

NHS reforms in England: managing the transition

Policy response

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This Nuffield Trust policy response assesses the 2011/12 Operating Framework for the NHS (Department of Health 2010b), together with guidance on the operation of Payment by Results (PbR) in 2011/12 (Department of Health 2011). It sets out the key challenges associated with managing the transition to a reformed NHS, as envisaged in the White Paper *Equity and Excellence: Liberating the NHS* (Department of Health 2010a) and proposes ways in which the risks associated with transition might be mitigated.

Key points

- The period from 2011 to 2014 is likely to be the most challenging ever faced by the NHS. PCTs are required to hold 2 per cent of their allocations with SHAs. Allowing for this, the recurrent resources available to PCTs to spend in 2011/12 fall by 2.3 per cent on average in real terms, with a minimum cut of 0.3 per cent and some PCTs facing a reduction of 2.5 per cent. Providers face the challenge of making a 4 per cent overall efficiency saving at the same time as they experience a 1.5 per cent cut to the tariff by which they are paid.
- There needs to be early development of clear guidance on the governance and structural arrangements for emerging GP consortia; this will ensure adequate local and national accountability for quality, financial control and value for money.
- The role of PCT clusters will be critical and extensive. If they are to retain staff and effectiveness they will need support, more clarity as to their priorities, and assurance of a future beyond 2013.
- There is little explicit advice in the Operating Framework about the biggest challenge: how to handle essential reconfiguration of services more effectively than in the past, in particular with regard to hospitals. This needs to be made much more explicit, so that PCT clusters and shadow GP consortia can be adequately supported.
- Integrated performance measures for PCT clusters and GP consortia should be extended to include indicators of the quality and efficiency of primary care. Primary care comprised 20 per cent of the health care purchased by PCTs in 2009/10.
- There are significant risks associated with extending Payment by Results (PbR) to mental health services and a phased approach would be more appropriate.
- The quality and efficiency of non-PbR activity in providers should be heavily scrutinised and challenged under the QIPP programme, given the recent significant inflation of non-PbR prices for providers.



Overview

The 2011/12 Operating Framework for the NHS seeks to fulfil three priorities (Department of Health 2010b, p14):

- to maintain and improve the quality of services, building on success to date
- to retain financial control and meet the quality and productivity challenge
- to make progress on the transition of the NHS to the new White Paper arrangements.

In this summary, these three priorities are used as the basis for identifying the challenges associated with implementation of the Operating Framework and PbR guidance, and the ways in which these challenges might be addressed within the reform process.

Priority one: maintaining and improving the quality of services

The role of PCT clusters

The challenge of maintaining and improving the quality of services is set out in the Operating Framework and falls to new primary care trust (PCT) clusters, at first on behalf of, but quickly in partnership with, GP consortia. From April 2013, GP commissioners will be free-standing commissioners, but there is a hint in the Operating Framework that PCT clusters may be retained by the NHS Commissioning Board (NHSCB) as a form of local outpost and development agency for consortia. The cluster approach makes sense as a way of assuring some security against major local failings of the health system during a period of major reorganisation. These PCT clusters are at the heart of the interim management plans for the NHS in 2011/12, and have a programme of work that is extensive. In line with the views of the Health Select Committee (Health Committee 2011) we suggest that clusters are set up as quickly as possible to enable them to focus on the development of consortia, and the management of health commissioning in this interim period.

Business as usual and strategic development

Some of the service priorities for PCT clusters set out in the Operating Framework are concerned with maintaining 'business as usual' (for instance achieving QIPP (Quality, Innovation, Productivity and Prevention) targets, ensuring that providers meet referral to treatment times and health care-acquired infection standards, and eliminating mixed-sex accommodation). Others, including dementia services, development of family nurse partnerships, expansion of health visiting, improved services for people with autism, extending cancer screening and implementing the Cancer Drugs Fund, represent significant service improvement challenges. One of the most significant challenges for PCT clusters in 2011/12 is the implementation of patient choice of consultant-led team for outpatient appointments. Furthermore, choice is to be extended in some mental health services, some diagnostic care, and within personalised care planning for people with long-term conditions.

These are major cultural and service changes for the NHS. Whether PCT clusters will have the capacity and capability to work with providers to enact such developments at a time of major transition and turmoil is questionable. There is a real danger that the 'business as usual' maintenance of the systems will be neglected if the programme is too ambitious. We suggest that there is a need for an order of priority to be given to the vast number of 'must-dos' ascribed to PCT clusters.

The challenge of being a transition body

To expect newly forming organisations (being created from the rapid dissolution of 150 PCTs) to engage in anything more than effective management of the transition itself is highly ambitious. Indeed, business as usual in an NHS charged with making unprecedented 4 per cent annual efficiency savings is a mammoth task. PCT clusters with a lifespan of two years are unlikely to have the capability or credibility to lead major service development, and can be expected to focus on ensuring that basic governance, contracting and other management tasks are fulfilled. We therefore suggest that PCT clusters as organisations are given some assurance of their future beyond two years, in order to provide a strong local presence for performance management, primary care contracting, and quality monitoring during a period of major organisational change, and ensure that the best management talent is both attracted to and retained within such clusters.

Performance management during transition

The scale of tasks allocated to PCT clusters is understandable, given the ambition of the government to maintain and improve service quality. However, there is a need for clarity as to what body will assume overall responsibility for assessing the performance (with respect to managing finances and the quality of services provided) of providers and of emerging GP consortia, during the period of transition. The Operating Framework asserts (p. 31):

“ In this time of change, the NHS needs to keep a forensic focus on maintaining and improving quality including patient safety, particularly in relation to older people. Delivery of the priorities in this NHS Operating Framework needs to be achieved alongside the core delivery and safety of services.

It appears this task will fall to SHAs until April 2012, and then to the new NHSCB thereafter, and the National Quality Board is cited as another key player. However, other organisations will also have a role to play in this area: a Provider Development Agency (for those NHS trusts as yet unable to gain foundation trust status), Monitor (becoming the economic regulator as it merges with the Cooperation and Competition Panel), the Care Quality Commission (CQC), PCT clusters, emerging Local Health and Wellbeing Boards within local government, Overview and Scrutiny Committees and a shadow form of the NHSCB. In this period of major organisational transition for the NHS, there is a need for extremely clear lines of performance management and accountability for NHS providers (primary, community health and secondary care). These lines need to be made explicit to the NHS and to the public.

We note that although the Government has outlined an ambitious approach to an outcomes-based framework for judging performance, it will be some time before this system is developed adequately. We welcome the proposal in the Operating Framework to have a basic set of integrated performance measures for the NHS during the time of transition, this being a basis for in-the-round performance assessment of the NHS by SHAs (and then the NHSCB), enacted through PCT clusters.

We note that for many of the indicators, there is still some way to go before they can be built into operational tools where good and bad performance are unambiguous. Even with a sound selection of measurable outcomes, there will still be a need to use process measures of performance and we support their continued use. We also believe it is important to establish ways to link with the intelligence being used by CQC in judging risks within a local health economy.

It is of concern that the high-level set of indicators suggested in the Operating Framework includes few indicators that relate to general practice and primary care (apart from access to NHS dentistry, screening for some diseases and NHS health checks). This is presumably on account of the shift in responsibility for primary care contracts from PCTs to the NHSCB. However, PCTs (or their clusters) will continue to hold General Medical Services (GMS) and Personal Medical Services (PMS) contracts until 2013, so it would make sense for primary care performance to be included in the integrated set of measures, to assure the public that quality of general practice is not deteriorating during a time of transition, especially given the expanded role of GPs as commissioners as well as providers.

Improving information

The ability of commissioners to monitor quality of care in providers has been a significant challenge for some time. Some of the more recent innovations in information offer an opportunity to move forward, although the reality for many PCTs is that their supply of analytical resources – which was small anyway – will be further eroded as organisations merge into the new PCT clusters and then seek to develop such support for GP consortia. PCT clusters will need clear and easily applied approaches to quality monitoring within providers. Without this, the risk of missing critical failures in organisational performance may be unacceptably high.

Ensuring accountability of GP consortia to the public

Quality of care is notoriously difficult to observe and monitor. At a time of major organisational transition, it will be especially important to have in place the performance measures referred to above. These measures will need to be supported by transparent and robust mechanisms by which GP consortia (and PCT clusters) can account to local people for the quality and performance of local health services.

We propose establishing clear and simple guidance on what are basic acceptable governance and structural arrangements for the emerging GP commissioning organisations. This is of particular importance given the removal (with the demise of PCTs) of the corporate board model of NHS governance from funding and commissioning bodies, a model of governance that has been present since 1991 within health authorities, family health services authorities and latterly PCTs. Although sometimes criticised for its limited public and patient accountability, the use of the corporate board model of governance for commissioning bodies did mean that NHS funding and purchasing decisions were in accordance with the Nolan principles of standards in public life (Committee on Standards in Public Life 1995).

Priority two: retaining financial control and meeting the Quality, Innovation, Productivity and Prevention challenge

Financial allocations to PCTs

The Operating Framework sets out the overall level of resources available to PCTs in 2011/12. This is accompanied by individual PCT-level allocations (Department of Health 2010c). The allocations are in line with the overall increases in health spending announced in the October 2010 Spending Review (HM Treasury 2010a).

In the Spending Review, total resource spending on health in England increased by 2.8 per cent in cash terms between 2010/11 and 2011/12. The increase in cash spending for PCTs set out in the Operating Framework is 3 per cent. Part of this funding will be transferred from PCTs to local authorities to invest in social care and part of the funding is for non-recurrent spending on dental, pharmaceutical and ophthalmology services. Recurrent funding is therefore growing at a lower rate of 2.2 per cent on average.

The buying power of the cash allocated to PCTs depends on the level of inflation. The latest Treasury estimate for inflation (the GDP deflator) in 2011/12 is 2.5 per cent – this means that for England as a whole, recurrent allocations to PCTs will be lower in real terms than spending in 2010/11 – the average real-terms cut in recurrent funding is 0.3 per cent.

PCTs are also being required to hold a further 2 per cent of their allocations with SHAs. This funding can only be accessed for short-term or one-off expenditure, which will need to be approved by their SHA with a business plan. Figure 1 shows the cumulative impact of this on the recurrent, real resources available for ongoing spending at PCT level. Overall the recurrent, real-terms resources available for PCTs for ongoing spending in 2011/12 fall by 2.3 per cent on average, with a minimum cut of 0.3 per cent and some PCTs facing a reduction of 2.5 per cent.

Financial summary

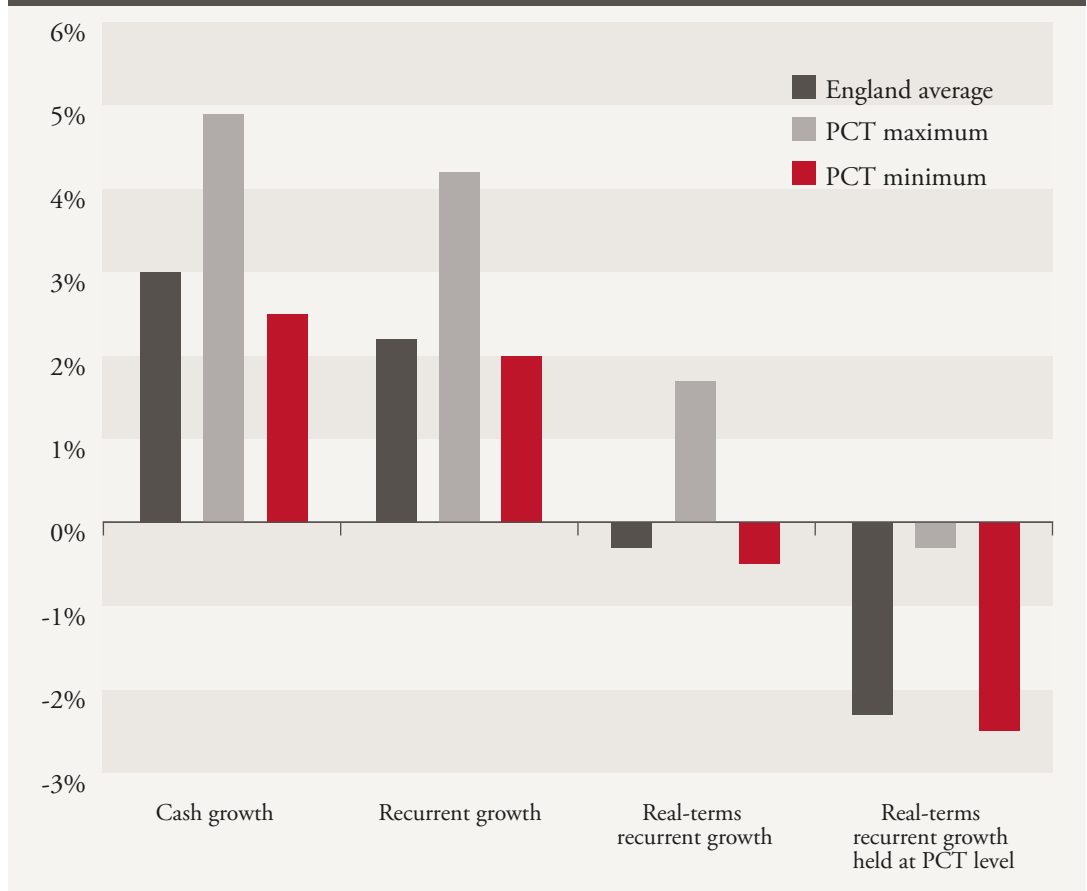
Overall the recurrent, real-terms resources available for PCTs for ongoing spending in 2011/12 fall by 2.3 per cent on average, with a minimum cut of 0.3 per cent and some PCTs facing a reduction of 2.5 per cent (see Figure 1).

NHS providers are required to deliver a 4 per cent efficiency saving, with tariff and non-tariff prices falling by 1.5 per cent in cash terms.

The second largest area of health care spending is primary health care, comprising 20 per cent of health care purchased by PCTs in 2009/10. The Operating Framework says very little about productivity in primary care.

The financial health of hospital providers does not look as strong as that of PCTs; in 2009/10 PCTs and strategic health authorities (SHAs) combined had a surplus more than double that of providers (see Figure 3).

Figure 1: Change in PCT allocations 2011/12



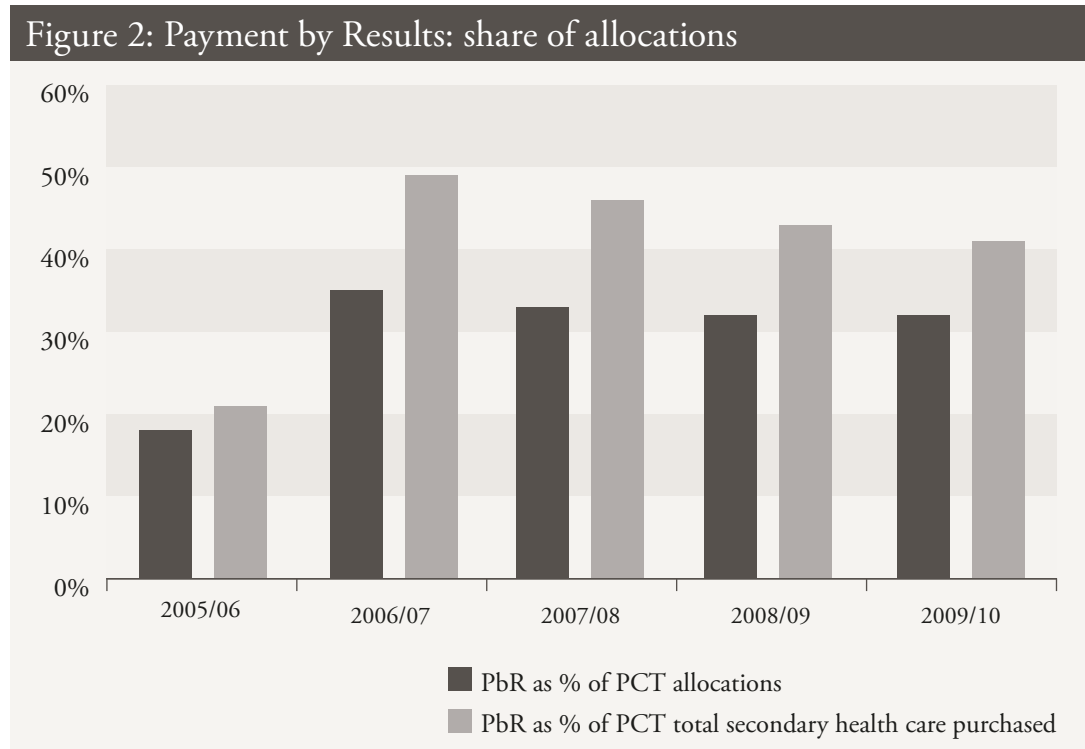
Source: Nuffield Trust analysis of PCT allocations (based on Department of Health 2011a) and GDP deflators (HM Treasury 2010b)

Delivering the service priorities set out in the Operating Framework within these new PCT allocations will be a substantial challenge for the NHS. Audit Commission analysis shows that emergency inpatient admissions continued to rise in 2009/10 and in the first quarter of the current financial year (Audit Commission 2010a, p. 11). This continues the trends reported in Nuffield Trust analysis which found that emergency admissions rose by 11.8 per cent over the five years ending in 2008/09 (Blunt and others 2010). Moreover, hospitals' income from inpatient and day case care has risen faster than activity rates (Audit Commission 2010a).

Scope and level of the NHS tariff

In 2009/10 provider activity rose by 3 per cent but provider income rose at twice this rate (6 per cent). Much of this seems to have been driven by the rapid increase in non-tariff income. Non-foundation acute and specialist trust income from tariff rose by just 1.1 per cent last year while non-tariff income rose by 21.5 per cent at the same providers.

This rapid rise in non-tariff income may explain why, since PbR was implemented nationally in 2006/07, the share of PCT total income and secondary care commissioning spend within the mandatory tariff has fallen (see Figure 2). The Operating Framework specifies that the 1.5 per cent reduction to tariff must also apply to non-tariff services (paragraph 5.32). This is a very welcome development, but improving efficiency and productivity in those services not covered by tariff must be a priority given the very rapid growth in spending over recent years.



Central measures for achieving the Quality, Innovation, Productivity and Prevention challenge

The Operating Framework sets out a number of proposals intended to help the NHS meet the efficiency challenge of saving £20 billion from revenue budgets. These proposals include:

- giving the NHS an additional year to achieve the QIPP challenge – from 2014, to March 2015
- cutting the NHS tariff by 1.5 per cent in cash terms in 2011/12 compared with 2010/11
- applying the same funding cut to services not covered by the tariff
- limiting the number of bed-days funded for some procedures
- extending the management costs reduction target to encompass ‘running costs’
- advocating local negotiation of a freeze on pay increments in addition to the existing two-year pay freeze for all staff earning over £21,000
- top-slicing funding from PCTs to cover the costs of transition, and requiring business cases for this from April 2011.

Spending on acute and general secondary care has been growing at the fastest rate of all the service areas purchased by PCTs – this area of spending increased by 15 per cent between 2008/09 and 2009/10 (Audit Commission 2010a).

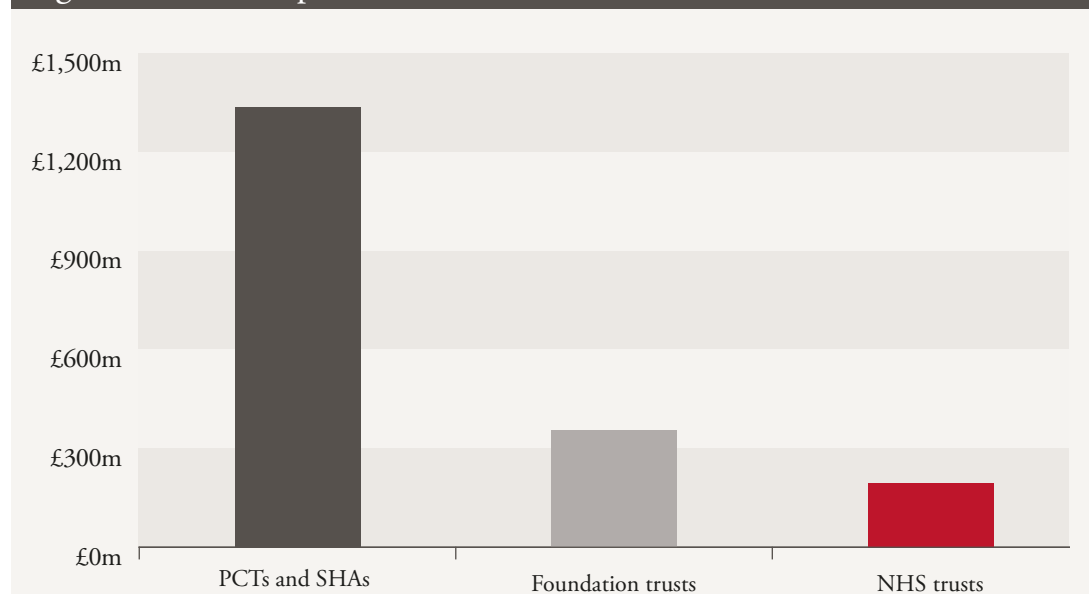
Improving productivity in the areas set out in the Operating Framework is a clear and pressing priority. However, it is unrealistic to imagine that the overall efficiency challenge for the NHS can be met by acute sector productivity improvement and management cost savings alone. Management and administrative costs are 5 per cent of overall health spending (HM Treasury 2010a). Acute and general secondary health care accounts for less than 40 per cent of health care purchased by PCTs.

The second-largest area of health spending by PCTs is primary health care – this made up 20 per cent of health care purchased by PCTs in 2009/10 (Audit Commission 2010a). The Operating Framework says very little about productivity in primary care; this is a concern. As we shift to a national approach to managing primary care contracts within the NHSCB, it is not yet clear how performance management for such a large network of small providers will operate.

Changes to Payment by Results

Of the changes outlined above, those relating to PbR merit further analysis here. The financial environment in the next four years will be very challenging for providers. The financial health of hospital providers does not look as strong as that for PCTs. In 2009/10 PCTs and SHAs reported a combined surplus of £1.337 bn, more than double the reported surplus on the provider side (see Figure 3).

Figure 3: NHS surplus in 2009/10



Note: FT and NHS trusts' surpluses are net of impairment adjustments (these are made when asset values fall below those recorded on the balance sheet).

Source: Flory (2010) and Audit Commission (2010c)

Meeting the QIPP challenge

If PCT clusters and GP consortia are to 'keep a grip' and manage the financial pressures inherent in the PCT allocations for 2011/12, they will need to accelerate the QIPP agenda and ensure that providers deliver their cost improvement plans. At the end of September 2010, Monitor reported that 63 per cent of foundation trusts were behind on delivery of their cost improvement plans (Monitor 2010), pointing to the challenge to be faced when harder economic times hit during 2011/12.

12%

of PCT spending is on
mental health services

In addition to the overall efficiency requirement there are further changes to the payment system for emergency admissions. In 2011/12 there will be zero payment to providers for readmissions within 30 days of discharge after an elective procedure. Coupled with the new marginal tariff for any emergency admissions above agreed baseline levels set out in NHS contracts, this will put pressure on hospitals to try and reduce unnecessary emergency admissions, and work with GP commissioners to develop new forms of urgent care, community support, and reablement. Work by the Nuffield Trust (Blunt and others 2010) concluded that the rise in emergency admissions over recent years was driven largely by clinical and management practice, rather than by demographic factors. This work highlights the potential for improvements in practice to reduce spending.

Changes affecting mental health services

Mental health services account for around 12 per cent of PCT spending. The operating plan and PbR guidance sets out plans for major changes to the system for paying for these services by extending PbR to mental health services over the next two years. This appears to hold a number of risks.

Current approaches to contracting for mental health and community services do not provide a level playing field or the robust comparative data that will be needed for effective operation of a tariff system. A tariff system would bring clear benefits but these can only be realised if the pricing system is based on accurate, reliable information.

The PbR guidance (Department of Health 2011) proposes that PbR for mental health is introduced in three stages:

- a national currency is mandated in 2011/12 with all patients allocated to a mental health 'cluster' (a disease category) by December 2011
- mandatory contracting based on clusters using local prices for 2012/13
- a national tariff is only possible at a later date.

This approach raises some concerns. First, a system to validate the currency data has not yet been developed and this is significant. Audit Commission analysis of coding of activity already covered by PbR has shown error rates of 11 per cent in 2009/10 down from 16 per cent in 2006 (Audit Commission 2010b), despite data being based on well-established metrics and data collection systems. Likewise, costing information for mental health clusters is being developed during 2011. This means that important resource utilisation information will not be available until late in the year – the underpinning work required for contracting with local prices for mental health clusters in 2012/13 will therefore be partial at best.

Introducing PbR with local prices for mental health at this pace poses potential challenges to provider and commissioner financial planning and to service quality. We do not know if mental health services will follow the experience of general acute elective procedures, where competition under fixed prices appears to lead to small but significant increases in quality (Propper and others 2008; Cooper and others 2010; Gaynor and others 2010), for evidence about competition in such sectors is lacking. Theoretical models of competition show that there are real risks where quality is hard to observe and monitor, and suggest that introducing price competition may compromise quality (Gaynor 2006). Given the financial pressures in the NHS from April 2011 onwards, the known difficulties in measuring quality in mental health and the scale of changes that will need to be managed by providers and commissioners, the timetable for PbR in mental health presents unnecessary risks.

The alternative would be to undertake the clustering work in 2011/12 but in the following year allow providers and commissioners to refine further the mental health PbR clusters and associated costings, whilst using PbR in shadow form. Furthermore, the NHSCB could then focus on developing a robust national, fixed tariff model for mental health pricing, thus avoiding the potential negative consequences of price competition in health services.

Price competition

The PbR guidance sets out a more restrictive approach to price competition than that signalled in the Operating Framework for 2011/12. SHAs must approve any proposals to set prices below the mandatory tariff following agreement by commissioners and providers.

Priority three: making progress on the transition of the NHS to new White Paper arrangements

Keeping financial control during a period of reorganisation

The measures in the Operating Framework designed to help meet the efficiency challenge demonstrate the 'getting a grip' element of the Operating Framework, underlining the recognition by Department of Health and government of the need to try and assure stability and control of NHS finances at a time of major transition and a drive for efficiency. The experience of 2005/06, when the NHS lost financial control during implementation of Commissioning a Patient-led NHS (Department of Health 2005), the previous major reorganisation of NHS commissioning and performance management, is instructive here, and that was at a time of significant additional investment in (not requiring efficiencies of) the NHS.

Evidence from international research into mergers and reorganisation highlights the very real risk of losing financial grip during a time of major change, and the likelihood of anticipated savings going unrealised, or at best under-realised (for example Marks 1997; Tetenbaum 1999; Dickinson and others 2006). The decision to push out the timescales for achieving QIPP and management cost savings therefore makes great sense. There will be a need for regular NHSCB review of the scale and achievements (both financial and time-wise) of the QIPP programme, so that the extent to which the NHS performs in line with research evidence is identified. Some further tweaking of timescales and overall efficiency ambitions may be required.

Local accountability

Tight and explicit financial control, with robust mechanisms of reporting progress, will be critical over the next three to five years. As with the comments above about assuring quality through performance management, it will be crucial to have clarity about accountability for financial performance, and in particular, in respect of new GP consortia, and how they report to PCT clusters, SHAs and the NHSCB.

PCT clusters will be required to develop a single operational plan for each PCT area that will identify how they will achieve QIPP savings, and how improved quality and outcomes will be delivered. While a single plan is to be welcomed, its remit is ambitious, and a cluster will have to develop several plans for the PCTs within its patch. This process will become increasingly complex, as GP consortia will have neither a geographical focus, nor coterminosity, with existing local authority or NHS boundaries.

Requiring plans from PCTs and their clusters is one thing – delivering on desired objectives for change is another. A look at the experience of NHS commissioning over the past decade is instructive here (Newdick and Smith 2010), where multiple plans and reports were required of commissioners, many of which were enacted for only a brief period of time, the number and complexity of reporting requirements overwhelming new or merging organisations, and having little if any impact on service quality and development. We recommend therefore that the principle of a single integrated operational plan for a geographical area is maintained over time, and suggest that further thought is needed about how these will relate to GP consortia, and the overall assessment of finance, quality and outcomes.

Reducing management costs

A critical question to be posed is the extent to which management cost savings will (or in fact could) actually be extracted in the long run. The range of responsibilities ascribed to PCT clusters will make them significant organisations, and it is hard to see how they will be dissolved in two years when they will presumably be playing a critical role in supporting GP consortia, undertaking core statutory functions that are best dealt with at scale (such as safeguarding), and acting as an important intermediary between a single NHSCB and possibly over 500 GP consortia.

Evidence from research and practice (Mays and others 2001; Smith and others 2005; Thorlby and others 2011; Casalino, forthcoming) underlines the vital, and typically underestimated, importance of significant and senior management and other infrastructure support for devolved approaches to health commissioning. Without this, and the retention of PCT clusters over the longer term, there is a real risk of at least some GP consortia struggling to deliver on their operating plans.

Conclusion

This is an unprecedented programme of organisational change for the NHS in England, made more challenging by the efficiency target applied to the health service, and the demand for a 45 per cent reduction in management costs. Managers within PCT clusters and SHAs face enacting one phase of mergers (PCTs to PCT clusters) only to know that these new entities may well last for just two years. As noted earlier, research evidence on the management of organisational transition is not encouraging in respect of the potential of such interim bodies achieving much more than handling of the actual transition.

The Operating Framework understandably places significant emphasis on the financial and organisational aspects of reform and performance. It is however critical that human resource and organisational development factors are also emphasised in policy and practice, and that managers are given time, space and the resources to do this. One of the main reasons for the failure of mergers and restructuring cited in research literature is the tendency of organisations to focus first and foremost on financial and commercial considerations, and not on human factors (Ranking 1998). An NHS-funded review of the evidence on organisational transition concluded:



Senior managers need to invest considerably in their own and others' time in the direct management of the human side of this process, with specific attention to the psychological support needs of senior and middle managers. Relentless communication of the purpose and detail of changes is required, along with a range of personal, team and organisational development interventions, and all within an open and participative style of leadership.

Dickinson and others 2006, p. 14

To end where we started, the measures outlined in the Operating Framework, such as developing PCT clusters, enacting central financial measures and controls, and easing up on some timescales for making financial savings, bear witness to how policy-makers and officials are balancing the twin pressures of the urgency of reform with maintenance and improvement of financial and service stability.

The framework provides some important signals about a desire to provide additional safety and stability for the NHS over the coming three years. We summarise here some measures that we believe will go a long way to mitigating the risks associated with the reform, and enabling the achievement of the more patient- and outcomes-focused NHS that is desired as a way of assuring both equity and excellence.

Summary of proposals

Maintaining and improving the quality of services

We propose that PCT clusters are formed as quickly as possible and that their governance arrangements in relation to PCT boards are confirmed by April 2011.

We propose that an order of priority is given to the list of service developments required of PCT clusters.

We propose that PCT clusters be given assurance of their future beyond two years.

We propose that the integrated performance measures for PCTs and GP consortia are extended to include primary care indicators.

We propose the development of clear guidance about what are acceptable governance and structural arrangements for emerging GP consortia, in order that accountability to the public for the quality and performance of local services, and of funding decisions, can be assured.

Retaining financial control and meeting the QIPP challenge

There will be a need for an extension of the QIPP programme if the NHS is to make and maintain progress in meeting efficiency targets, given reduced real-terms funding.

We suggest that primary care should be a key focus on the QIPP agenda in 2011/12 and that the NHS needs to strengthen the arrangements for performance-management of primary care during the transition to GP commissioning.

Reducing avoidable emergency admissions should be a core target for PCT clusters and GP commissioners, as a fundamental part of the QIPP agenda.

Given the scale of overall changes in the NHS, we propose that Payment by Results in mental health be introduced on the basis of a national fixed price tariff, and with a more phased timescale over the coming years.

Making progress on the transition of the NHS to new White Paper arrangements

We suggest that the pace and extent of the QIPP programme be kept under regular review, and that a range of development and technical support be made available to providers and commissioners to help them learn from good practice elsewhere.

We suggest that further work is needed to examine how a single operational plan for a PCT area will relate to GP consortia, and that thought is given to how such a plan will underpin the set of integrated performance measures proposed in the Operating Framework.

We propose that management cost targets are regularly monitored and reviewed, in tandem with assessment of GP consortias' readiness to assume budgets and financial risk.

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