissioning support?

5.2 Consortia will require support from those who already have direct experience of doing this, namely existing NHS staff. However, consortia should not rely on external providers of commissioning support to facilitate the commissioning process. Consortia need to develop a

local infrastructure of personnel who are accountable within the commissioning process. This should consist of current PCT, SHA and public health staff who have local knowledge, experience, and appropriate expertise and skills. Consortia should only turn to external providers if they are unable to gain the commissioning support they need from the expertise that is currently within the NHS, and the services offered are affordable.

5.3 As a separate exercise, it might be useful to look at models of clinical leadership and professional collaboration within provider organisations that contract exclusively with each other.

Managing financial risk

- Are these the right criteria for an effective system of financial risk management? What support will GP-led consortia need to help them manage risk?

5.4 Risk management must enable consortia to pool commissioning risk. The smaller consortia will naturally face the greatest risks. The current proposals seem to differ little from existing arrangements in PCTs. There appears to be no incentive not to spend any remaining funds at the end of the financial year, on items or short-term projects that are of little long-term benefit, as there remains a risk that unspent money will not be carried over into the next year.

5.5 Consortia must have the opportunity to balance their budgets over a longer time frame than a single year, especially in the initial years. Commercial providers within the NHS market invariably make financial plans over a three or five year period. If consortia were to be judged on annual balances this would force short-term behaviours and prevent consortia delivering long-term projects, such as the infrastructure required to move services from secondary to primary care. For example, the provision of effective services for long term conditions will involve long-term planning – in some instances it can be many years before the full effects are known. Consortia should also be supported in making budget overspends during the course of the financial cycle, provided a proper business plan was in place and the investment would lead to long-term savings. Consortia and lead consortia would need experienced financial managers to assist them in this process. Adopting the primary care group model suggested previously could be beneficial in this area.

5.6 The risk management of the commissioning budget and the setting of the commissioning budget are closely linked. Consortia must have budgets that are appropriate for their commissioning populations. This does not mean a ‘fair share’ budget that is proportional to the commissioning group’s needs. Historic NHS funding is entrenched in local health economies and any sudden move away from this would destabilise health systems that are vulnerable to small shifts in funding. The previous Government had implicitly recognised this difficulty by slowing the move from historic indicative Practice Based Commissioning budgets to ‘fair share’ indicative PBC budgets, which were supposed to reflect more fairly the health needs of a locality.

5.7 Developing a commissioning budget that realistically reflects the existing and likely health needs of a local population and enables consortia to commission all of their patients’ care will be very difficult, and commissioning budgets should move towards this goal slowly. Any budget formula must be highly sensitive, or consortia could be held responsible for overspends which have more to do with an inadequate budget than ineffective commissioning. It will also require accurate and timely data and analysis, including information on expenditure, referrals, prescribing and clinical performance across secondary and community care. It is the BMA’s view that the provision of such information to practice based commissioners by PCTs in the past has been poor. Consortia will only be able to commission effectively when the relevant information is to hand. Budgets should be agreed

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by consortia and a dispute process put in place in the event that the budget cannot be agreed.

5.8 There should be no expectation that an effective commissioning process will generate surplus resources on a regular basis. Although services must be commissioned with reference to available NHS resources, patient demand can vary year-on-year and an expectation of budget surplus is unrealistic.

**Transparency and fairness in investment decisions**

- What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

5.9 It is the responsibility of doctors to act with transparency and fairness when making commissioning decisions. The points raised previously regarding probity, conflicts of interest and audit decision trails all apply in this instance. As suggested, establishing a split within the consortium between the design of a care pathway (led by clinicians) and the procurement of services to fulfil that pathway (led by procurement experts) would ensure that clinicians had no influence over the actual procurement of services that they had decided should be commissioned. As such, they would avoid conflicts of interest in commissioning.

5.10 We believe there should be explicit transparency and openness in commissioning decisions. Details of commissioning decisions should be published alongside details of organisations tendering for a service and the winning bidder. This could include information such as the named directors of provider organisations. We believe this information should be routinely publicly available rather than being available only via a request under the Freedom of Information Act.

5.11 Fair commissioning will also be demonstrated by the outcomes achieved and evaluation of the commissioned service.

5.12 It should also be noted that the market approach, intended to increase choice and competition, will require openness but will also lead to increased transaction costs in commissioning, reducing the resources available to spend on patient care. The BMA is critical of the direction of travel seen in the NHS in England in recent years, which is continued by the proposals set out in the White Paper and this consultation. We remain opposed to the commercialisation and active promotion of a market approach in the NHS and wish to see an NHS that is a public service working cooperatively for patients.²

**Accountability to patients and the public**

- What are the key elements that you would expect to see reflected in a commissioning outcomes framework?

5.13 We believe it is essential that any commissioning performance indicators are neither directly nor indirectly detrimental to the main focus of a clinician’s role, which is to prioritise the care of each individual patient. Indicators should be high-level and encourage long-term patient-centred goals rather than being financially driven. Targets should be few in number and avoid focussing on organisational elements which could increase the bureaucratic burden on practices. It should be remembered that process remains a vital proxy for outcomes and that there is always a temporal delay between adherence to processes and the firm proof of a successful outcome. The assessment of outcomes over a period of less than a year would be meaningless, while some commissioning changes will take several years to demonstrate.

- Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?

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5.14 The BMA would not support the linking of practice income to outcomes. We believe this would cause serious and irreparable damage to the doctor/patient relationship, fundamentally destroying the GPs' prime role as advocate for the individual patient and their professional duty to have the care of the patient as their prime concern. Many GPs would be deeply unhappy with the creation of such a link and it is possible some would refuse to engage meaningfully with the initiative as a consequence. It is also likely that a link would result in frequent legal disputes between practices. Where practice income is generated from the provision of specialist services, commissioned by their own or other commissioning consortia, it is entirely appropriate to link outcomes to practice income.

- What arrangements will best ensure that GP-led consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

5.15 If performance indicators are perceived to be unachievable by GPs in areas of higher inequality, they will not engage with the framework and inequalities will widen. It is important that practices perceive the indicators to be achievable and that the importance of process is not forgotten amid the focus on outcomes. Indicators should also be mapped across socio-economic classification groups. The indicators should not form a new layer of bureaucracy, taking more time away from clinicians wishing to deliver patient care. The NHS Commissioning Board could play a role in ensuring the balance is restored and maintained in areas where disparity has occurred in the past, such as commissioning of mental health services, which varies significantly across England.

5.16 GP-led consortia and LMCs should have a formal, statutory role in local primary care commissioning decisions. Consortia, practice outcome measures and funding should be based on improvements rather than absolute measures, along with continued funding of the QOF process, meaning that consortia and practices would be incentivised to reduce inequality and the money would follow not just the patient, but the patient's needs.

5.17 Increasing links between practices and public health doctors, along with clinical academics working in the field, would also undoubtedly be beneficial in promoting equality and reducing inequalities in health, along with greater public engagement both locally and nationally.

5.18 Given the current financial constraints and the likelihood that resources are not going to increase in real terms, we would urge the Government to take care not to increase public expectations of the NHS unrealistically. An increase in demand for services will come at the expense of those with the highest levels of need.

5.19 It will be important that consortia leadership is properly representative of the local health economy, to ensure that the needs and views of all sections of the population and healthcare providers are included in the decision-making process. We would urge that this needs to be explicit in consortia governance arrangements.

6. Partnership

Patients and the public

- How can GP-led consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?

6.1 The National Association for Patient Participation (NAPP) is currently mapping Patient Participation Groups, so this work could feed into the NHS Commissioning Board.

6.2 Only where piloting and evaluation shows them to be beneficial to patient care, appropriate Patient Reported Outcome Measures (PROMs) could be built into contracts and published on the NHS Choices website. Where services are commissioned from primary care providers these services should be required to undertake PROMs review in the same way as the services of other providers. Patients should be able to observe consortia meetings and have an opportunity to submit their views and ask questions, while Patient Participation
Groups should be encouraged at a practice level. It could be that each consortium is required to appoint a patient representative, to ensure the patient voice is at the core of the developing consortia model. It will also be important for consortia to actively engage with carers’ groups.

6.3 It should be remembered that large scale public involvement may require resources that consortia do not have access to. Patient expectations need to match resources.

- How can GP-led consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?

6.4 It will be necessary for a formal process to be developed to enable consortia to consider the views of all relevant stakeholders and the public in relation to significant commissioning decisions. Partnership with local authorities will be vital to enabling this process in some areas, such as mental health, children’s services and geriatrics. However, it is unlikely that consortia will have the time or resources to match the level of work carried out by PCTs in this area, so it will be important to be realistic about what consortia will be able to achieve.

- How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices’ Patient Participation Groups?

6.5 Resources within the GP contract could be associated with the creation, support and running of Patient Participation Groups, with contractual requirements put in place to ensure that GPs engage with patients and take their views into consideration when making decisions. A more focussed financial commitment from the NHS to patient participation would ensure wider uptake than is seen currently.

- What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they (the proposals) can promote equality of opportunity and outcome for all patients and, where appropriate, staff?

6.6 The BMA is concerned that NHS staff could be disadvantaged if they do not have full access to the NHS pension scheme and national terms and conditions under the new proposals. It is essential that all NHS staff are treated equitably and we would vigorously oppose any move towards local terms and conditions for NHS staff.

6.7 The emphasis on ‘choice’ within the proposals continues to risk reducing equality of opportunity as it requires a level of engagement that many patients are not able or willing to undertake. If there is not equal engagement with ‘choice’ across the socio-economic scale then it is likely that it will lead to increased inequality.

Local government and public health

- How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?

6.8 Links between consortia and local authorities will be most effective where consortia are at least the size of a local authority. We believe it would be particularly difficult for smaller organisations with fewer resources to establish and maintain strong links. If there are to be smaller organisations, we would urge the Government to acknowledge that it is unlikely that local links will be stronger than under the previous system.

6.9 An increased emphasis on close working with public health colleagues and social services staff would be beneficial, linking them not just through GP-led consortia but also to individual practices. It could be beneficial for every GP practice to have a named public health consultant for liaison as well as named and attached social workers. If, as a result of the proposals, practices merge and become much larger, it would become more feasible for practices to have an attached social worker, bearing in mind inevitable changes in social
work personnel over time and the fact that social workers work within their own specialisms, such as child care or mental health.

- Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts, Children’s Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to new arrangements?

6.10 It may be that there are examples of practices working well in conjunction with named social workers. These would be a valuable model for future best practice. However, it is our view that clear examples of best practice in relation to joint-working are not readily apparent and there is much still to be done to improve practice in this area. It will be challenging to do so with a significantly reduced budget.

Other health and care professionals

- How can multi-professional involvement in commissioning most effectively be promoted and sustained?

6.11 We believe that collaboration rather than competition should be the focus if effective multi-professional involvement in commissioning is truly the goal. Collaboration favours the development of integrated services across service boundaries that are designed around the requirements of service users. The result of increased competition in the NHS is increased fragmentation of services and it is likely that competition within and between professional groups could lead to a reduction in the involvement of allied health professionals in consortia.

6.12 However, despite the intrinsically fragmentary nature of the proposals, consortia will have to develop local systems and work closely with colleagues from secondary care and public health, as well as others such as medical academics and social care professionals, to enable evidence-based, integrated decision-making and ensure integrated care pathways are in place. This will help to promote multi-professional inclusivity and support and build confidence among healthcare professionals in the decisions of GP-led consortia. Consortia will need to design mechanisms to resolve any conflicts that might develop along professional lines in the course of multi-professional working.

6.13 Commissioning is a sophisticated process and is not just about price. Local consultants will have a valuable input into commissioning decisions and ensuring commissioning plans are clinically relevant. Advice about new technologies and service developments will be critical in helping service planning for the future, as will research evidence and knowledge of clinical effectiveness and capacity planning. In areas where there is significant research activity spanning primary and secondary care, it will also be particularly important to seek advice from clinical academics on ensuring commissioning plans incorporate appropriate safeguards to protect, and, if possible, enhance, clinical research activity\(^8\). Similarly, public health consultants are specialists in critically appraising the evidence base, in translating evidence into protocols and pathways, in comparing the effectiveness of groups of treatments and in prioritising treatments within and across care pathways and as such they will play an essential role in assisting commissioners in reaching objective, defensible and sustainable commissioning decisions.

6.14 There should be continued public health input into commissioning and reciprocally, continued GP input into public health strategies\(^9\). We believe it is vital that public health is embedded in the commissioning process and not seen as a last minute addition.

6.15 The focus of a commissioning consortium will be to design effective care pathways which cross between GPs, local hospitals, local authorities and community services. The commissioning population will therefore depend primarily on the natural clinical community of the local hospitals and local health economy. Where a consortium overlaps with more

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\(^8\) Consultant involvement in commissioning. Op cit.

\(^9\) Annual Representative Meeting. BMA, 2010. Emergency Motion 2
than one hospital and potentially other groups, these will have to work together to coordinate their efforts and possibly appoint a lead commissioner as PCTs do at present. By involving clinicians from secondary care, safe and effective pathways for appropriate patient management can be developed.

6.16 The ‘any willing provider’ policy has the potential to undermine the development of these pathways if it means that, in order to promote competition, multiple providers would have to be in place for each one. If this multiplicity of potential providers is indeed the intention, it would be impossible to achieve the goal of integrated pathways. This would also be inefficient, as each pathway would need to have multiple providers in place, despite the fact that they would definitely not be awarded the work.

6.17 It will be important that all those involved in commissioning decisions declare any conflicts of interest, to help ensure transparency and confidence in consortia. Consortia will be looking to involve clinicians from provider units in commissioning decisions, to utilise their expertise and create integrated pathways. This could create a conflict of interest for these clinicians who will be competing for the work.

7. Direction of travel in the NHS in England

7.1 The BMA is critical of the direction of travel seen in the NHS in England in recent years, which is continued by the proposals set out in the White Paper and supplementary consultations. This response should be viewed in the context of our continuing opposition to the commercialisation and active promotion of a market approach in the NHS. We wish to see the NHS restored as a public service working cooperatively for patients. We are committed to an NHS that:

1. Provides high quality, comprehensive healthcare for all, free at the point of use.
2. Is publicly funded through central taxes, publicly provided and publicly accountable.
3. Significantly reduces commercial involvement.
4. Uses public money for quality healthcare, not profits for shareholders.
5. Cares for patients through cooperation, not competition.
6. Is led by medical professionals working in partnership with patients and the public.
7. Seeks value for money but puts the care of patients before financial targets.
8. Is fully committed to training future generations of medical professionals.

7.2 Further, although the proposals in the consultations apply to doctors working in the NHS in England, we are aware of the concerns of doctors working in the devolved nations that they could yet have an adverse, knock-on effect in their countries.

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