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4 October 2010

White Paper Team  
Room 601  
Department of Health  
79 Whitehall  
LONDON  
SW1A 2NS

Dear Sir/Madam

**NHS White Paper – Equity & Excellence: Liberating the NHS**

The NHS White Paper was considered at length by both North and South Essex Local Medical Committees at their meetings in September.

The LMCs also organised three evening meetings for GPs and practice staff with the aim of sharing information and obtaining views on the proposals contained in the Consultation document. Feedback from these meetings is attached as an Appendix.

Until the proposals are finally agreed and the operational implications can be properly assessed, it is difficult to measure the true impact on practices and patients. As part of the discussions that have taken place, there have however been a range of issues raised which it was agreed should be brought to the attention of the Department of Health as part of the consultation process as follows:-

- Commissioning responsibilities were being shifted to GPs without the management resources to support them.
- Inherited financial deficits and reducing primary care allocations will minimise the opportunity for consortia to maintain viability.
- The proposals appear to be designed in a way that encourages greater private sector involvement in commissioning and primary care.
- Training and management costs need to be properly resourced. Senior clinical time needs to be costed appropriately as it is likely that senior partners in practices will be heavily involved.
- Consortia must be accountable to constituent practices to enable ownership of the new arrangements by practices.
- No mention is made in the Consultation document of services for the Armed Forces. PCTs currently fund some areas of secondary care provision for this group of the population.
- Consideration needs to be given as to which PCT functions will be devolved to consortia.

- The performance management of practices by consortia is fraught with danger if not handled sensitively.
- Consortia members need to be elected/appointed by means of a process that has the support of GP practices.
- The proposals do present an opportunity to reduce excessive bureaucracy.
- GPs have yet to be consulted on whether they wish to assume this commissioning role. Serious consideration needs to be given to a ballot of the profession.
- This whole process must be bottom up in order to retain credibility. PCTs have an important role in facilitating, but not leading, the organisational change.

It is hoped these comments are of help.

Yours faithfully



**Brian Balmer**  
Chief Executive

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## FEEDBACK FROM LMC WHITE PAPER ROADSHOWS – SEPTEMBER 2010

### Basildon

- Will the NHS Commissioning Board have powers to expel poorly performing practices from consortia?
- The expertise of PCTs must be used to help to establish commissioning consortia.
- Coterminosity with Local Authorities is important. Thought needs to be given to how best to involve smaller unitary authorities in the new commissioning structures.
- The relationship between GPs and their patients will be fundamentally different.
- The advocacy role of GPs and their wish to concentrate totally on the well-being of patients is directly in conflict with the need to achieve financial balance.
- What constitutes a consortium in terms of minimum size?
- Consortia leadership must have credibility with practices locally.
- Is there any good practice that can be shared on the establishment and functioning of GP consortia?
- Where will the funding for primary care contracts be held?
- How much will the management allowance for consortium be and what will it fund?
- How will large consortia be able to adequately reflect local need identified at practice level?
- Will the private sector have a role in commissioning consortia?
- Will GP consortia be expected to inherit and manage financial deficits from existing PCTs?

### Feering

- Will dispensing by practices be in any way affected by these changes?
- Involving patient groups is important but difficult. How do we involve patients without a lobbying interest?
- The transfer of the Public Health function to Local Authorities needs to be carefully managed. Consortia need to establish close links with LAs and have a clear understanding of local health needs.
- How will the ability of patients to register with any practice of their choice anywhere in the country impact on commissioning budgets? How will home visits be managed and commissioned?
- The White Paper makes no reference to capital funds. How will primary care premises developments be funded in future? Are there any proposals to change rent reimbursement arrangements?
- What will happen to PCT owned premises under the proposed arrangements? How will they be funded and used?
- Have PBC groups made much progress in preparation for the move to shadow consortia? Are there any examples of good practice and/or lessons that can be shared?
- Great opportunity for primary and secondary care clinicians to work closer together, particularly on service redesign. Consortia cannot introduce changes to care pathways in isolation.
- The skills and expertise of PCT managers need to be retained and utilised during the transition and beyond.

- Practices being forced to work in a particular consortium will be difficult to manage. More thought needs to be given to this scenario as “alliances of the unwilling” won’t work.
- Will consortia be responsible for meeting the redundancy costs of PCT staff who transfer their employment?
- During the transition how will the double running costs of PCTs and consortia be funded?

## **Stansted**

- Will any future investment in primary care infrastructure need to be funded from savings arising from changes in activity/care pathways?
- Who will undertake all the work previously carried out by PCTs and not transferred to consortia?
- Any further advice on the size of consortia? The larger they become the more difficult they are to manage effectively.
- GPs need to be involved in the QIPP Agenda now. How can GP time be funded to allow their increased involvement in taking forward QIPP initiatives?
- Commissioning work needs to be properly resourced to allow locum cover to be provided in practices. In some areas there may be a shortage of GPs to undertake the work.
- There needs to be close working between consortia and secondary care clinicians in the redesign of care pathways.
- Experience to date demonstrates that secondary care is keen to offload work to primary care but without the associated resources.
- Will the commissioning of Out of Hours/Urgent Care be the responsibility of consortia?
- How will patients access specialist services commissioned by the NHS Commissioning Board?
- How confident can consortia be that financial allocations will be fair and realistic?
- There is a danger that consortia leaders will dictate to and not respect the views of other GPs.
- How do consortia utilise the skills of existing PCT staff whilst they are still employed by the PCT?
- It is important that PCT staff being aligned to consortia are the ones that consortia would wish to employ at some point in the future.
- Consortia will need a degree of financial security and assurances that contracts placed will be honoured.
- What thought has been given to risk sharing between consortia and/or NHS Commissioning Board?
- Will there be controls in place to stop consortia commissioning work from GPwSI at inflated prices?
- Estimates are that 20% of activity will need to transfer from secondary to primary care over a period of three to four years. Has the impact of this on local secondary care providers been properly assessed?
- The changes in commissioning arrangements and the move to a new single GP contractual framework threaten to destabilise primary care if not properly resourced.
- How can the rationing of services to patients be safely managed by consortia?
- How will consortia be monitored and what will the success criteria be?
- Patient education is crucial. Patient expectations are often unreasonable, particularly given the worsening financial position.
- Do these proposed arrangements create a major opportunity for private providers?