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Institute of Commissioning Professionals

**INSTITUTE OF
COMMISSIONING
PROFESSIONALS**

**LIBERATING THE NHS – IMPACT
ON COMMISSIONERS**

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Liberating the NHS - White Paper

Impact on Commissioners

1. Commentary

This paper sets out the main proposals as they affect commissioners and commissioning and seeks to clarify some of the issues for our members. As you are aware, a White Paper is the precursor to legislative change and it allows for consultation.

2. Key Proposals

Key Changes in Legislation

- Enabling the creation of a Public Health Service, with a lead role on public health evidence and analysis;
- Transferring local health improvement functions to local authorities, with ring-fenced funding and accountability to the Secretary of State for Health;
- Placing the Health and Social Care Information Centre, currently a Special Health Authority, on a firmer statutory footing, with powers over other organisations in relation to information collection;
- Enshrining improvement in healthcare outcomes as the central purpose of the NHS;
- Making the National Institute for Health and Clinical Excellence a non-departmental public body, to define its role and functions, reform its processes, secure its independence, and extend its remit to social care;
- Establishing the independent NHS Commissioning Board, accountable to the Secretary of State, paving the way for the abolition of SHAs. The NHS Commissioning Board will initially be established as a Special Health Authority; the Bill will convert it into an independent non-departmental public body;
- Placing clear limits on the role of the Secretary of State in relation to the NHS Commissioning Board, and local NHS organisations, thereby strengthening the NHS Constitution;
- Giving local authorities new functions to increase the local democratic legitimacy in relation to the local strategies for NHS commissioning, and support integration and partnership working across social care, the NHS and public health;
- Establishing a statutory framework for a comprehensive system of GP consortia, paving the way for the abolition of PCTs;

- Establishing HealthWatch as a statutory part of the Care Quality Commission to champion services users and carers across health and social care, and turning Local Involvement Networks into local HealthWatch;
- Reforming the foundation trust model, removing restrictions and enabling new governance arrangements, increasing transparency in their functions, repealing foundation trust deauthorisation and enabling the abolition of the NHS trust model;
- Strengthening the role of the Care Quality Commission as an effective quality inspectorate;
- Developing Monitor into the economic regulator for health and social care, including provisions for special administration; and
- Associated with these changes, reducing the number of arm's-length bodies in the health sector, and amending their roles and functions.

NHS Commissioning Board

The NHS Commissioning Board will be an independent organisation which is free to set guidelines on best practice for local commissioners and to use outcome measures for monitoring performance which are clinically based. It will also;

- Provide national leadership on commissioning for quality improvement;
- Promote public involvement;
- Allocate NHS resources to GP Consortia;
- Set standards, have an assurance and specialised commissioning role;
- Be accountable to the SoS for meeting the outcomes set out in the NHS Outcomes Framework; and
- Ensure financial stability.

The role of the NHS Commissioning Board

The Board will have five main functions:

1. Providing national leadership on commissioning for quality improvement:

- setting commissioning guidelines on the basis of clinically approved quality standards developed with the advice of NICE in a way that promotes joint working across health, public health and social care;
- designing model contracts for local commissioners to adapt and use with providers;
- designing the structure of tariff and other financial incentives, whilst Monitor will set tariff levels;
- hosting some clinical commissioning networks, for example for rarer cancers and transplant services, to pool specialist expertise;
- setting standards for the quality of NHS commissioning and procurement;

- making available accessible information on commissioner performance; and
- tackling inequalities in outcomes of healthcare.

2. Promoting and extending public and patient involvement and choice:

- championing greater involvement of patients and carers in decision-making and managing their own care, working with commissioners and local authorities;
- promoting personalisation and extending patient choice of what, where and who, including personal health budgets; and
- commissioning information requirements for choice and for accountability, including through patient-reported measures.

3. Ensuring the development of GP commissioning consortia:

- supporting and developing the establishment and maintenance of an effective and comprehensive system of GP consortia; and
- holding consortia to account for delivering outcomes and financial performance.

4. Commissioning certain services that cannot solely be commissioned by consortia, in accordance with Secretary of State designation, including:

- GP, dentistry, community pharmacy and primary ophthalmic services;
- national specialised services and regional specialised services set out in the Specialised Services National Definitions Set; and
- maternity services.

5. Allocating and accounting for NHS resources:

- allocating NHS revenue resources to GP consortia on the basis of seeking to secure equivalent access to NHS services relative to the burden of disease and disability;
- managing an overall NHS commissioner revenue limit, for which it will be accountable to the Department of Health; and
- promoting productivity through better commissioning.

The Board would not have the power to restrict the scope of the services offered by the NHS.

GP Consortia

The role of GP commissioning consortia

- The goal is to put GP commissioning on a statutory basis, with powers and duties set out in primary and secondary legislation.
- Consortia of GP practices, working with other health and care professionals, and in partnership with local communities and local authorities, will commission the great majority of NHS services for their patients. They will not be directly responsible for commissioning services that GPs themselves provide, but they will become increasingly influential in driving up the quality of general practice. They will not commission the other family health services of dentistry, community pharmacy and primary ophthalmic services. These will be the responsibility of the NHS Commissioning Board, as will national and regional specialised services, although consortia will have influence and involvement.
- The NHS Commissioning Board will calculate practice-level budgets and allocate these directly to consortia. The consortia will hold contracts with providers and may choose to adopt a lead commissioner model, for example in relation to large teaching hospitals.
- GP consortia will include an accountable officer, and the NHS Commissioning Board will be responsible for holding consortia to account for stewardship of NHS resources and for the outcomes they achieve as commissioners. In turn, each consortium will hold its constituent practices to account against these objectives.
- A fundamental principle of the new arrangements is that every GP practice will be a member of a consortium, as a corollary of holding a registered list of patients. Practices will have flexibility within the new legislative framework to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. We envisage that the NHS Commissioning Board will be under a duty to establish a comprehensive system of GP consortia, and we envisage a reserve power for the NHS Commissioning Board to be able to assign practices to consortia if necessary.
- GP consortia will need to have a sufficient geographic focus to be able to take responsibility for agreeing and monitoring contracts for locality-based services (such as urgent care services), to have responsibility for commissioning services for people who are not registered with a GP practice, and to commission services jointly with local authorities. The consortia will also need to be of sufficient size to manage financial risk and allow for accurate allocations.
- GP consortia will be responsible for managing the combined commissioning budgets of their member GP practices, and using these resources to improve healthcare and health outcomes. The Government will discuss with the BMA and the profession how primary medical care contracts can best reflect new complementary responsibilities for individual GP practices, including being a member of a consortium

and supporting the consortium in ensuring efficient and effective use of NHS resources.

- GP consortia will need to have sufficient freedoms to use resources in ways that achieve the best and most cost-efficient outcomes for patients. Monitor and the NHS Commissioning Board will ensure that commissioning decisions are fair and transparent, and will promote competition.
- GP consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities (such as demographic analysis, contract negotiation, performance monitoring and aspects of financial management) they may choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.
- We envisage that consortia will receive a maximum management allowance to reflect the costs associated with commissioning, with a premium for achieving high quality outcomes and for financial performance.
- GP consortia will have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, and the wellbeing of local populations.
- GP consortia will have a duty of public and patient involvement, and will need to engage patients and the public in their neighbourhoods in the commissioning process. Through its local infrastructure, HealthWatch will provide evidence about local communities and their needs and aspirations.

Public Health Service

Local Directors of Public Health will be jointly appointed by local authorities and the Public Health Service. Local Directors of Public Health will also have statutory duties in respect of the Public Health Service.

Local Authorities

Local authorities' new functions

Each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement.

Local authorities will therefore be responsible for:

- Promoting integration and partnership working between the NHS, social care, public health and other local services and strategies;
- Leading joint strategic needs assessments, and promoting collaboration on local commissioning plans, including by supporting joint commissioning arrangements where each party so wishes; and

- Building partnership for service changes and priorities. There will be an escalation process to the NHS Commissioning Board and the Secretary of State, which retain accountability for NHS commissioning decisions.

These functions would replace the current statutory functions of Health Overview and Scrutiny Committees.

As well as elected members of the local authority, all relevant NHS commissioners will be involved in carrying out these functions, as will the Directors of Public Health, adult social services, and children's services. They will all be under duties of partnership. Local HealthWatch representatives will also play a formal role to ensure that feedback from patients and service users is reflected in commissioning plans.

These arrangements will give local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to public health and social care. While NHS commissioning will be the sole preserve of the NHS Commissioning Board and GP consortia, our aim is to ensure coherent and coordinated local commissioning strategies across all three services, for example in relation to mental health or elderly care. The Secretary of State will seek to ensure strategic coordination nationally; the local authority's new functions will enable strategic coordination locally. It will not involve day-to-day interventions in NHS services. The Government will consult fully on the details of the new arrangements.

Commissioning Performance

'We are very clear that there will be no bail-outs for organisations which overspend public budgets.'

So who takes the final risk and how much will that cost? Will the guarantees be fixed or unlimited?

The NHS Commissioning Board will take over the current CQC responsibility of assessing NHS commissioners. Greater transparency will make it easier to compare the performance of commissioners and providers.

Tariffs

These are to reflect the cost of excellent care.

Timescale

The Department of Health has published the Government's proposed timetable (subject to Parliamentary approval for legislation). The following key dates will be of particular relevance to employers.

- All staff affected by SHA and PCT abolition to have had a discussion with their line managers – by end of September 2010.

- Separation of SHA's commissioning and provider oversight functions – by end of 2010.
- Public health white paper published – late 2010.
- GP consortia established in shadow form – 2011/12.
- Majority of reforms come into effect – April 2012.
- Formal establishment of all GP consortia – 2012.
- SHAs are abolished – 2012/13.
- PCTs are abolished – from April 2013.
- All trusts become, or are part of, foundation trusts – 2013/14.
- NHS management costs reduced by over 45 per cent – by end of 2014.

3. The Overview for Commissioners

Context

From what we can identify, there are 152 PCTs in England, some 35000 GPs and 10000 GP practices for a population of 51m. The NHS budget is £110Bn of which some £80Bn is for GP Consortia. Some commentators have suggested that there will be 500 GP Consortia which implies £160m per organisation of about 20 practices. This will be modified due to provisioning for local emergencies and disasters through a risk premium.

Local authorities will be responsible for securing the national objectives for Public Health, setting up partnerships and the JSNA. Generally instead of dealing with one PCT, they will be dealing with 3-4 GP Consortia who will be commissioning for all people plus any residual PCT functions. Does that mean changes to the Children's arrangements where DfE provide funding for certain vulnerable children?

So each GP consortium will have a lead with a consequent increase in the numbers of CEOs and Directors of Commissioning. What about all the Joint Commissioning posts between Councils and the PCTs. Will there be a joint commissioner for every GP Consortium?

With GPs taking patients from anywhere, the GP Consortia will have to be prepared to deal with a number of Councils.

In Adult Social Care, with the advent of personal budgets and substantial cost reductions in these areas, then will more cases be passed to the GP Consortia? Will they be able to handle direct payments?

Professional Development

The NHS Commissioning Board will have to address the criticisms made by the Parliamentary Health Committee report on Commissioning. Indeed, the White Paper implies an improvement but is not explicit about further actions to raise standards. It discussed workforce development and Education Commissioning but misses the point about how to address the workforce development of commissioners. It also makes no statement on how or if the commissioning profession will be regulated.

Recently an academic commented about the 'Taylorist' approach taken by many PCTs towards commissioning where the function is disaggregated into its constituent parts. Smaller GP Consortia will require more rounded commissioners who meet the full spectrum of skills and knowledge requirements.

This debate will affect the insurance companies particularly if employee-led organisations emerge from the embers of the PCTs.

The GP Consortia will have to be formalised and therefore issues of risk and liability, warranties and guarantees will have to be clearly stated. What changes are implied to the NHS Compensation Scheme or with the provider focus moving towards the third sector, will a centralised scheme still be appropriate under the new regulation and inspection arrangements?

GP skills will need enhanced in order to run large scale consortia and the GP contract will require modification.

It would appear that the US Health Management Organisations would be in an advanced state of preparedness due to having advanced IT which measures performance and can handle the accounting requirements. Would the Any Willing Provider rules or the Right to Request to establish a Community Enterprise be extended to the commissioning function?

4. Conclusions

This White Paper represents a considerable set of opportunities for commissioners as well as some real threats. We are not as naive to suggest that commissioning is the complete answer to the opportunities and problems within the NHS. We have a healthy scepticism which revolves around the issues for clarification. The opportunities include;

- Development of a key professional basis for a major funded health service;
- More closely linking clinicians and commissioners to work for the patient;
- Potential removal of bureaucracy;
- Developing robust commissioning standards and linking these to education;
- Formation of a library of best practice in commissioning;
- Achieving professional recognition;
- Extending the scope and training of the professional commissioner;
- Formation of employee-led GP Commissioning Consortia;
- Potential to use market making skills to enhance local service delivery;
- Development of enhanced relationships with Councils and the Third Sector; and
- Implementing local development of the vision on 'Liberating the NHS'.

What we can say is that our members are committed to making this work but that requires a similar commitment from the government and DH to invest in raising professional standards and recognising the efforts of commissioners. Commissioning has a wider locus than DH and this needs to be recognised too.

The consequence of failure of the policy is considerable as local or widespread breakdown of the NHS and consequential reputational risk could lead to an electoral failure. The last government did not wish to recognise that its policies were being 'built upon sand'. This government cannot afford any risk of failure in commissioning.

Whilst the White Paper is a start for the reform process, there are a number of issues which require further clarification.

Issues for Clarification

- Is DfE planning parallel legislation for Children or does this imply Children's Social Services are again the remit of DH;
- How can £80Bn pa be awarded to GPs who are in the private sector without competition? GPs have responsibility but who has the authority to spend? The GP Consortia will do that from within or outwith the private sector.
- What organisational form and what warranties, guarantees and liabilities will these have? The implication of no bail outs means that overspending comes from the owners' pockets. The corollary is where does the profit go? So the instruction from the owner will be to underspend as downside risk is unacceptable. Will there be any compensatory mechanism? How quickly will the organisations become insolvent?
- Are there any lessons which could be learned from the shared service operations between councils?
- The first step with commissioning is to ask the service user how their needs can be met. So who asked the GP's and Commissioners if they wanted the proposed changes and what issues need to be addressed?
- What VAT and taxation implications are there - particularly for GP Consortia, the management charge and any outsourcing of the service?
- Will health commissioners be recognised as a Health Professional?
- How will the maximum management fee be determined?
- Will the GP consortia be able to get other income i.e. from special rebates or promotions from suppliers? Will they offer GP services to BUPA?
- What conflicts of interest could emerge between GP Commissioning Consortia and the GP Practices and how will these be mediated, arbitrated and regulated?
- The translation of needs to outcomes – the development of Outcome Based Assessment practices are required to enable better focus upon improving health outcomes. Who is charged with their development?

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