NHS Alliance

Putting GP Commissioning into Practice: Feedback from Listening Events

NHS Alliance

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1. Executive summary

In response to the White Paper, "*Equity & Excellence: Liberating the NHS"* proposals on GP Commissioning, the NHS Alliance was keen to capture feedback from frontline primary care professionals. This report forms just one element of the NHS Alliance response to the five consultations. Other reports replying to each of the consultations have been submitted separately. These include the results of the *"Listen up*" survey on GP Commissioning and the formal response of the NHS Alliance GP Commissioning Federation.

The comments outlined in this report do not represent formal NHS Alliance policy. They are opinions, experiences and views from the frontline.

They are the results of a series of four Listening Events, run by the NHS Alliance in association with the Royal College of General Practitioners, and generously supported by MSD. These events were open to all clinicians and managers, not merely NHS Alliance members. Almost 400 primary care clinicians and managers from practices, PBC consortia and PCTs attended events held in four locations in September and October 2010: London; Wetherby near York; Leicester and Newbury, Berkshire.

Delegates heard keynote addresses from Department of Health leads including:

- Dame Barbara Hakin, Managing Director of Commissioning Development
- Dr David Colin-Thomé, National Clinical Director of Primary Care
- Ben Dyson, Director of Primary Care
- Jill Matthews, Director of Primary Care Improvement Team

They were joined by NHS Alliance leaders and guest facilitators including:

- Michael Dixon, Chair
- Mike Sobanja, Chief Executive
- Professor Mayur Lakhani, past Chair, Royal College of General Practitioners
- Julie Wood, National Director GP Commissioning,
- Dr Amit Bhargava, GP Commissioning co-clinical lead

There was a lively exchange of views between delegates and speakers. A clear thirst for information was striking: including but not limited to whether the reforms would be properly funded; what structures were needed; how new bodies, such as the NHS Commissioning Board (NHS CB) or health and wellbeing boards, would operate. Delegates had different perspectives but shared some common concerns.

There was cynicism, with people citing experience of previous reforms that had not lived up to promises of putting GPs in the driving seat. There was also impatience. GPs said their profession took a practical approach and a recurring comment was:

"Tell us what you [the government] want and we will get on with it".

But there was an equally strong demand for freedom and flexibility, and an end to command and control top-down management approaches.

1.1 Key messages

For Department of Health

- Offer greater clarity about funding, particularly the management allowance. GPs are concerned that GPCC will have to take on a broad range of statutory functions from PCTs without the funding to obtain sufficient professional management support.

- Ensure SHAs and PCTs facilitate the development phase of GPCC. GPs want freedom and flexibility and an end to top-down command and control management, but in some areas SHAs or PCTs are not yet acting in accordance with those aims and with the thrust of the White Paper. Some PCTs are pulling funding from established PBC consortia, for instance. Some SHAs are moving their favoured candidates into posts early, while others are micro-managing PCT chief executives in order to encourage them to leave.

- Provide more guidance about the roles of, and relationships between, the NHS Commissioning Board, Monitor, the Care Quality Commission, local authorities, Health Watch and GPCC. Ensure all these organisations understand the reforms are about the frontline leading, not a top down restructure. Delegates were keen to build relationships but uncertain, at this stage, what form these different organisations will take and what their functions will be.

- GPs and primary care teams require support in order to embrace demanding new roles. There are considerable educational and developmental needs. Organisations such as the NHS Alliance, the NHS Institute, local deaneries and others should be involved in designing and providing courses and educational initiatives to support new leaders and the wider workforce involved in GP commissioning.

- Support localism – local areas making their own decisions based on local circumstances. Understand that people in different PCT and local authority areas have different experiences and are at different stages of development.

  Some existing PBC groups, PECs or other groups of GPs have good relationships and experiences with their SHAs, local PCTs, councils, social services or acute or community trusts. Others do not and may be hampered by vested interests, or take much longer to establish trusted relationships with partners.

For SHAs

- Facilitate GPs, practices and other primary care clinicians to develop their ideas and consider how to tackle the challenge. Avoid a top-down approach. Live up to the spirit of the White Paper and ensure you are supporting the frontline, not dictating to them.

- Ensure PCTs are facilitating and supporting emergent GPCC, not attempting to control their development, boundaries or key personnel.

- Ensure PCTs and GPCC are communicating on an equal basis. GPs need comprehensive information

about the roles and responsibilities of PCTs, particularly in relation to statutory functions.

For PCTs

- Facilitate and support emergent GPCC. Do not take a top-down command and control line management approach.
- GPs may not want to work within the boundaries of existing groupings, such as PCT areas or PBC groups. Respond to what local practices want rather than imposing formats.
- Encourage key directors and members of staff to work closely with GPCC in preparation to hand over PCT functions.
- Talent spot potential GP leaders and offer them development opportunities, in association with local deaneries and other sources of support. Ensure there is proper funding for backfill for clinical duties as GPs will need to devote significant amounts of time to establishing GPCC.

For GP Commissioning Consortia

- Don't wait for guidance. GPCC will have to decide their own destiny.
- Start talking to your colleagues, fellow GPs, other primary care staff and PCTs now. The transition stage is vital. You need to build relationships and consider who will be in your consortia, where you boundaries will be, and what your priorities are.
- Work closely with key PCT leads to learn about their roles, responsibilities and functions. There is a steep learning curve, particularly in relation to the broad range of PCT statutory functions such as safeguarding.

1.2 Key themes

A. Cost pressures
GPs were worried that GPCC management would not be properly resourced. Delegates warned that they were being asked to take on statutory duties from PCTs that they do not have the skills or capacity to deliver without professional management support.

"Are we being set up to deliver functions we cannot afford?"

Others said estimates of proposed funding for the management allowance had already being reduced from £12 per head of population to £10 to £9 and were concerned it may fall further. At one event, a speaker reported a successful integrated care trust said current management costs were £24 a head. So GPs were being asked to do much more for far less.

Delegates were also concerned about overall budgets. A recurring question was whether GPs were being "set up to fail" at a time of constrained resources, or to "take the rap for rationing".

"General practice's greatest success in making the White Paper work could be its greatest failure".

This speaker said commissioning inevitably included decommissioning. If GPs were responsible for taking unpopular decisions to close local hospitals, the profession could lose public support and be left without that crucial bulwark in any future arguments with central government – of whatever political leaning.

GPs were unsure whether it was possible to pursue patient choice at the same time as cost-effective

commissioning in a world of constrained resources.

They asked whether patients should have the right to choose expensive hospital services over local primary care run services? And why primary care should invest time, money in developing new services if those services might not be used?

Many argued choice should only start at the point of referral to secondary care – if a service had been commissioned and was provided in primary care, there should be no choice. An NHS Alliance lead explained patient choice might mean deciding from an agreed, limited menu.

One speaker was concerned that restricted choice could lead to the introduction of top-up payments, with those patients who were able to pay getting a superior service.

B. Local flexibility
All delegates agreed GPCC need the freedom and flexibility to make decisions at local level.

"If the reforms are going to be as brave as [the government says] then they will have to give up the desire to know everything. They will have to trust that we share the same goals and will deliver the goods. That is the test for politicians."

Trust was a real issue for many attendees: whether the government actually trusts GPs to get on and do the job and whether GPs can take the government at its word. Also whether SHAs and PCTs will live up to the White Paper promise of reforms led by the frontline, freeing clinicians from top-down, command and control management. One delegate reported an SHA attempting:

"… to get rid of PCT chief executives by grinding them down with another abusive request to fill out a 27 page report by 4pm."

GP commissioners do not want to be overburdened with statutory responsibilities transferred from Primary Care Trusts. GPs and other clinicians must be able to be "fleet of foot" rather than bogged down in bureaucracy. At present they do not have the skills or experience to manage many of the functions of PCTs such as safeguarding. However, some delegates recognised that GPCC will have to take on new tasks including those for which there is less enthusiasm.

C. Thirst for guidance
Potential commissioners need much more information and support to enable them to take on new and demanding responsibilities. Delegates were concerned that the timescale for reform was very tight. One commented:

"I am not sure that the government or Department of Health is aware how vast the change is. They want to do this in their first term. I feel GPs are being set up to fail."

Delegates wanted information about a variety of issues. Chief among these were funding, what government expects and the structure, functions and roles of GPCC, the NHS Commissioning Board (NHS CB), Health & Wellbeing boards and local authorities. A recurring theme was that the NHS CB should concern itself with *what* commissioners should do, not *how* they do it.

"We do not want heavy handed regulators – GPs will walk if the regulation is too heavy-handed."

D. Transition
Delegates warned the transition phase was vital. Some delegates urged potential GPCC to start building relationships with managers in PCTs now.

"Good people are already leaving the NHS – you can't wait for all the detail or to be told what to do."

Others said GPCC need to spend the next two years learning from PCTs about all the functions that GPs are not currently responsible for, and how much is spent in these areas. In contrast, some speakers were sceptical:

"Why would you want to learn from someone who has failed to do their job well?"

Still others pointed out GPCC may have radically different structures from PCTs. They may not want to have a finance director but to employ a finance manager, they may not want a director of commissioning – different GPCC will organise themselves in whichever way best meets their own needs and the needs of the population.

E. Maternity services
Delegates across all four events objected strongly to proposals for maternity commissioning to be an NHS CB responsibility and could not understand the logic.

"If you take maternity out, why not take out cancer too?"

On a show of hands, two-thirds of delegates at one event objected to the proposals. Only one or two thought the NHS CB should commission maternity care. The remainder were undecided.

Others feared if these services were commissioned by GPCC it would drain resources.

"*Maternity always seems to bust the budget."*

2. The debate: detailed feedback

2.1 Resources

Delegates wanted reassurances about the size of budgets that commissioning groups will control.

'Will they be based on per head of population – registered GP population or census data – or historic PCT allocations?'

A GP asked about moving towards the fair shares allocation, saying many practices were "not happy" and so even more worried about future funding under GPCC.

Many speakers were concerned that GPCC would be hampered by inherited deficits or expensive PFI or LIFT schemes that would limit their ability to invest in local services.

2.1.2 Quality premium

Several doctors were concerned about the quality premium linking practice income to the performance of the GPCC.

"Is this a clever way to get GPs policing each other's referral patterns?"

Some delegates were worried the premium would be punishing GPs for factors that they couldn't control, such as year-on-year variation in practice spend. Just one seriously ill patient who needed expensive treatment could have a significant effect on practice income.

A delegate won some support for saying the premium should be set at a high enough level to change behaviour. "If it's 2% of the budget, GPs will not be engaged." People in one workshop commented QOF targets were too easy so GPs get paid before there is a real difference in what they do. Any new quality payments should have a focus on activities where there is strong

evidence of health gains, such as disease prevention.

Others warned quality payments should be assessed and delivered at the start of the financial year if they were to be influential, and budgets should be set over a lengthy period.

"We need three to five year budgets – one or two years will not encourage behaviour change. To move people forward we need financial assurance over longer periods."

2.1.3 NHS tariff

There was debate about the role of the NHS tariff. Delegates asked, why should the NHS have a set price for procedures and care at all? It means there is less freedom for consortia to compare providers. Some commented that the tariff always inflates costs.

2.1.4 Other resource issues

One speaker pointed out GPs will be taking on responsibility for tackling supply-driven demand from acute trusts. Delegates said it was vital that commissioners work with secondary care to overcome incentives to ramp activity up. GPCC will have to discourage unnecessary consultant-to-consultant referrals. They need more levers such as referral or hand-off limits.

Many delegates made the point that management allowances must be sufficient to support the range of statutory functions GPCC are being asked to take on.

There was also concern that GPCC might have to take on PCT staff transferred to the new organisation under TUPE arrangements, with NHS pay grades, terms and conditions. Delegates reported receiving conflicting information here. Some speakers had been told categorically TUPE would not apply, while others had been told equally strongly that it would.

Equally, delegates feared GPCC would be hampered by existing contracts for Independent Sector Treatment Centres (ISTC).

"ISTC contracts need to go. GPCC should not be tied to contracts that may not be the most quality and cost effective solution for local needs."

2.2 Setting up GPCC - population and boundaries

At every event, delegates asked whether there was a certain minimum size for commissioning groups. Despite reassurance from Department of Health and NHS Alliance leads that it was for local clinicians and managers to decide, delegates kept returning to the issue.

"*We are hoping to set up a GP consortium from April,"* one said, *"but there are big questions and it would be useful to have the numbers or know when [guidance] is coming out."*

They argued that there must be a minimum size required for financial sustainability and to ensure sufficient funding for the management functions that will be transferred from PCTs.

Many delegates said there should be no restrictions – the centre could set criteria and standards but size must be left to local discretion. They agreed consortia must be large enough to be financially viable and strong in negotiations with secondary care. They discussed whether there is a way of managing risk so that groups can be small enough to be responsive to local needs but large enough to be viable.

Some felt there was an advantage in configuring GPCC along local authority boundaries, in order to plan services for the local population and build strong relationships with social care, public health and other functions.

Others said where the bulk of spending would be with one acute trust, it made more sense to group around this. In contrast, some delegates warned it could be dangerous, giving one trust too much power.

A number of speakers said size should be dictated by task. Groups should decide what they want to achieve first and then look to see what arrangements flow from that. Consortia may seek out like-minded practices as a starting point.

One workshop group discussed what they described as the Starbucks model where a GPCC might have no geographical boundaries, but operate franchises around the country. A patient could go into a branded practice or service and know they would receive the same service in one part of the country as another. However, a real disadvantage would be this kind of system would not have the same local knowledge and buy-in as local schemes.

There was concern about tension between the existing partnership model of primary care colleagues working together to improve healthcare and the corporate model of GPCC.

Some delegates suggested Practice Based Commissioning consortia may be a building block for GPCC but others felt strongly that the reforms should start from scratch with a new blueprint.

Delegates discussed two main models:

- A small GPCC based on a locality but sharing functions with other groups to achieve economies of scale, pool risks and have real negotiating power with acute trusts. This could have a patient population of 100,000 to 150,000.
- A larger GPCC, with a locality structure to retain links with the frontline but having the scale to negotiate with acute trusts and to pool risks. Groups covering 750,000 patients would be too large even with a locality structure, while five practices would be too small to be effective. Groups with 100 practices would inevitably have passengers who do not contribute to the work of the GPCC. Some felt a population of around 500,000 would be the optimum size.

2.3 Setting up GPCC – governance

There was debate about which governance structures would be appropriate to engage GPs and ensure legitimacy while having the levers to influence behaviour. A common theme was that the NHS CB should limit itself to assessing whether proposed GPCC structures were fit for purpose – the details should be left to local discretion.

Many delegates agreed with a speaker who said:

"*You need the freedom to decide what works for you – how you triangulate freedom, accountability and statutory responsibilities.*"

Some delegates would like a GP to be the accountable officer for statutory purposes, having equivalent responsibilities to current PCT chief executives. Others said GPs will need to or prefer to spend their time on their core role, and may employ a manager or director to do the job. Some felt anyone with the right skills could be the accountable officer.

One delegate suggested GPCC should have a senate structure akin to universities:

"*Where every GP in the area has a say and no key decisions are made without the senate being happy."*

Allied health professionals pressed the case for involving other clinicians beyond GPs and nurses. Some delegates agreed that, as care is provided by multi-disciplinary teams, it's important that they are represented on the boards of GPCC. Others were not enthusiastic. They said it was crucial to have input from different professions but not necessary to have them on the board itself.

This topic was linked to discussions on Patient and Public Involvement (PPI) and how the public should be represented and included as part of governance structures and processes. Ideas included:

- laypeople sitting on boards
- a patient group for each GPCC
- using existing practice participation groups
- recruiting people from existing networks such as voluntary organisations.

Health Watch was barely mentioned.

2.3.1 The risk of failure

There was considerable debate about risk and what would happen if a GPCC fails. Some speakers said GPCC needed a clear risk management system so participants have an opportunity to address any serious problems before crisis point is reached.

Any regime for dealing with failure must allow participants to understand what the problems are and to distinguish between poor management or reasons beyond the control of the GPCC. Delegates agreed with NHS Alliance chief executive Mike Sobanja when he highlighted the need to be clear about what was meant by success or failure and how stakeholders define those terms – overspending, poor media coverage, or other factors?

2.3.2 Conflict of interest

Delegates said there is a danger of conflicts of interest when GP commissioners purchase services from primary care. They pointed out that GPs have set up new services under PBC that they don't want to lose.

Many felt transparency and clear governance will be the key here, comparing primary care to industry and commerce.

"Business deals with conflicts of interest every day by being open, transparent and allowing outside scrutiny where that is needed."

Doctors should tell patients when they refer to a service where the practice is a stakeholder. Patient and public involvement in commissioning new services will be a safeguard.

Delegates felt strongly that policy-makers should understand that this is not solely a GP issue. Conflicts of interest happen in other sectors and when NHS functions or services are outsourced. Some insisted conflict is inherent whenever clinicians have the option to treat or refer, in secondary care as much as in primary care.

2.4 Engaging GPs

There was a strong warning that GPs could block change if they were not sufficiently persuaded of the advantages of reform to them and their patients. They need incentives to engage. GPs are practical and become interested when they can see that a policy actually changes the lives of patients. Many said peer pressure is vital – GPs are influenced by their colleagues.

Leadership is equally important *"to avoid the idea that this is someone else's responsibility".* Potential GP leaders should be talent spotted, supported and equipped with the resources to bring their colleagues on board. That must include backfill to cover their clinical workload and

free up their time to work on GP commissioning.

2.5 NHS Commissioning Board

Delegates wanted to know much more about the role and structure of the NHS CB. They stressed it must establish a relationship of trust with local commissioners and have credibility with GPs. It should trust the strategy developed by local GPCC and allow change to work through.

"The Commissioning Board could be the most critical enabler but also the most critical destroyer of this system. It needs to be really credible with primary care."

They wanted to know what NHS CB authorisation for GPCC would look like. How rigorous would it be, and in what circumstances would it reject proposals? How could the NHS CB facilitate GP commissioning? Most delegates felt it should check whether GPCC are fit for purpose but not interfere beyond that.

"It mustn't be like World Class Commissioning or we will all fail. It must be about the what [we do], not the how [we do it]."

The Board needs to demonstrate trust and a genuine belief in localism.

Speakers suggested the NHS CB may ask PCTs for information when considering authorising a GPCC group, or look at the performance of relevant PBC groups.

Delegates asked whether there would be local outposts of the NHS CB. Some felt this was necessary to support GPCC. Others that it could lead back to a command and control line management system. One speaker was concerned that the NHS CB would be about "jobs for the boys" and reported that West Midlands SHA was already moving its favoured candidates into suitable posts. Delegates felt the NHS CB should have a transparent recruitment process both centrally and in any local outposts.

Delegates also said the NHS CB should encourage sensible use of joined up local working and share learning. They were keen to know more about the timescale for establishing the board.

The NHS CB should engage GPCC in specialist commissioning. While there was logic in a central or regional body carrying out low-volume specialist commissioning, there should be communication with GPCC. One method would be GPCC deciding themselves which areas should be referred up to the NHS CB. GPCC will need to have "a handle" on the specialist commissioning spend.

2.6 Scope of commissioning

Delegates were not yet certain what GPCC would commission, which areas they would be given and which they wanted to control. They wanted guidance but also recognised that individual GPCC themselves needed to come to a view locally about priorities.

People were concerned that patients may move practices in order to gain services commissioned by one consortium and not another. And that patients who are informed, willing and able to move practices will be at an advantage over those who are not.

Delegates said there are possibilities for joint social care/health commissioning to smooth out care pathways such as for end of life care. And real opportunities to work creatively with local authorities, sharing problems and solutions.

People commented on the tension between focusing on local priorities and balancing the books with accountability for public money. Delegates felt working with local authorities and public health could help. But they warned the split

between the public health budget and the consortium budget must be rational otherwise there could be protectionism and cross-charging

Low priority treatments were the topic of considerable discussion. There was a call for clarity nationally about what the NHS will or will not do. It was felt GPCC would need to engage the public in deciding which treatments will not be funded and clinicians will need to be able to explain this to individual patients. Both require considerable communication and people skills and an understanding of the complexities of Patient and Public Involvement (PPI).

2.7 Patient choice

There was considerable discussion about what patient choice means and to what extent it is possible in a cash-limited system.

"I have three words – choice, choice and choice – how is it going to work?

If a GPCC has set up a community service should the patient in the consulting room still have a choice about whether to go to hospital "costing us three times as much", asked one delegate. Why would GPs and primary care professionals invest their energy, time and resources developing new primary care services if patients could choose to go elsewhere? Others suggested that GPs were able to persuade patients out of exercising choices that would be costly or otherwise unattractive for the clinician.

"In reality Choose & Book often means I choose, they book,"

Many felt patient choice should only be an issue once the GP has to refer to secondary care – if there was a service within the practice "that is not a choice". Others argued that full public and patient involvement in commissioning decisions would show some level of patient choice had already have been exercised.

2.8 NICE

Delegates were concerned that GPs might be overwhelmed with 350 commissioning guidelines, and that this would draw the NHS back into command and control management. Speakers suggested NICE had little expertise in primary care and that primary care had little input into NICE's judgments or work programmes.

2.9 Maternity services

There was sharp criticism of the proposal to commission maternity services at NHS CB level rather than GPCC. Delegates described this as "outrageous". Maternity, they felt, was part of primary care.

"*It is a vital link between GPs and the most disadvantaged, for whom it may be their only contact with primary care*."

Speakers could not understand the logic of taking maternity services out of GP commissioning. They felt GPs were best placed to facilitate maternity networks are they are the common factor in each pathway.

On a show of hands, two-thirds of delegates at one event said maternity services should be commissioned by GPCC. Only two people voted for the NHS CB to stay in charge, with the rest undecided.

Some delegates felt GPs needed to take control of local spending on maternity services, in order to stop unnecessary overnight admissions. Others suspected the Royal College of Midwives would object to GPs taking charge of maternity services, or felt that GPs were suspected of being hostile to home births.

A few delegates said taking responsibility for maternity services will, eventually, be unavoidable but pointed out spending is unpredictable.

"*Maternity services always seem to bust the budget*".

2.10 Outcomes and public health

Delegates believe strongly that any new commissioning arrangements should have a clear focus on outcomes, not processes. Yet, they pointed out, there are currently few well-developed patient outcome indicators.

"Outcomes are poorly defined – how will they become well-defined and meaningful?"

People said it would take two to three years of continued work to develop reliable and useful health outcome measures.

Public health information and expertise is essential when considering outcomes, delegates said. Public health needs to inform commissioning and services. Partnerships with local authorities are required when delivering or commissioning services such as sexual health.

Yet there were fears that primary care might find it harder to access support from colleagues in public health once that function is transferred to local authorities. Delegates felt strongly that commissioners will have to build bridges with councils and social services and work closely with them to address the needs of the population. Local authorities and commissioners should share information, problems and solutions.

2.11 Patient engagement

Patient and public engagement was seen as vital in a time of financial constraint. Speakers referred to Harvey Picker's dictum: "Nothing about me without me." The patient voice had to be represented in decisions about resource allocation and decommissioning.

Many delegates were concerned that GPs would be forced to make cuts in NHS services and would be blamed by the public for this.

Some delegates commented there was a need for public engagement on the big picture of overall spending priorities while individual patients or patient groups had a role in discussing the provision of particular clinical services.

A practice manager commented that practices already have patient participation groups (PPG) and that GPCC should use those existing methods of consulting with patients. Others said having a PPG was not enough and GPCC needed a new strategy for PPI. Consortia needed a governance structure for patient and public engagement.

One delegate warned patient and public engagement was very demanding.

"It involves lots of legwork. Some people will not sit around a table. It's challenging and it's a lot of hard work."

Patient engagement was not just about seeking views but about listening to users "even if it's not what you want to hear". She gave an example of a maternity services liaison committee, where the professionals were all very proud of a new unit yet one patient with disabilities had been highly critical.

"*There was a huge amount of discomfort and resistance from the professionals*."

A pharmacist said patients and public representatives could not be controlled and kept to specific topics where the professionals wanted to consult them. This tended to lead to a lot of "defensiveness" from clinicians. Engagement meant listening to patients as much as sharing information with them. Others said NHS bodies need to acknowledge and respond to feedback – all forms of feedback, not

merely where feedback has been formally solicited.

Many agreed with a speaker who said it was difficult to recruit a wide range of patient and public representatives, especially those from marginalised groups such as users of mental health services, or people who were not confident about speaking up in meetings. Some speakers suggested GPCC could draw on the expertise of the voluntary sector and other NHS services. Others suggested local authorities would be a source of help as they have more experience of engaging with the public at local level.

It was felt GPCC need to think carefully about how to respond to patients and the public. Listening was not enough. People need to see how their views translated into actual services. Patients should have input into designing care pathways and the front end of secondary care. Data capture and benchmarking was essential. Information should be shared in order to involve patients in decision-making.

GPs wanted to know when statutory public consultation would be required. There were other concerns that local councillors, sitting on Foundation Trust boards or in their local authority role, would need to be brought on board ahead of any changes to services.

At one event, delegates distinguished between public representatives who have some kind of democratic legitimacy and those lay people who bring specific skills sitting as non-executive directors, in fields such as finance.

2.12 Secondary care

Delegates said the success of the reforms rests on changing the culture where primary and secondary care clinicians operate largely in isolation. Increased understanding of each other's roles is vital.

Delegates at each event warned there will be a clash of objectives between GPCC and acute trusts.

"Primary care and secondary care are in direct conflict – 'gimme gimme gimme' and 'no, no no'. Acute trusts want to pull patients in to maximise their income while we have to stop patients getting through the door in the first place."

GPCC will pursue better health outcomes for fewer resources, while acute trusts, especially foundation trusts, will want their workload and income to grow. One speaker was supported when she warned acute trusts might seek to prevent their consultants working with primary care to redesign services. Others reported examples where this was already happening. Some delegates feared consultants themselves would not share the same goals as GPCC.

"Consultants won't want to train people to take patients away from secondary care."

A number of delegates agreed GPs need a way to give secondary care clinicians the confidence to move outside acute trusts, working in chambers or partnerships. SPMS contracts may give them that assurance. Alternatively, secondary care clinicians could be part of the consortium itself. Delegates responded positively when it was suggested that GPCC could recruit their own consultants should acute trusts try to block progress.

There was support for a proposal that all providers of NHS services should have to invest in professional training.

2.13 Community services

Similar points were made about the importance of working with colleagues in community healthcare.

"We are in danger of losing a pearl – really creative innovative use of community services could be lost as

they need a new home by April and the logic is they will be sucked up by acute care."

While one speaker felt it was up to GPCC to specify what community services they wanted, others objected saying the contracts were being put in place now and would be inherited by GPCC.

2.14 Information and data

Many delegates shared concerns that current information systems are not rapid enough or accurate enough. For instance, in many places practices did not know for some time when one of their patients had been admitted to hospital. In contrast, it was reported that in Hampshire, hospitals are able to inform practices on the same day.

Speakers felt GPCC needed robust and comprehensive data systems, as well as access to comprehensive data from other parts of the NHS, such as secondary care. Consortia and practices will need good data to demonstrate outcomes.

They said the current range of different systems in use decreases confidence in the data and its usefulness and gives non-co-operative GPs an excuse to ignore data.

Validation was needed to cross-check secondary care data. And there are educational needs for GP practices in analysing and interpreting data.

2.15 GP and primary care education

"I'm very aware that over the next two years we will be asked to manage a budget of £200m when our experience is of managing a budget of £750,000."

A recurring comment was that there are massive educational needs. GPs are experienced in running small businesses, not in taking corporate responsibility for large and complex organisations. They need to develop a thorough understanding of the work of secondary care.

Some delegates suggested organisations such as NHS Alliance, the NHS Institute or local deaneries might be sources of educational support. And leadership development, as mentioned above, is vital if primary care is to take on this challenge.