How to tackle the barriers to generating strong, agile GP-led commissioning organisations
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A new horizon for healthcare in England
The issues facing the NHS in 2011 are essentially no different to those facing any Western healthcare system either now or in the last few decades. They are simply becoming more pressing. As demography changes and healthcare developments open up opportunities for patients, greater control on healthcare spending becomes an ever more pressing feature of how care services must be managed. The information technology revolution also fuels patients’ desire for informed choices about their care. As long-term conditions become the predominant challenge for healthcare services, knowledgeable patients and their carers increasingly have very specific views about what care services they require and how those services need to be provided.

The Coalition Government’s health proposals provide a radical rethink of how, in practical terms, the NHS needs to work to put patients’ first. Putting patients first means providing choice, engendering individual responsibility, reducing bureaucracy and exercising the best management skills over scarce resources.

The means by which the Government proposes to achieve this are:

1. Placing the general practitioner (GP) in the frontline position both to directly provide primary care for patients, and having responsibility over the shaping and arrangement of secondary care services (commissioning). This will better align resource allocation decisions to the responsibility for clinical referral and handover along the pathway of care. A National Commissioning Board will oversee this.

2. Using commercial forces to strengthen efficiency, innovation, customer focus and choice in care provision by providing a decentralised care services market. Healthcare provision will become subject to competition law with commissioners being required to consider any willing provider when making decisions around where to place care contracts.

Key themes

- Governance is important to not only protect patients and public funds but also the reputation of GP consortia members.
- New organisations take time to build effective systems and behaviours but must start from sound principles.
- It is a common error to undersize the task.
- The PCTs and others do have a useful legacy from which to learn.
- It is not possible to outsource or delegate reputational risk.
3. Providing protected resources for health, expected to rise at least in line with price inflation to help meet future service needs

4. Refocusing system incentives by orientating funding and target regimes towards improved outcomes of care

This paper focuses on the first of these major policy aims, which is in turn influenced by the other factors of provider development, known resource restraints and changing incentives. In short, the 152 English Primary Care Trusts (PCTs) and the ten Strategic Health Authorities (SHAs) are to be replaced by a National Commissioning Board (NCB), local GP Commissioning Consortia (GPCCs) and local government control over public health and scrutiny of service redesign.

All GPs holding a patient list will be required to be part of a GPCC. The Secretary of State has been at pains to emphasise that he wishes to see an organic and locally appropriate development of GPCCs, and has thus only minimally stipulated their form and structure. 220 wave GPCC pathfinders have already been identified, and these are setting about their own development rapidly to take on commissioning functions and responsibilities from local PCTs. At the same time the number of PCT organisations has effectively been reduced by clustering arrangements, whereby residual PCT functions and accountabilities are increasingly being organised on a shared basis.

The expected form for a GPCC is straightforward. The GPCC will be a clinically-led organisation with the prime function of commissioning secondary care services. It will be made up of a geographically cohesive grouping of list holding GPs. Leading the GPCC will be an accountable officer, supported by a director of finance. Each GPCC will be a statutory body, established by a process of authorisation and governed by a locally developed constitution. The GPCC will be accountable to the NCB, and will be required to produce annual accounts. The GPCC will have a variety of key responsibilities as it acts on behalf of patients, such as working with the new Health and Wellbeing Boards to be developed within local authorities and with the local HealthWatch, which will be developed as the guardians of patients’ interests.

The challenges

During the autumn of 2010 and early 2011 Capsticks and the Good Governance Institute (GGI) have sought to better understand what will make the Government’s vision for health services in England work. This has been undertaken through a variety of individual and group discussions with opinion leaders, GPs (both those ‘connected’ to the current PCT structures and those who have not been so intensively engaged in previous commissioning activity), colleagues currently responsible for commissioning, those leading the development of provider organisations and academics who have sought to identify the challenges that the new GPCCs will need to overcome in order to succeed. We are also now working with a number of GPCCs which gives us additional insight.

Our first briefing (published November 2010) highlighted the importance of simultaneously tackling three tasks: PCTs carrying on with business as usual, GPCCs, with support, preparing to be open for business, and all focusing on the new arrangements delivering the anticipated benefits of the reforms. This paper gives a flavour from this work, and then goes on to suggest what we believe will need now to be put in place to best ensure the success of the new policy and thereby enhance the interests of patients.

The lens through which we do this is our own work on governance and accountability. We believe that good governance supports better care services by:

- Ensuring fairness and transparency
- Promoting better decision-making and decision-taking
- Protecting the reputations of those making difficult decisions, apportioning resources and placing contracts
• Providing stewardship of and clear accountability for taxpayers’ resources, including proper risk management

• Helping organisations maintain a strategic focus

• Supporting better management through providing constructive challenge and oversight

• Assuring quality, safety and innovation, with the board acting as ‘the first-line regulator’ and being the as guardian to patients’ and other stakeholder interests

• Ensuring that proper standards for a public body are maintained, in line with the Nolan principles

• Maintaining patient and community confidence, through good practice in patient and public involvement, and the proper stewardship of confidential data, for example

• Building on the better practice of other organisations

The NHS has to date adopted a fairly fixed approach to governance, prescribing unitary boards with little clinical involvement operating within a stringent compliance regime. Because of the centrally controlled shaping of local governance arrangements, governance structures and systems are often poorly owned, burdensome and provide little visible added value other than in focusing resources on centrally driven targets. We believe that the new Government policy holds the potential to develop proportionate, locally owned and, as a result, much more effective governance arrangements.

Our time spent with stakeholders suggests, however, there is a chasm of understanding that will need to be crossed to enable those leading the development of the GP commissioning consortia and supporting their efforts to get the benefits that can accrue from good governance. The majority of those we spoke to identify governance with administration or bureaucracy. At worst, governance was felt to be a leaden burden or a series of irksome chores completed only out of a sense of abstract angst in order to achieve utterly meaningless compliances. Risk management, clinical governance, information security, audit and quality assurance were all lumped in together as a porridge of unthinking pettiness which was being liberally poured over innovation and effort, stifling any chance of improvement. At best, GPs looked at governance as a necessary evil to protect them from being called to account by regulators pettifogging.

Those connected to organisations with formal governance systems, such as PEC Chairs, often confused the current NHS approach to governance with governance in toto. In other words, what they understood to be governance was the system the NHS has adopted in recent years i.e. of the unitary board supported by a series of committees, each checking off issues on behalf of regulators, centrally driven dictate or on behalf of special interest groups.

What we did not find were colleagues who could explain, for example, the basic principles of governance, and why these had been developed over time. Nor could the advantages accruing to good governance be readily seen. Indeed, when pressed as to why those connected to the current system used governance the usual response was the Nuremberg defence – ‘we are only following orders from a higher authority’.

However, in discussion, it was not difficult to unearth a keen awareness of many of the issues good governance issues address. For example, most GPs were concerned about protecting their professional reputations when patients might believe they were party to limiting resources for their own financial benefit. The leader of the Royal College of GPs, Dr. Claire Gerada summed this up with a hypothetical question from doctor to patient ‘You’ve got a nice BMW car but you will not allow me to have this cytotoxic drug that will give me three more months of life.’ GPs were also concerned about the consequences of financial pressures, and how they needed to act to ensure that they did not become personally or professionally liable for overspends. And of course most GPs were actually
involved in rudimentary governance systems within their practices. They simply understood these to be usual business practice rather than identifiable as ‘governance’.

Another theme worth mentioning was a lack of understanding of some of the basic principles of good governance. Once explained, GPs welcomed the concept of constructive challenge in order to support better decision taking. GPs viewed non-executives as community representatives rather than as part of the machinery of better decision-taking, transparent accountability and risk management. The idea of scrutiny through an audit committee across all governance processes was perceived as a novel (but good) idea. Most believed that audit committees were essentially a finance committee. Indeed, internal audit and a comprehensive audit programme were not understood.

Thinking of the task ahead, we identified some broader themes that will affect how quickly and successfully the reforms can be made to work. We identified that most GPs significantly undersized the managerial task ahead of them in terms of running a statutory body commissioning many millions of pounds worth of patient care. Many were aghast when competition law or judicial reviews were explained to them, and the range of responsibilities currently undertaken by PCTs. We agree with the view of many GPs that the task as described in August 2010 is not the task as panning out in April 2011. As the National Commissioning Board starts to develop, the Pathfinder programmes around the country have been initiated and as PCTs have started to cluster the national management of the reforms has moved on. There is currently a developmental hiatus in terms of the direction of local work to support the development of GPCCs as clusters finalise their own local approach to this task.

One variation of the development approach that is gaining traction in some areas is that of federated GPCCs. Some emerging consortia are keen to both keep their own organisations modestly-sized in order that they maintain the benefit of direct access to their patient lists, but at the same time are keen to benefit from economy of scale solutions to some of the commissioning support functions, or indeed band together as stronger purchasing groupings. It is very early days still and GPCCs interested in a federated approach are currently working through what this will look like. It is important to track such developments as they progress.

We have highlighted that GPs largely undersized the task before them. There appeared to be a lack of understanding of what, specifically, it was that a commissioning organisation needed to do, and when. The same was true of what organisational development tasks were required to set up a public body of the size and sophistication of a GP commissioning consortia. Few had thought through the mechanics of operating such an organisation. This included some of the very basic questions such as ‘how shall we be constituted’, ‘who can take decisions?’, ‘how do we surface issues of concern’, ‘how do we report what we do’ and even ‘how often should we meet?’ Indeed, we found that GPs are finding it an issue to simply manage their time in order to properly and fully lead the development of their own consortia while at the same time maintain their clinical workload.

Despite these significant issues in respect of understanding the governance role, what good governance should deliver and how to run a larger commissioning organisation, GPs were quickly able to grasp the benefits of governance to creating a well-run, clinically led organisation.

Making the reforms work – the contribution of governance

In ‘The Prince’ Machiavelli wrote “There is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things.” Our experience with organisations at a time of reform and our discussions with GPs and their advisors confirm our view that good governance is not just a useful tool for developing organisations, but actually the building block upon which they need to be built if the new reforms are to succeed and deliver benefits for patients. The compelling case is for governance of the new GP commissioning consortia to be:

- Based on sound governance principles and to a high industry standard
• Chosen, understood and valued by all members of the GPCC
• Proportionate and appropriate to function
• Seen to add value and deliver benefits for stakeholders
• Subject itself to continuous quality improvement effort
• Inclusive of all aspects of good governance practice, including strategic focus, risk management, clinical and corporate in application and able to satisfy all stakeholders


**Duties**

- To have a constitution that sets out:
  - the name of the consortium and the GP practices that are members;
  - the area for which the consortium is responsible that is relevant to their commissioning responsibilities and to define which Health and Wellbeing Board(s) it is a member of;
  - how it carries out its functions (i.e. who will be responsible for day-to-day executive decisions about commissioning);
  - how the consortium makes decisions, how it deals with conflicts of interest, and how it ensures effective participation of all its members

- To have an Accountable Officer, responsible for ensuring that the consortium carries out its functions in a way which ensures continuous improvements in quality and proper stewardship of public money
- To publish an annual report on how the consortium discharged its functions in the previous financial year, with particular reference to how it has discharged its function in relation to quality improvement and patient and public involvement. To hold a meeting to present the annual report to the public
- To have regard to the proper stewardship of patient and other personal information and manage information risk in line with guidance published by the NHS Information Governance Toolkit by assigning Caldicott Guardian and Senior Information Risk Ownership responsibilities
- To provide information or explanation where the NHS CB has reason to believe that the consortium might have failed or might fail to discharge its functions
- To offer NHS pension arrangements to staff employed by the consortium.

**Powers**

- Power to appoint staff and to decide on pay, terms and conditions for employees
- Power to select an Accountable Officer, who can be a member of a GP practice in the consortium or an employee of the consortium and who is then appointed by the NHS CB as part of consortium authorisation.

**What this could include in practice**

- Developing the consortium so that all of its GP practices, and the other health and care professionals and public and patient groups are collaboratively engaged in commissioning, and are able to work together effectively and in an open and transparent manner
- Developing arrangements to protect against conflicts of interest
- Developing effective systems to assess and manage service and financial risks, and to ensure service and business continuity
- Accessing communications support, including effective media handling
- Acting as a good employer, including providing training and development opportunities for all staff and having fair systems for determining pay
- Developing a constitution, which reflects the ‘Nolan principles’ of conduct in public life.
Next steps

It is important to patients that the Government reforms work, and are introduced with minimal disruption to care services. We feel that good governance will be a critical part of ensuring this, with an effectively shrinking financial envelope and at a time when public confidence will inevitably be tested. GPs will come, we believe, to value good governance as a practical help to keeping confidence and maintaining the very positive reputations that GPs enjoy with their patients. Our part is to help ensure that all governance investment adds value, is proportionate and delivers what it promises.

During the coming months we will continue our national dialogue with those in GPCCs and others to identify the value the above supports will be, and continue to involve GPs and others in their incremental development,

If you are interested in supporting this programme of work please contact
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Next steps for PCTs

Invite key clinicians to engage in PCT decision-making and find strategies to build insight into how commissioning works

Ensure that remaining PCT functions do not fall between the gaps during the period of transition

Draw up legacy documents of duties, contracts and obligations for GPCCs. This should seek to include softer intelligence on relationships and agreements with partners and suppliers.

Introduce GPCCs to roles of internal and external advisors including audit, HR, legal and information system support

Next Steps for GPCCs

Prepare a strategic cycle of business to clarify essential tasks and deadlines

Establish an internal review mechanism to chart priorities, plans and progress towards good governance

Explore the desirability of working in federation with colleague GPCCs

Clarify authorisation and regulatory requirements and design systems to provide assurance requirements are met without surprises.

Engage with PCTs and Local Authorities to determine what support they can offer and what obligations (contracts, leases etc that will pass to GPCCs)

Conduct exit interviews with key PCT staff

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