Commissioning Update for GPC July 2011

This is a report of commissioning developments which have occurred since the May GPC meeting.

Health and Social Care Bill 2011

Following the pausing, listening, reflecting and then the improving exercise, the proposals made by the NHS Futures Forum have largely been accepted by the Government. The Bill is likely to be taken back to Parliament shortly and now it appears to have broader support in the Commons and Lords and across the Conservative and Liberal Democrat Party. It is expect that the Bill will be passed in the amended form.

Changes to plans for NHS following the NHS Future Forums report

As a result, the Government has now pledged:

• A wider range of clinical experts will be involved in commissioning services, with hospital doctors and nurses working alongside GPs and other experts. GP commissioning consortia will now be known as clinical commissioning groups.

• Clinical commissioning groups will take charge of commissioning when they are ready and able.

• There will be a more phased approach to the introduction of Any Qualified Provider

• Clinical commissioning groups will have a duty to promote joined up services both within the NHS and between health, social care and other local services.

• Monitor's core duty will be to protect and promote patients' interests; it won't be required to promote competition as if it were an end in itself

• Additional safeguards against privatisation will stop private companies 'cherry-picking' profitable NHS business. Competition will be based on quality, not price

• There will be a duty to promote patient choice. Personal health budgets will be extended across health and social care

• All health service providers will make a fair contribution to the costs of education and training of NHS staff.

SHA Clusters

The Government has also announced that the 10 Strategic Health Authorities, which were to be abolished on 31 March 2012, will be retained throughout the transition period (until April 2013) but will be expected to cluster from October 2011.

The clusters are:

- London
- The North (North West, Yorkshire and Humber and North East)
- The Midlands (West Midlands, East Midlands and East of England).
- The South (South Central, South West and South East Coast).

The people appointed to the SHA clusters may also at the same time be appointed into the NHSCB, 4 sub-national zones. (i.e. the "regional" offices of the NHSCB will be the same as the SHA cluster but the regional offices will not employ all those who are currently employed by an SHA.

SHA clusters will disappear at the same time as SHAs i.e. April 2013. The 4 sub-national outposts of the NHSCB will remain.

NHS Commissioning Board (NHSCB)

NHSCB will be established in October 2011 and become a statutory body in April 2012. The CEO will be Sir David Nicholson and will have its headquarters in Quarry House in Leeds.

The structure of the NHSCB will be published shortly. Over the summer key appointments will be made to the Board. The Board will have a Medical Director and a Director of Nursing.

PCT clusters

The 152 PCTs have now been reduced to about 50 PCT clusters and vary in size around the country from 200,000 to 1.7 million. The clusters are expected to support the development of clinically led commissioning and ensure that emerging Clinical Commissioning Groups (CCGs) have met the requirement of the authorisation process to enable the CCG to become a statutory body by April 2013. Some CCGs may take longer to get to this point. It is therefore essential that in addition to supporting CCG there is a gradual and significant transfer of responsibility and accountability from the PCT cluster to the CCG. This will mean the CCG needs to be running in full shadow mode by 1st April 2012.

Good PCTs are not only supporting the process of clinically led commissioning but also developing their organisations into a sustainable format of a commissioning support unit (CSU). The CSU could be hosted by a CCG, the Local Authority, become a Social Enterprise or remain as part of the NHS, all these options are still to be discussed.

The CSU, in my view, could also take on the function of primary care commissioning and act as the "field force" of the NHSCB. It could then manage the performers list locally, performance issues, IT to name but a few.

The key relationship would be that the CCG are the statutory NHS body responsible for commissioning services and supported by the CSU and not the other way round.

Ultimately I do not believe the NHSCB or the 4 sub-national bodies will be able to carry out many of the operational functions that are required, so an alternative needs to be found.

PCTs and PCT clusters will be abolished on 1st April 2013. For those CCG which are not ready to become statutory bodies, the NHSCB will become responsible for commissioning for that population.

Clinical Senates

Clinical Senates are one of the new proposals that came out of the listening exercise. There will be 14 Clinical Senates in England, largely based on population flows in healthcare. These will cover an average population of about 4,000,000, although I would suspect London will have 1 Clinical Senate covering a population of closer to 10,000,000. The Clinical Senates will be established by the NHSCB and funded by them. The Senate will be seen as a place to offer and give clinical advice and help for a large population. They will be purely advisory and have no power to compel CCGs to take any particular line of action. The risk is that the Clinical Senate covers such a vast geographical areas that it becomes irrelevant to the population and clinicians it serves.

It may be that within a defined local population the CCGs and the provider trusts establish a local Clinical senate.

CCGs

As you can see the terminology has changed from GP Commissioning Groups to Clinical Commissioning Groups. This is to satisfy the demands of some of our colleague who cannot cope with the term GPCCs. These will still be GP led with the majority of GPs sitting on the decision making board if the Practices wish this to be the case.

The additional complication is that there must be one Secondary Care Consultants and one Nurse (neither of whom should work for a local provider) who will sit on the CCG Governance Committee.

The Governance Committee will include at least two **lay members**, one with a lead role in championing patient and public involvement, the other with a lead role in overseeing key elements of governance such as audit, remuneration and managing conflicts of interest. One of the lay members will undertake either the role of Deputy Chair or Chair of the governing body. If Deputy Chair, the lay member would take the Chair's role for discussions and decisions involving a conflict of interest for the Chair.

The CCG will be responsible for hundreds of millions of pounds of tax payers money it was always clear that there would need to be external scrutiny of the clinical and financial decision making process. This is why the 2 lay members, the consultant and the nurse have been introduced.

It must be remembered that the 2 lay members, the nurse and consultant will sit on the Governance body, which will hold its meetings in public. This is not the same as the decision making body. In a mature organisation, I would expect consultants to be involved in and have influence over the commissioning process, especially where clinical pathways are involved. Public Health advice will also be critical and CCGs may decide to include a lay member, and other son its decision making body but this will not be prescriptive from the NHSCB.

Authorisation process

For CCGs to move from shadow organisations to statutory NHS Bodies they will have to go through a process of authorisation.

The aim of this process is to ensure that CCGs are capable of taking over the responsibility for commissioning the healthcare for a large population and managing the allocated budget. There must be a demonstration that the organisation is truly clinically led and there is a focus on added clinical value.

CCGs will need to:

- Have a GP Clinical majority
- Be clinically led and focused
- Open and transparent
- Lean
- Capable and efficient
- Demonstrate and ability to work effectively with others

The will be 6 key domains for CCGs:

1. Clinical focus and added value
2. Engagement with patients and their communities
3. Clear and credible plan to deliver quality improvements within financial resources
4. Properly constituted with capacity and capability to deliver their responsibilities, including the delivery of financial control

5. Collaborative arrangements for commissioning with other clinical commissioning groups, LAs and NHSCB
6. Leadership capacity and capability

Primary care commissioning

Discussions have started about how practice contracts, premises, IT funding, performance procedures, etc will be delivered after the abolition of PCTs. No decisions have been made.

Dr Nigel Watson 20th July 2011