

Giving GPs budgets for commissioning: what needs to be done?

The new Coalition Government has made clear its intention to 'strengthen the power of GPs to act as patients' expert guides through the health system', by enabling them to commission care on their patients' behalf (Cabinet Office, 2010). This briefing paper has been developed jointly by six national organisations who have been working together over a number of months to explore what needs to happen if GPs are to be given real power and responsibility for leading commissioning in the NHS.

Key points

We believe the following are some of the most critical issues to be resolved in creating what we have termed 'GP commissioners':

- Recognising that the term 'commissioning' encompasses a wide range of specific activities, so a 'one size fits all' solution will not work.
- Determining the appropriate population size for GP commissioning groups and how a fair budget can be set, together with establishing the range of services to be included.
- Clarifying how budgets will be allocated to GP-led commissioning groups, who will hold them to account, how their performance as commissioners will be assessed and managed and how patients and the public will be involved.
- Establishing what it means to hold a real commissioning budget, and the appropriate blend of associated risks and incentives.
- Determining whether a minimum level of involvement in certain aspects of commissioning should be mandatory or voluntary.
- Ensuring that the particular potential of GP budget-holders in developing extended primary and community services is harnessed, while managing conflicts of interest and maintaining competition and choice for patients.
- Finding ways of engaging specialist clinicians alongside GPs in budget-holding and commissioning, in particular in reshaping urgent care and the management of long-term conditions. This includes reviewing the existing payment mechanisms, incentives and contracts that shape current specialist practice.
- Ensuring that GP leadership is supported and developed in a context of significant reductions in management costs and potential cuts in training budgets.
- Developing a powerful and convincing narrative to explain how GPs can both focus on individual patient needs and take responsibility for wider population health and funding.
- Effectively managing the transition to the new arrangements in a way that ensures a focus on quality improvement and rigorous financial control is maintained.

Introduction

The new Coalition Government has made clear its intention to ‘strengthen the power of GPs to act as patients’ expert guides through the health system’, by enabling them to commission care on their patients’ behalf (Cabinet Office, 2010). It promises an:

‘opportunity for GPs to work with community leaders and their local authorities to take the reins and steer their local services to improve quality standards and outcomes.’

GP-led commissioning has a 20-year history in the English NHS, and similar policies have been implemented in other healthcare systems during this period. Evidence suggests it has the potential to strengthen primary care services, and to engage GPs in decisions about local service planning and in developing new care pathways and alternatives to hospital admission.

However, the same evidence base highlights significant challenges in trying to engage more than an enthusiastic minority of GPs in holding real budgets for commissioning, especially in relation to making and sustaining change beyond primary care provision itself, and in shifting resources from secondary to primary care. This means that current proposals to give more power to GPs and enable them to take the reins as commissioning budget-holders create significant opportunities for the NHS, but also present important policy and management challenges.

This briefing paper has been developed jointly by six national organisations who have been working together over a number of months to explore what needs to happen if GPs are to be given real power and responsibility for leading commissioning in the NHS, including responsibilities for holding and managing commissioning budgets. It seeks to inform the new Government’s aim of devolving power to GPs. This paper:

- highlights the potential of GPs holding real budgets for commissioning health services
- sets out the practical challenges to be addressed, and the risks that will need to be managed, if GP-led commissioning is to be taken forward in this way
- identifies the key issues for policy-makers.

The organisations contributing to this paper are committed to working together with policy-makers and with the NHS to help shape an environment in which the opportunities created by the new government’s policy can be fully and quickly exploited. This paper outlines what

we believe are some of the most critical issues where early dialogue and clarification at a national level will help facilitate rapid and effective local implementation.

The potential of GP commissioning

Commissioning has historically been a widely used but ill-defined concept in the NHS. We would describe it as the process of assessing the health needs of a population, then planning, securing and monitoring the best possible range and quality of health services and health improvement services for that population, given the resources available. Commissioning takes place at various levels and by different bodies, including the very large-scale (for specialist services) but also at a community level, where detailed knowledge of smaller areas is needed, and at an individual patient level.

The idea that GPs should come together as a group to hold real budgets and commission a significant proportion of local health services is based on an implicit belief that GPs are well placed to be local ‘accountable custodians’ of NHS resources, as they actively support individual patients in managing their own health and advocate for them when they require health services, while being in a position to take a community-level view on how better quality and value for money could be achieved for the wider population. In this paper we use the term ‘GP commissioning’ to describe these activities.

One of the things that would appear to distinguish the proposed new form of clinically-led commissioning organisation from the existing model of practice-based commissioning (PBC) is that a group of GPs will hold real budgets for commissioning NHS services, and will take on a commensurate degree of autonomy and accountability. A group of clinicians (GPs, ideally working with specialist colleagues) would be accountable for health outcomes of the local population, patient experience of health services, and financial performance in respect of the commissioning budget. This extensive degree of accountability would be new for general practice, as previous forms of GP commissioning did not operate in this way.

Potential opportunities presented by organisations of this type include:

- Giving clinicians more negotiating and commissioning ‘clout’ with the hospital sector, through the holding of real budgets

- Greater incentives for providing higher-quality primary care, as groups would take responsibility for scrutinising and performance-managing the quality of local GP services
- Tackling the wider health agenda for local communities, including a greater focus on disease prevention and health improvement.

Learning from the evidence

Belief in the potential of GPs to effectively manage comprehensive commissioning budgets needs to be tempered by research evidence from the UK and elsewhere about previous forms of GP commissioning, which reports limited achievements in terms of GP commissioners having a significant impact on hospital care, and sustaining initial gains in the management of prescribing and other primary care budgets.

UK evidence

GP fundholding in the 1990s enabled GPs to hold a real budget to purchase community, outpatient and elective care for their patients. Total purchasing pilots (TPP) went further and allowed GPs to hold a budget for a wider range of elective and emergency services. Other approaches such as GP and locality commissioning drew doctors together into consortia to plan and commission new forms of healthcare.

Evaluation of these schemes showed that participating GPs were able to improve primary care services, make savings through more efficient prescribing (although such savings turned out to be short-lived), and develop community-based alternatives to hospital care, although they were rarely able to shift resources from hospital budgets to fund these (Mays and others, 2001). There was also some evidence that some 15 to 20 per cent of those groups holding real budgets were able to secure shorter waiting times, achieve lower referral rates and, in the case of TPP, reduce emergency bed-days. Primary care commissioners were not however able to reshape the volume and location of hospital services in a significant manner (Smith and others, 2004).

Since 2005, commissioning has been in the hands of both primary care trusts (PCTs) and GPs in the form of practice-based commissioning (PBC), the latter entailing practices holding an indicative budget for some services, delegated from the PCT. Although there have been many examples of successful service improvement led by both PCTs and practice-based commissioners, this model of NHS commissioning has been unable to achieve

a widespread transformational shift in health service delivery or to check rising expenditure on acute services, while evidence of effective cooperation between specialist and primary care to provide new models of care outside hospitals remains limited (House of Commons, 2010; Smith and others, 2010).

Explanations for this lack of progress with respect to PBC include: an absence of clear financial incentives due to the indicative nature of the PBC budget; a lack of other incentives for clinicians to get involved in PBC; perceptions of poor support from PCTs and excessive bureaucracy associated with PBC business cases; the small size of PBC groups resulting in weak purchasing clout with hospitals and a lack of the critical skills needed for successful commissioning; and poor data to inform referral and commissioning decisions (The King's Fund and NHS Alliance 2009; Curry and others, 2008; Smith and others, 2010).

International evidence

Forms of GP commissioning have been used internationally, including in the United States, where there is learning from two decades of experience, with physicians coming together in groups to take on risk-bearing contracts for services for a defined group of patients (Ham, 2010). Associate Professor Larry Casalino of Cornell Medical College, who has carried out extensive research into budget-holding by physician organisations in the US (Casalino, 2001; Hurley and others, 2002), has set out a number of lessons for the NHS about giving real and risk-bearing budgets to GPs for commissioning:

1. Fundholding by a medical group can entail high transaction costs if the group sets up its own office to pay claims, and can result in major crises if groups run out of funds before the fiscal year ends. It is possible for the funder (for example an insurer) to fund and pay for services and to track the cost of care for the physician group's patients, though this tracking is best carried out in real time.
2. Groups should be accountable for quality and patient experience, not just cost.
3. It is very difficult and takes time to create a high-performing commissioning/purchasing organisation.
4. It is important to distinguish medical groups – organisations with a single 'bottom-line', administrative structure and so on, from physician networks, in which physicians remain in their own practices. The extent to which practices come together into an organisation can vary according to what they

wish to achieve, and should be allowed to develop from the bottom up.

5. Risk has to be matched to the types of providers in the risk-bearing organisation – groups that do not include specialists or hospitals should be cautious about bearing large amounts of risk for the costs of specialist/hospital services.
6. Services for which a group takes the risk should be matched with the group's capabilities in terms of its size, management capabilities, and the range of services (for example GP, consultant, hospital services) it can 'make' rather than buy in.
7. Service risk is different from insurance risk – that is, the costs of care that providers can control, should be distinguished from those that are beyond provider influence.
8. Incentives should be strong enough to reward clinical leaders and to gain support from the medical rank and file. They should improve at least two of the following:
 - quality of care for patients
 - doctors' income
 - the quality of doctors' working day
 - respect from medical peers.

This evidence highlights some of the issues that will need to be addressed if the benefits of GP groups seeking to commission services are to be maximised, and the risks mitigated. In particular, it suggests the need to: match the risk assumed to the ability of the group to influence cost, utilisation and quality, find ways of engaging specialist clinicians as members of commissioning groups, and allow time for necessary organisational development. It also underlines the need to be clear about what is meant by 'budget-holding' in this context, and about the distinction between enabling GPs to make autonomous decisions about the use of a budget, and actually giving them full responsibility for holding the cash, letting and managing contracts, and paying providers' bills. Related to this, it is crucial that there is clarity about whether budget-holders have full autonomy and responsibility for determining how budget surpluses and deficits should be managed.

The challenges of giving GPs real budgets for commissioning

The NHS in England faces a significant challenge in the next few years. Against a backdrop of constrained resources it must:

- deliver continued improvements in patient experience
- expand its ability to prevent and treat chronic illness
- narrow the gap in avoidable health inequalities.

Evidence suggests that GP groups holding budgets to commission services have real potential to help the system address these challenges, through new forms of 'local clinical partnership' (Nuffield Trust and NHS Alliance, 2009) or 'community health collaboratives' (NAPC, 2009) or primary care federations (RCGP, 2008). These would be led by clinicians and take responsibility for local population health, patient experience of health services and management of local health resources.

For this to be enabled, however, there appear to be four core challenges to be addressed:

1. Establishing an appropriate blend of risks carried by and incentives available to GP-led commissioning groups.
2. Determining the right scope (range of services commissioned) and scale (population covered) of these groups.
3. Creating a supportive and challenging environment for GP budget-holding.
4. Ensuring sufficient levels of clinician engagement.

Balancing risk and reward

It will be very important for policy-makers to establish what it means for GPs to hold a real commissioning budget, and the appropriate blend of associated risks and incentives that come with that budget.

Risk for what?

A critical question is: 'For which services will GP budget-holders assume financial and service quality risk?'

Options include different mixes of primary, community and acute services. A range of options might extend from full risk for the health outcomes and services associated with a population, through to general medical services (GMS) primary care services.

As the overall scope and size of a group's budget

decreases, however, so too will its ability to leverage higher quality or more efficient services from providers. It will be important to avoid groups ‘cherry-picking’ services, and to ensure that they have some accountability for referrals to services beyond their budget-holding, to avoid them diverting referrals into services for which they do not hold the budget.

If there is variability, arrangements will be needed to enable the commissioning of services for populations whose GPs elect to take risk for only a restricted set of services. As explored in a recent Nuffield Trust and King’s Fund monograph (Smith and others, 2010), this will necessitate an overall ‘continuum of commissioning’ to be managed for a population.

Experience from the US suggests that it will be vitally important to distinguish between bearing risk for outcomes that the GP group can control (‘service risk’ – for example avoidable re-admission to hospital) versus risk for outcomes that are beyond the GPs’ control (‘insurance risk’).

Dealing with failure

Evidence from the US suggests that failures are likely if a full risk-bearing model is adopted. This will mean defining failure (which has been a challenge in the acute sector) and developing the mechanisms to prompt improvement or trigger the tendering of new contracts. It is important that there is clarity about what happens if a group overspends and/or fails to meet health outcome or patient experience targets. The extent to which this risk would be carried by GPs as individuals, by practices, or by the collective group, needs to be thought through carefully, including in terms of how commissioning performance will be assessed, and by whom.

A failure regime for GP commissioning might include a practice or group being required to ‘scale down’ and stop carrying out such extensive commissioning, possibly reverting to primary care provider-only status. This assumes however that the primary sanction for poor performance would be to have to stop commissioning. In a truly risk-bearing situation, logic would dictate that practitioners would take some personal accountability for commissioning spend, something that would be challenging to negotiate (especially if it meant that practices were allowed to go bankrupt and hand over patients to others), without commensurate rewards being on offer for strong performance.

What sort of incentives and rewards?

Reward structures need to be transparent. They might entail GP groups retaining 100 per cent of any savings made through their commissioning activity, and being required to reinvest these in local services. The vehicle for this might be to have commissioning groups set up as mutuals or social enterprise organisations.

Alternatively, some savings might be used to enhance GP income. The latter would appear to offer direct incentives to practices to engage in commissioning, but would be difficult to implement in a context of constrained public finances where senior public sector incomes are under scrutiny. It might however be possible to offer direct personal financial incentives in return for excellence in commissioning, as part of a new GMS contract. The experience of collective rewards within PBC, and limited to a proportion of savings accruing to the group, is instructive here. There seems to be a need for more sophisticated reward arrangements that would reflect different levels of achievement by groups in relation to health outcomes, patient experience and financial control.

It should be noted that even if savings from efficiencies prove possible, for example by reducing emergency bed days, these are likely to diminish over time as the maximum potential for improvement is achieved. This points to a need for regular review of risk and reward arrangements, flexing these to encourage the behaviours desired at each stage.

Though they should not be underestimated, financial incentives are not the only kind that matter to clinicians. Others include increased autonomy to provide and design new forms of care, more attractive working conditions, the reward of offering demonstrably higher quality of care for patients, and increased bargaining power and respect in the eyes of other clinicians.

Who gets the reward: individual practitioner or group?

Where financial incentives are at stake, it is necessary to examine how any rewards would be distributed within the group. At least two models are possible: the first is a genuinely joint venture with practices pooling their commissioning activity within a single ‘bottom line’ and with a collective reward. The second, a looser network of practices, could operate with each practice having its commissioning activity written into its GMS contract, and having risk and reward for that activity managed at practice level, presumably by the overall commissioning organisation.

Getting the right scope and scale

Another set of challenges for policy-makers concerns scale, in particular the need to determine the appropriate population size for GP commissioning groups and to work out how a fair budget can be set, together with establishing the range of services to be included.

The importance of local clinical engagement

For effective GP commissioning, scale matters from a number of different perspectives. In relation to the need to deliver much better clinical engagement with both primary and specialist clinicians, there is evidence that a relatively local and small scale of population is effective for GP commissioning. Very large groups might threaten the links between practices and the collective organisation. There is also a need to consider whether groups should be based on geographical communities, or like-minded GP practices and, if the latter, how population coverage for commissioning will be assured.

Scale for insurance and clinical risk

Learning from the United States (see above) suggests it is important to distinguish between ‘service risk’ – the use of services that can be controlled or influenced by the GP group and ‘insurance risk’ which cannot. From a financial point of view, if organisations bear ‘insurance risk’, a large scale is essential to offset the probability of catastrophic and expensive conditions. Evidence from GP fundholding suggested that a minimum population coverage of 100,000 was required for this (Smith, 1999), while Bachmann and Bevan’s (1996) work on total purchasing schemes identified a minimum of 30,000 as appropriate. In practice, it seems likely that other bodies will need to retain responsibility for commissioning specialised services for rare conditions across larger populations: this could be part of PCTs’ residual role in commissioning, or rest with the proposed NHS Independent Board.

Recent work to develop a person-based risk-adjusted resource allocation formula for the Department of Health, now incorporated into the fair shares formula for allocating commissioning budgets to general practices across England, shows that in the absence of risk-sharing arrangements, approximately one third of practices will over- or underspend on their annual commissioning budget by ten per cent or more, simply due to chance (Dixon and others, forthcoming). This ten per cent figure declines with increasing population size covered by the

practice if a ‘stop loss’ ceiling is applied (for example if annual expenditures per person over £20,000 are excluded) or if certain high-cost treatments (such as specialised services) are excluded.

The report of this work on resource allocation recommends that the Department of Health urgently commissions detailed empirical work on the arrangements for risk-sharing to reduce practices’ random fluctuations in expenditure (Dixon and others, forthcoming).

Bearing ‘service risk’ likewise requires a degree of scale, so that the GP group has some meaningful leverage over hospital and other providers. This is also a function of the density and size of hospitals in a given area – GP groups need to have access to a significant proportion of a hospital’s market to exercise influence, which will vary according to region.

Scale for infrastructure support

The organisation will need to be of a scale to justify appropriate infrastructure support, and this will be a particular challenge in an environment of reducing management overheads. More specifically, organisations will need:

- sophisticated management and IT infrastructure
- the capacity to negotiate and manage contracts with providers
- resources to analyse data and use this for population health planning
- access to capital and other funding to expand the organisation and its services or withstand potential losses.

Being of sufficient scale to access capital is a critical issue for risk-bearing GP groups, for they are likely to need funding to develop facilities and services that will enable new services outside hospitals, and for wider infrastructure development.

Ensuring patient and public engagement

Larger groups may however make public involvement more challenging, as those designing and commissioning services risk appearing remote from local experience. A key rationale for GP commissioning is to have decisions taken in response to patient needs and to make investments reflecting local people’s preferences. Research evidence suggests that GP commissioning organisations struggle to achieve effective patient and public engagement, yet without effective local

involvement, accountability is arguably incomplete. The Coalition Government proposal for PCT boards to have elected members could go some way towards strengthening public engagement in commissioning, but only if these boards have a formal relationship with GP commissioning groups.

Creating the right environment

In order to enable GP commissioning with real budgets to be enacted in an effective manner, there is a need for a supportive, and yet challenging, policy environment that makes clear the expectations and accountability associated with GP budget-holding, and gives this new approach to commissioning the best chance of success.

Setting a person-based risk-adjusted budget

GPs will need to undertake commissioning within an agreed resource envelope. Whether the budget is made up of 'real cash' or held by the PCT or Independent NHS Board on behalf of the GP group, it is critical that clinicians can commission using a level of resources that is appropriately adjusted for the health risks of the local population. Significant advances in developing risk-adjusted capitation budgets have now been made, with results at least comparable to international methods such as those employed in Germany, the Netherlands and in Medicare in the US (Dixon and others, forthcoming), but these can be developed further. As noted above, there will be a need for explicit arrangements about how gains and losses as a result of risk-adjusted budget setting will be handled (Dixon and others, forthcoming), as part of agreeing what is considered to be a fair budget. This will be critical to the establishment of a trusting and constructive environment within which groups can assume risk for population health and service delivery.

Aligning foundation trust and commissioner incentives

Provider trusts are currently incentivised through Payment by Results to maximise income through expanding activity, in part by reducing the length of stay of admitted patients and thus freeing up beds for new admissions (Blunt and others, 2010). Commissioning groups need the flexibility to modify the tariff to enable funding of an integrated service across primary, community and acute care. GP commissioners may seek to commission care with, as well as from, specialist colleagues, and payment and contracting mechanisms will need to reflect this joint planning and service development activity. A further possibility will be the development of vertically integrated

systems where hospitals run community health (and possibly primary care) services.

Fostering competition and choice

Whether or not patients are able to choose their commissioning group (as for most patients this will be determined by their choice of general practice), patients should always have a choice of specialist or hospital. The commissioning group doctors may prefer certain specialists, hospitals or alternative providers of care, and can make that preference known to the patient, but the patient should not be locked in. Furthermore, competition law, together with an overall concern for transparency/avoidance of conflicts of interest, may require commissioning groups to use competitive tendering for services, something that would be time-consuming, and might deter some clinicians from getting involved. This would however need to be balanced with the potential for GP commissioners using their budgets for 'make or buy' decisions; in other words, developing services within primary care, and then purchasing specialist advice and services as required.

Assuring accountability

The nature of accountability for a commissioning group will depend on its scope and scale, in particular the services for which it assumes risk. A transfer of real budgets to a commissioning group will entail a parallel transfer of accountability and regulation. There will need to be clarity about how responsibility for public funds will be shared between the GP commissioning group and the proposed Independent NHS Board. Assuming responsibility for GMS/PMS (Personal Medical Services) resources would require the commissioning group to manage the performance of these contracts. There is also a need to decide which of the current bodies – the Care Quality Commission or the proposed Independent Board and economic regulator – will set and monitor standards for GP group commissioning and provision of services, or whether an alternative approach needs to be considered.

Whatever the scope and scale of a commissioning group, robust arrangements for identifying and governing conflicts of interest will be needed. In particular, these will need to address the potential conflicts of interest faced by GPs and their teams when acting as commissioners of services that are within the same overall care pathway as where GPs provide primary care. Having careful arrangements to address any perceived or actual conflicts of interest will help reassure funders (whether the PCT or Independent Board) and the general public about GPs' clinical decisions not being

compromised by referral decisions that in some way might favour their own financial or other interests.

The PCT role

The coalition's programme for government sets out the future role for PCTs to act as a champion for patients, commissioning those residual services that are best undertaken at a wider level, rather than directly by GPs, and taking responsibility for improving public health for people in their area. It has also been suggested that GP commissioning groups could choose to buy commissioning support from PCTs in the future, although they could also get support from independent organisations or local government.

Whatever the system ultimately looks like, PCTs will play a critical role in the transition to the new arrangements for commissioning. They are already exploring ways of transferring greater responsibility to the existing practice-based commissioning groups in advance of full GP commissioning being implemented, but will need to ensure that existing commissioning arrangements remain in place during the transition, and continue to deliver improvements in quality and productivity during this year.

Ensuring clinician engagement

Creating organisations that are fit for purpose

Evidence from abroad underlines the importance of physician groups being owned by their members, and established in a way that makes it impossible for statutory authorities to abolish them. Given the known difficulties in securing high levels of engagement by GPs in PBC, it seems important that new commissioning arrangements are able to be based on clinically-led and owned organisations in which clinicians can have a long-term and personal stake. This may lead groups of doctors to set up organisations that are incorporated in some way, including as companies limited by guarantee, or community interest companies. They may also seek to use mutual arrangements as a way of enabling wider staff ownership of the organisation. Forthcoming work from The King's Fund, Nuffield Trust and Hempsons (funded by the Royal College of General Practitioners) will set out more detail on the organisational options available to practices wishing to federate for the purposes of commissioning and/or provision. This builds on work by the National Association of Primary Care and NHS Alliance that has demonstrated how different models of GP group organisation can be developed, disseminated and replicated within the NHS.

Developing effective leadership

Evidence on high-performing healthcare organisations underlines the critical importance of high-quality and sustained clinical and general managerial leadership (Baker and others, 2008).

While some commissioning organisations will have established clinical leaders, others will need to identify and develop such individuals, and this will require investment in personal skills and organisational development. The importance of this is underlined by research from 2009 suggesting that 80 per cent of GPs in PBC felt they lacked commissioning skills (The King's Fund and NHS Alliance, 2009). Furthermore, groups will require high-level general and specialist management support from people who understand the nature of general practice, primary and acute care, and have the sophisticated commissioning skills necessary for enabling new forms of service that can deliver both efficiency and quality. This will be a particular challenge at a time when management capacity in NHS commissioning bodies – which many would argue is underpowered – is being reduced. It is likely that some of this support may be secured from private sector providers but, given the novelty of GP commissioning skills, this knowledge will need to be developed in both the private and public sector (Smith and others, 2010; Naylor and Goodwin, forthcoming).

Renewing the GP and consultant contracts

The success of GP commissioning will depend on its ability to lever improvements within general practice and primary care, and to work effectively with specialists, community services and social care. This suggests that consideration should be given to GP commissioning groups taking on responsibility for managing GMS and PMS contracts, thereby having a more complete scope for influencing the delivery of local care. The Coalition Government has signalled a desire to renegotiate the GP contract. This represents an opportunity to include commissioning activity as a core element (or option) within the practice contract (for those GPs who would undertake commissioning and hold a budget at practice level), and to connect this with the work that GPs carry out as providers. Consideration could also be given to revising consultant contracts to enable specialists to become part of commissioning groups. A further option would be for a central core medical contract, held by the commissioning group, with scope for the group to negotiate additional services from generalists or specialists.

Engaging and working with specialists

Commissioning groups will need to work collaboratively with specialists in order to develop an extended range of care in community settings. Some groups may try to contract with specialists for their input to commissioning. However, more productive specialist–GP relationships may develop where GP budget holders find ways of working with specialists as equal partners. This underlines the importance of renewal of GP and consultant contracts, in a way that enables clinicians to be ‘uncoupled’ from traditional primary or secondary care settings. Other factors important for this include the crafting of employment offers for GPs and consultants that make new organisational ‘homes’ attractive. Without such engagement of specialists, there is a risk of GP budget-holding driving a wedge between primary and secondary care, and making service transformation much harder.

Communicating the vision

While there is a cohort of enthusiasts for an extended form of GP commissioning, research into PBC offers a serious caution as to how difficult it will be to engage the majority of GPs in active commissioning of care using real budgets (Curry and others, 2008; Coleman and others, 2009). A key decision for policy-makers will be whether or not to make GP commissioning mandatory. This in turn will affect how the overall message about engagement in this activity is communicated.

Arguably, given the half-hearted nature of clinician engagement in PBC, it will make sense to offer a range of options for involvement in extended GP commissioning, with incentives offered for fuller engagement and risk-bearing. There will also be a need for skills development and training for GPs engaging in budget-holding, for these new responsibilities will require sophisticated analytical, planning and other managerial skills. The benefits of involvement, along with a careful description of arrangements for risk and reward, will need to be articulated in a thorough and thoughtful manner.

Issues for policy-makers

In this paper, we set out the potential of GP commissioning, especially in relation to developing improved primary care and community services, and shaping care that is more focused on maintaining population health and avoiding unnecessary hospital admissions. We support the view that groups of GPs, holding real budgets, with the right blend of risk and rewards, with appropriate management and policy support, and within an overall framework of financial and

public accountability, could effectively take a lead role in planning and developing health services for local people.

This paper does not however recommend a single policy approach for GP budget-holding for commissioning. Our view is that policy needs to be developed as a result of full discussion of the points raised above. We believe that the experience of PBC, coupled with the substantial variations in the configuration of health economies, suggests that a single-model, mandatory system for ‘real’ GP commissioning could be problematic. Although arguably messier from a policy perspective, one possibility would be to develop a spectrum of risk tiers for GP commissioning, closely linked to a new contract for primary care service delivery, and hence with a clear set of arrangements for risk and reward.

These tiers of participation in GP commissioning could include:

1. Full risk-bearing, based on existing enthusiastic PBC or PMS groups, developed on an experimental basis, and assuming a small number in the first instance, with the potential to learn about their experience through carefully designed evaluation.
2. Partial risk-bearing: clinicians involved in a commissioning group and actively running ‘real commissioning’ for some services used by patients of their own practices and for the patients of those practices that have opted to be provider-only. The GPs would have their commissioning activity written into their GMS/PMS contract, with clear arrangements for risk-sharing and rewards. There would be a requirement to tackle certain core commissioning priorities such as urgent care – a regression to small-scale selective purchasing would not be an option.
3. Provider-only primary care: as providers who decline to commission, these clinicians get non-financial incentives such as autonomy, but have to accept peer performance management and the fact that their commissioning will be done for them by the GP commissioning group or a private provider nominated by the proposed Independent NHS Board.

Based on the analysis in this paper, we suggest that the following issues need attention by policy-makers:

- Articulating what is meant by the term ‘commissioning’, recognising that it encompasses a wide range of specific activities that cannot all be performed at the same level in a healthcare system, and can therefore suggest different roles and functions to different groups and individuals.

- Working out at what scale (in terms of population covered) it will be appropriate for GPs with real budgets to come together in commissioning groups, and how a fair budget for these groups can be set. Existing evidence points to the need for a large scale (a minimum of 100,000 people) for commissioning the full range of services or taking full financial risk, and also for the provision of adequate infrastructure support to groups. However, further empirical analysis is needed to develop a risk-adjusted capitation formula for setting budgets, and to improve the timeliness of data available for such analysis.
 - Determining the right range of services to be included in the scope of GP-held commissioning budgets, ensuring that the services for which they are responsible are those where GPs' clinical decisions can have an influence and that GP-held budgets for commissioning health services can be aligned where necessary with budgets for commissioning public health, social care and other related services.
 - Clarifying how budgets will be allocated to GP-led commissioning groups, who will hold them to account for the use of those budgets, and to what extent and how their performance as commissioners will be regulated and managed. The accountability arrangements will need to include a governance framework for handling potential conflicts of interest for GPs working as both providers and commissioners. Patients and the public will need to be involved.
 - Establishing what it means to hold a real commissioning budget, and the appropriate blend of associated risks and incentives. This will include identifying the balance between collective and personal risks to GPs taking on budgets for commissioning, and to those taking on specific leadership responsibilities in managing those budgets. It also involves clarifying the incentives and benefits to GPs of participating in commissioning, and ensuring appropriate governance and accountability for this. As outlined above, it may be helpful to consider a tiered approach to GP budget-holding, whereby practices can assume a level of risk and responsibility that matches their experience and readiness for extended commissioning.
 - Determining whether a minimum level of involvement in certain aspects of commissioning should be mandatory or voluntary for GPs. Mandatory status potentially threatens GP goodwill; a voluntary approach means no leverage would be held over the spending decisions of GPs who choose not to participate. Options should be explored whereby GPs might take responsibility for commissioning – perhaps through their contract – but could choose not to do it themselves.
 - Ensuring that the particular potential of GP budget-holders in developing extended primary and community services is harnessed, while managing conflicts of interest and maintaining competition and choice for patients.
 - Finding ways of engaging specialist clinicians alongside GPs in budget-holding and commissioning, in particular in reshaping urgent care and the management of long-term conditions.
 - Ensuring that GP leadership is supported and developed, and examining how this will happen in a context of significant reductions in management costs and potential cuts in training budgets.
 - Developing a powerful and convincing narrative for the health professions, NHS managers and the public about the value and potential of extended GP commissioning, including how GPs can focus on individual patient needs while being responsible for wider population health and funding.
 - Effectively managing the transition to the new arrangements in a way that ensures a focus on quality improvement and rigorous financial control is maintained.
- We reiterate our commitment to work with policy-makers to find solutions to these challenges.

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About this briefing

This joint briefing paper has been produced by the Nuffield Trust, NHS Alliance, National Association of Primary Care, Royal College of General Practitioners, The King's Fund and the NHS Confederation. It was developed following a seminar hosted by the Nuffield Trust, with participation from the above organisations, and was written by Dr Judith Smith, Head of Policy, Nuffield Trust, and Ruth Thorlby, Senior Fellow, Nuffield Trust, on behalf of the six organisations.

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Examining the prospects for developing GP commissioning forms a key element of the work programme of all the organisations that have come together to produce this briefing. For more information visit:

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