
LIBERATING THE NHS: COMMISSIONING FOR PATIENTS

A Briefing for Practices



NORTH & SOUTH ESSEX LMCs LTD

INTRODUCTION

Commissioning for Patients provides more detailed information on the Government's intended arrangements for GP Commissioning and the establishment of the NHS Commissioning Board, which will have a key role supporting consortia and holding them to account.

This document forms part of the public consultation on specific aspects of the White Paper: "Equity and Excellence: Liberating the NHS" and it seeks views on a number of specific consultation questions.

For ease of reference, a list of all the Consultation questions is included as an Appendix to this briefing. All responses to the questions should be sent to nhswhitepaper@dh.gsi.gov.uk by 11th October 2010.

THE NHS COMMISSIONING BOARD

The NHS Commissioning Board will be an independent statutory authority with its own Chair, Chief Executive and Executive and Non-Executive Board Members. It will have five broad functions as follows: -

- Provide national leadership on commissioning for quality improvement, for instance by developing commissioning guidelines based on quality standards and by designing tariffs and model NHS contracts.
- Promote and extend public and patient involvement and choice.
- Ensure the development of consortia and hold them to account for outcomes and financial performance.
- Commission certain services that are not commissioned by consortia, such as the national and regional specialised services.
- Allocate and account for NHS resources.

The NHS Commissioning Board will be accountable to the Secretary of State for managing the overall commissioning revenue limit and for delivering improvements against a number of measures of health outcomes. The Board will in turn hold consortia to account for the outcomes they achieve, for stewardship of NHS resources and for fulfilling criteria such as public and patient involvement and partnership with local authorities.

ESTABLISHMENT OF GP CONSORTIA

What status will GP consortia have?

Consortia will be statutory public bodies with powers and responsibilities set out in primary and secondary legislation. Each consortium will have both an Accountable and Chief Financial Officer, (although the latter role could be discharged for more than one consortium).

Will participation by practices be compulsory?

Yes – every practice will be required to be a member of a consortium as a corollary of holding a list of registered patients. All GPs and practice staff will not be expected to be involved in every aspect of commissioning. All practices will, however, be required to contribute to the goals of the consortium by providing services in ways that support high quality outcomes and the efficient use of NHS resources.

What form will consortium take?

GP practices will have the flexibility to form consortia in ways that they think will be able to secure the best healthcare outcomes for patients. This might include preserving existing PBC groupings where these have proved successful.

There will be no prescribed minimum size in terms of numbers of patients that consortia need to meet. There is no evidence available to suggest a single correct size.

Consortia will however need to:-

- Have sufficient geographic focus to be able to agree and monitor contracts for locally based services.
- Have boundaries that interlock so that taken together they cover the entire country.
- Be of sufficient size to manage financial risk and allow for accurate allocations.

Will consortia require formal approval?

The NHS Commissioning Board will have the duty and powers to authorise consortia. There will be a formal process in place to ensure that consortia are able to demonstrate their ability to fulfil their statutory duties and accountabilities.

The Board will have a duty to ensure comprehensive coverage of GP consortia across the country and the power to assign practices to consortia in the case of last resort.

WHAT SERVICES WILL BE COMMISSIONED BY GP CONSORTIA?

Consortia will be statutorily responsible for commissioning the vast majority of NHS services including elective hospital and rehabilitative care, urgent and emergency care (including Out of Hours) and most community, mental health and learning disability services.

There will, however, be some exceptions. The NHS Commissioning Board will have commissioning responsibility in the following areas:-

- Primary Medical Care – holding contracts with individual practices.
- Other family health services, eg. Primary dental, primary ophthalmic and community pharmacy services.
- National and regional specialist commissioning, ie. those covered by the Specialised Services National Definitions Set (SSNDS) such as heart transplant, spinal injuries, burns and renal dialysis.
- Maternity services.
- Health services for those in prison or in custody.

RESPONSIBILITIES OF GP CONSORTIA

The NHS Commissioning Board will calculate practice level budgets and allocate these budgets directly to consortia.

Consortia will be responsible for managing their combined budget and for deciding how best these resources should be used in meeting the healthcare needs of their local population.

GP consortia will be the responsible commissioner for any patients registered with constituent practices. In addition, consortia will be responsible for ensuring the provision of comprehensive emergency services for any person in their area.

The specific accountabilities, responsibilities and duties of consortia will be set out through primary and secondary legislation. This will include accountability and responsibility for: -

- Determining healthcare needs, including contributing to the wider joint strategic needs assessment led by local authorities.
- Determining what services are required to meet these needs and ensuring the appropriate clinical and quality specification of these services.
- Entering into and managing contracts with providers.
- Monitoring and improving the quality of healthcare provided through these contracts.
- Providing oversight, with the NHS Commissioning Board, of healthcare providers' training and education plans.

The legislation will also set out a consortium's duties in relationship to financial management, including: -

- Ensuring that expenditure does not exceed its allocated resources.
- Requirements in relation to reporting, audit and accounts.

RELATIONSHIP BETWEEN CONSORTIUM AND INDIVIDUAL PRACTICES

It is already apparent that if the Government's reforms are to prove successful and the alignment of clinical and financial responsibilities is to have the desired effect of improving healthcare outcomes and increasing patient choice, then constructive working relationships between consortia and individual practices will be absolutely crucial.

Whilst recognising that the duties and responsibilities ultimately rest with consortia, each consortium will be required to develop their "own arrangements to hold constituent practices to account".

Individual GP practices will be able to "ensure that commissioning decisions reflect their views of patients' needs and their own referral intentions" but this will need to be balanced against the contractual requirement that all practices contribute to the goals of the consortium which will include the need to address national commissioning priorities, drive up the quality of outcomes and improve the overall utilisation of NHS resources.

The environment within which practices will be expected to operate will therefore be completely different. "Commissioning for Patients" proposes a number of significant contractual changes, that if not handled sensitively and fairly at a local level, will fundamentally threaten the constructive working relationship between practices that is essential to the success of the new reforms.

Key issues that practices need to be aware of include: -

- Consortia will be required to develop arrangements to hold constituent practices to account.
- Existing contractual arrangements will be changed to make membership of a consortium compulsory for all practices who hold a registered list of patients.
- Practices will be contractually required to support consortia in ensuring the efficient and effective use of NHS resources.
- Commissioning budgets will be distinct from the income that practices earn under their primary medical care contracts from which they meet practice expenses and derive personal income.
- A proportion of practice income, to be known as a “Quality Premium” will however be directly linked to the overall outcomes that practices achieve collaboratively through their role in commissioning consortia.
- The “Quality Premium” will be paid to the consortium who will be free to decide “how best to apportion it between member practices”.
- The premium will be paid from existing resources. The Government’s incentive to practices to participate appears to be that in order to maintain current income levels, practices will be required to contribute to the successful achievement of the consortium’s goals.
- Consortia will have a key role in working with individual practices to drive up the quality of primary medical care and improve the utilisation of NHS resources.
- The NHS Commissioning Board will have the ability to delegate some of its work involved in the management of primary care contracts to consortia. Consortia could therefore become actively involved in reviewing and benchmarking the performance of individual practices and ensuring clinical governance requirements are met.
- Over time a single contractual and funding model for GP practices will be developed. This model will aim to provide quality improvement, deliver fairness for all practices, support free patient choice and remove unnecessary barriers to new providers.
- This new contract will concentrate on those services that all patients should expect to receive at their local GP practice.
- Commissioning budgets will include a maximum allowance to cover management costs. Consortia will be free to decide how best this resource should be used to support the delivery of the commissioning agenda at a local level.
- GP commissioners will have a statutory obligation to participate as members of new Local Health and Wellbeing Boards.

FREEDOMS, CONTROLS AND ACCOUNTABILITIES

Freedoms

GP consortia will be free to decide commissioning priorities that reflect local needs and will be supported by a national framework of quality standards, tariffs and national contracts produced by the NHS Commissioning Board.

- Consortia will have the ability to undertake commissioning activities themselves, by establishing local commissioner arrangements and/or by buying in external support.
- It will be for consortia to decide whether any commissioning activities can be undertaken at a sub-consortium or practice level and where this is deemed appropriate, ensure internal controls are in place.

Managing financial risk

- Consortia will have sufficient freedoms to invest resources in ways that achieve the best and most cost effective outcomes for patients.
- Consortia will, however, need to manage resources in ways that control financial risk. Flexibilities will exist to help consortia manage the financial risk within the overall requirements set by the NHS Commissioning Board.
- The NHS Commissioning Board will have a major role in managing financial risk, eg. by means of risk pooling within and between consortia.

Transparency/fairness of decision making

- The NHS Commissioning Board will develop a framework that ensures transparency, fairness and patient choice.
- Services will, in the main, be commissioned in a way that enables patients to choose from any willing provider. The any willing provider model will be particularly important in cases where a consortium proposes to commission services from one or more of its constituent practices.
- Consortia will be commissioning organisations and therefore unable to provide services in their own right.
- It is, however, recognised as being essential that individual/groups of practices have the opportunity of providing new services where this provides best value in terms of quality and cost.
- A framework will be developed that allows the commissioning of new services whilst guarding against real or perceived conflicts of interest.

Accountability arrangements

- Consortia will be accountable for the outcomes they achieve, their stewardship of NHS resources and for meeting any duties/obligations placed upon them.
- Consortia will need to meet the priorities identified for them as part of the NHS Commissioning Framework produced by the NHS Commissioning Board.
- Legislation will allow the NHS Commissioning Board to intervene in the event that a consortium is unable to fulfil its duties effectively.
- In cases where there are concerns that an individual practice is being wasteful or inefficient in its use of resources, then the consortium of whom the practice is a member will have powers to work with the practice in addressing the issues.
- If problems persist then these will be dealt with by the NHS Commissioning Board as part of its responsibility for managing primary care contracts.

PARTNERSHIP WORKING

- Consortia will work closely with the patients and local communities they serve, including through Local Involvement Networks (which will become local Health Watch bodies), patient participation groups, and with community partners.
- New local Health and Wellbeing Boards will enable consortia, alongside other partners, to contribute to effective joint action to promote the health and wellbeing of local communities, including combined action on health improvement, more integrated delivery of adult health and social care, early years' services and safeguarding of children and vulnerable adults.
- GP commissioners will have a statutory obligation to participate as members of the Board and act in partnership on these functions.

IMPLEMENTATION TIMETABLE

2010/11	<ul style="list-style-type: none"> ➤ GP consortia to begin to form on a shadow basis (building on practice based commissioning consortia, where they wish) and, where they are ready to do so, begin to take on some responsibilities from PCTs, supported by indicative budgets.
2011/12	<ul style="list-style-type: none"> ➤ A comprehensive system of shadow GP consortia in place, taking on increased responsibility from PCTs, including increased responsibility for the leadership of the existing Quality, Innovation, Productivity and Prevention (QIPP) initiative. ➤ The NHS Commissioning Board to be established in shadow form as a Special Health Authority from April 2011 and to have a role in supporting the development of GP consortia.
2012/13	<ul style="list-style-type: none"> ➤ Formal establishment of GP consortia, together with indicative allocations. ➤ The NHS Commissioning Board to be established as an independent statutory body. ➤ The NHS Commissioning Board to announce (in the third quarter of 2012/13) the allocations that will be made directly to consortia for 2013/14.
2013/14	<ul style="list-style-type: none"> ➤ GP consortia to be fully operational, with real budgets and holding contracts with providers.

COMPILATION OF CONSULTATION QUESTIONS

“Commissioning for Patients” seeks views on a number of specific consultation questions. Examples of existing practice and evidence that support respondents’ views are encouraged.

All the consultation questions are listed below. Responses to the questions should be sent to nhswhitepaper@dh.gsi.gov.uk by **11th October 2010**.

CONSULTATION QUESTIONS

- In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?
- How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?
- Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?
- How can other primary care contractors most effectively be involved in commissioning services to which they refer patients, eg. the role of primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?
- How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?
- What arrangements will support the most effective relationship between the NHS Commissioning Board and GP consortia in relation to monitoring and managing primary care performance?
- What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?
- How can the NHS Commissioning Board develop effective relationships with GP consortia, so that the national framework of quality standards, model contracts, tariffs, and commissioning networks best supports local commissioning?
- Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?
- What features should be considered essential for the governance of GP consortia?
- How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?
- Should there be a minimum and/or maximum population size for GP consortia?

- How can GP consortia best be supported in developing their own capacity and capability in commissioning?
- What support will GP consortia need to access and evaluate external providers of commissioning support?
- Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?
- What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?
- What are the key elements that you would expect to see reflected in a commissioning outcomes framework?
- Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?
- What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?
- How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?
- How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?
- How can we build on and strengthen existing systems of engagement such as Local Health Watch and GP practices' Patient Participation Groups?
- What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?
- How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?
- Where can we learn from current best practice in relation to Care Trusts, Children's Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to the new arrangements?
- How can multi-professional involvement in commissioning most effectively be promoted and sustained?

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