GP commissioning: making it happen

WORKSHOP

Building relationships with federated models, support agencies and commissioning partners

facilitators:
Nick Goodwin
Candace Imison
Chris Naylor
Agenda for workshop

▷ Lessons from previous approaches to GP-led commissioning
  - The characteristics of more successful PBCs?
▷ Understanding the tensions between provider and commissioner functions
▷ Securing effective support to commission services
  - The skills and capacity to commission effectively
  - Commissioning at different ‘levels’
<table>
<thead>
<tr>
<th></th>
<th>GP fundholding</th>
<th>Total purchasing</th>
<th>PBC</th>
<th>GP comm’ng</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
<td>1991-7</td>
<td>1994-7</td>
<td>2005-present</td>
<td>from 2011</td>
</tr>
<tr>
<td><strong>Average Size</strong></td>
<td>10,000</td>
<td>30,000</td>
<td>63,000</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>3000-50,000</td>
<td>8000-80,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage</strong></td>
<td>c.70% - rural</td>
<td>52 sites:</td>
<td>National coverage</td>
<td>National coverage</td>
</tr>
<tr>
<td></td>
<td>and suburbs</td>
<td>rural/suburbs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Budget</strong></td>
<td>Real</td>
<td>Indicative</td>
<td>Indicative &amp; delegated</td>
<td>Real</td>
</tr>
<tr>
<td></td>
<td>negotiated</td>
<td>negotiated to</td>
<td>negotiated to capitated</td>
<td>‘fair shares’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>capitated</td>
<td></td>
<td>formula</td>
</tr>
<tr>
<td><strong>Scope</strong></td>
<td>Elective care</td>
<td>Selective of all</td>
<td>Selective of all HCHS</td>
<td>All HCHS, except</td>
</tr>
<tr>
<td></td>
<td>only</td>
<td>HCHS</td>
<td></td>
<td>NCB and maternity</td>
</tr>
<tr>
<td><strong>Clinical governance</strong></td>
<td>No</td>
<td>No</td>
<td>Sometimes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Formal status</strong></td>
<td>Independent</td>
<td>Sub-committee</td>
<td>Partnership with PCT</td>
<td>Statutory</td>
</tr>
<tr>
<td><strong>How selected?</strong></td>
<td>Voluntary,</td>
<td>Voluntary,</td>
<td>Voluntary, ‘compulsory’</td>
<td>Mandatory, self-selected?</td>
</tr>
<tr>
<td></td>
<td>self-selected</td>
<td>self-selected</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The characteristics of more successful practice-based commissioners

No ‘one’ model, *but* ...

- Historical local legacy of locality and GP-led commissioning
- Supportive PCTs – compacts developed to address local need *and* financial issues (i.e. common ground)
- Large consortia, most working with an external support partner in addition to PCT
- Strong clinical leadership – not just GPs
- Pooled management budgets /information support teams
- Incentive frameworks for individual practices
- Separate commissioning and provider functions
  - very clear governance and accountability rules
  - clear roles and relationships
- Risk sharing with PCT where budgets ‘devolved’
Some key challenges

- GP motivation and leadership
- Mandated vs. self-selected
- Size, scope and risk
- Provider vs. commissioner roles
- Commissioning competences
- Governance and accountability
- Management and transaction costs
- Developing commissioning partners
- Competition and choice
- Managing the transition
Managing the tension between providing and commissioning

GP Federations & GP Consortia

The King's Fund
Ideas that change health care
The History

- PCTs weak procurement practice
- Practice Based Commissioners - often practice based providers
- Good PCT procurement could manage conflicts of interest
- Sometimes few formal obstacles to establishing new services - growing examples of local innovation
The future

GP Consortia - Commissioning

- Separate bodies
- Conflict of Interest?
- Duplication of management costs?
- Who is driving innovation?

GP Federation - Providing

The King's Fund
Current guidance

- Transparency (audit trail)
- Proportionality (process)
- Non-discrimination (provider)
- Equality (across sectors)

10 Principles for cooperation and competition - tests - VFM, choice, equity, patient benefits + procurement principles
Questions

1. Is current guidance adequate in managing the inherent conflicts of interest?

2. Will the new structure promote or inhibit innovation?
Securing effective support to commission services

GP consortia will need to work with other organisations

▸ Many GP consortia will not have all the skills or capacity to commission effectively and may require external support

▸ Commissioning is a complex task that needs to be done at multiple levels
External support in PCTs

- External support can help, but using it effectively is not always straightforward

- Practical challenges:
  - Identifying what support is needed
  - Procuring support effectively
  - Building productive working relationships
  - Managing support providers against their contract
External support in GP consortia

- Will consortia have the skills and managerial capacity to use external support effectively?
- What arrangements need to be put in place to safeguard public accountability if outsourcing models are used?
The commissioning continuum

- Different services are commissioned most effectively at different levels.
- Two levels (GP consortia and National Commissioning Board) will not be enough.
- GP consortia will need to aggregate and also work with other partners e.g. local authorities.

<table>
<thead>
<tr>
<th>National specialised commissioning group</th>
<th>Supra-regional specialised commissioning groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional specialised commissioning groups</td>
<td>Joint commissioning with local authority</td>
</tr>
<tr>
<td>Primary care trust</td>
<td>Practice-based commissioning consortia</td>
</tr>
<tr>
<td>Personal health budgets</td>
<td></td>
</tr>
</tbody>
</table>
Questions

1. How can GPs work with providers of external support effectively?

2. How can the need to commission at multiple levels be reconciled with GP commissioning?