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LIBERATING THE NHS: COMMISSIONING FOR PATIENTS
A consultation on proposals

Executive summary

Introduction

1. The White Paper *Equity and Excellence: Liberating the NHS* sets out the Government's strategy for the NHS. Our intention is to create an NHS which is much more responsive to patients, and achieves better outcomes, with increased autonomy and clear accountability at every level.

2. This document, *Commissioning for patients,* sets out the intended arrangements for GP commissioning and the NHS Commissioning Board's role in supporting consortia and holding them to account, and invites views on the implementation of these proposals.

3. It is part of a suite of documents supporting the White Paper and should be read alongside the parallel document *Local democratic legitimacy in health*, which sets out plans to increase local democratic accountability. These documents can be found on the Department of Health website at www.dh.gov.uk/liberatingthenhs .

Proposed commissioning arrangements

4. Our proposals for GP commissioning and the NHS Commissioning Board mark a fundamental break with the past. Most commissioning decisions will now be made by consortia of GP practices, free from top-down managerial control and supported and held to account for the outcomes they achieve by the NHS Commissioning Board. This will push decision-making much closer to patients and local communities and ensure that commissioners are accountable to them. It will ensure that commissioning decisions are underpinned by clinical insight and knowledge of local healthcare needs. It will enable consortia to work closely with secondary care, other health and care professionals and with community partners to design joined-up services that make sense to patients and the public.

5. Our proposed model will not mean all GPs, practice nurses and other practice staff having to be actively involved in every aspect of commissioning. Their predominant focus will continue to be on providing high-quality primary care to their patients. It is likely to be a smaller group of primary care practitioners who will lead the consortium and play an active role in the clinical design of local services, working with a range of other health and care professionals. All GP practices, however, will be able to ensure that commissioning decisions reflect their views of their patients' needs and their own referral intentions. It will be a requirement for every GP practice to be part of a consortium and to contribute to its goals, not least in ensuring that as a practice they provide services in ways that support high-quality outcomes and efficient use of NHS resources.

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6. Nor will the practitioners who lead the consortia need to carry out all commissioning activities themselves. Whilst it is likely that they will coordinate most of the clinical aspects of commissioning themselves, consortia will be able to employ staff or buy in support from external organisations, including local authorities, voluntary organisations and independent sector providers, for instance to analyse population health needs, manage contracts with providers and monitor expenditure and outcomes. Consortia will have the freedom to decide which aspects of commissioning activity they undertake fully themselves and which aspects require collaboration across several consortia, for instance through a lead commissioner managing the contract with a large hospital or commissioning low-volume services not covered by national and regional specialised services.

7. GP consortia will also be supported by the role of the NHS Commissioning Board in developing commissioning guidelines, model contracts and tariffs.

8. Transferring commissioning functions to consortia and, in some cases, the NHS Commissioning Board, alongside the potential role for local health and wellbeing boards set out in *Local democratic legitimacy in health*, means that PCTs will no longer have a role. We expect that PCTs will cease to exist from April 2013, in light of the successful establishment of GP consortia. A number of PCTs have made important progress in developing commissioning experience. We will be looking to capitalise on that existing expertise and capability in the transitional period, where this is the wish of GP consortia.

9. PCTs will have an important task in the next two years in supporting practices to prepare for these new arrangements. We want implementation to be bottom-up, with GP consortia taking on their new responsibilities as rapidly as possible and early adopters promoting best practice.

Responsibilities of GP consortia

10. In order to shift decision-making as close as possible to individual patients, the Department will devolve power and responsibility for commissioning most healthcare services to groups of GP practices.

11. Consortia of GP practices will commission the great majority of NHS services on behalf of patients, including elective hospital care and rehabilitative care, urgent and emergency care (including out-of-hours services), most community health services, and mental health and learning disability services.

12. Consortia will not be responsible for commissioning primary medical services, which will be the responsibility of the NHS Commissioning Board, but consortia will become increasingly influential in driving up the quality of general practice. The NHS Commissioning Board will also commission the other family health services of dentistry, community pharmacy and primary ophthalmic services, as well as national and regional specialised services, maternity services and prison health services, but with the influence and involvement of consortia.

13. The NHS Commissioning Board will calculate practice-level budgets and allocate these resources directly to consortia. Consortia will be responsible for managing these combined budgets, which will be kept separate from GP practice income, and deciding how best to use resources to meet the healthcare needs of their patients. They will have a duty to ensure that expenditure does not exceed their allocated resources. They will enter into contracts with providers and hold providers to account for meeting their contractual duties, including required quality standards and patient outcomes.

14. 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 and public health.

15. Consortia will need to engage patients and the public on an ongoing basis as they undertake their commissioning responsibilities, and will have a duty of public and patient involvement.

Relationship between consortia and individual practices

16. 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 a duty to be a member of a consortium and to support it in ensuring efficient and effective use of NHS resources.

The role of the NHS Commissioning Board

17. To support consortia in their commissioning decisions we will create a statutory NHS Commissioning Board, which will:
    - 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.

18. 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 their performance.

Establishment of GP consortia

19. The intention is to put GP commissioning on a statutory basis, with powers and responsibilities set out through primary and secondary legislation.

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20. Every GP practice will be a member of a consortium, as a corollary of holding a list of registered patients. Within the new legislative framework, practices will have flexibility to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality. The NHS Commissioning Board will have a duty to ensure comprehensive coverage of GP consortia, and we envisage a reserve power for the Board to assign practices to consortia if necessary.

21. Consortia will be formed on a bottom-up basis, but will need to have sufficient geographic focus to be able to agree and monitor contracts for locality-based services (such as urgent and emergency care), to have responsibility for commissioning services for people who are not registered with a GP practice, to commission services jointly with local authorities, and to fulfil effectively their duties in areas such as safeguarding of children. The consortia will also need to be of sufficient size to manage financial risk effectively, notwithstanding their ability to work with other consortia to manage financial risk.

Freedoms and accountabilities

22. We envisage that consortia will receive a maximum management allowance to reflect the costs associated with commissioning. Consortia will have the freedom to decide what commissioning activities they undertake for themselves and for what activities they choose to buy in support from external organisations, including local authorities, private and voluntary sector bodies.

23. Consortia will have the freedom to use resources in ways that achieve the best and most cost-efficient outcomes for patients. At the same time, the economic regulator and the NHS Commissioning Board will ensure transparency and fairness in spending decisions and promote competition, for instance by ensuring wherever possible that any willing provider has an equal opportunity to provide services. The Department will discuss with the NHS the safeguards that will be needed to ensure these objectives, particularly with regard to consortia commissioning services from general practice (over and above the primary care services that they already have a duty to provide).

24. The NHS Commissioning Board will be responsible for holding consortia to account for the outcomes they achieve, for stewardship of NHS resources and for fulfilling duties such as public and patient involvement and partnership with local authorities. In turn, each consortium will develop its own arrangements to hold its constituent practices to account.

25. We propose that the NHS Commissioning Board, supported by NICE, will develop a commissioning outcomes framework so that there is clear, publicly available information on the quality of healthcare services commissioned by consortia, including patient-reported outcome measures and patient experience, and their management of NHS resources. The framework would also seek to capture progress in reducing health inequalities.

26. We propose, subject to discussion with the BMA and the profession, that a proportion of GP practice income should be linked to the outcomes that practices achieve collaboratively through commissioning consortia and the effectiveness with which they manage NHS resources. The NHS Commissioning Board will need powers to intervene in the event that a consortium is unable to fulfil its duties effectively or where there is a significant risk of failure. We propose working with the NHS to develop criteria or triggers for intervention.

Partnership

27. Consortia will need to work closely with the patients and local communities they serve, including through Local Involvement Networks (which will become local HealthWatch bodies) and patient participation groups, and with community partners.

28. The proposed new local authority health and wellbeing boards would 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.

29. We will work with the NHS and the health and care professions to promote multi-professional involvement in commissioning.

Implementation

30. Our proposed implementation timetable is:

In 2010/11

- GP consortia to begin to come together in shadow form (building on practice-based commissioning consortia, where they wish)

In 2011/12

- a comprehensive system of shadow GP consortia in place and the NHS Commissioning Board to be established in shadow form

In 2012/13

- formal establishment of GP consortia, together with indicative allocations and responsibility to prepare commissioning plans, and the NHS Commissioning Board to be established as an independent statutory body

In 2013/14

- GP consortia to be fully operational, with real budgets and holding contracts with providers.

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Conclusion and responding to the consultation

31. We are consulting on how best to implement the changes outlined in this summary and draw your attention to the full version of this consultation document which contains specific consultation questions, the White Paper, and other related consultation documents, available on the Department of Health website at www.dh.gov.uk/liberatingthenhs . Responses to the questions in the full consultation document should be sent to nhswhitepaper@dh.gsi.gov.uk or to the White Paper team, Room 601, Department of Health, 79 Whitehall, London SW1A 2NS by 11 October 2010.

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