

Liberating the NHS Commissioning for Patients

CIPFA Draft Consultation response

3. Responsibilities

Questions

Q1 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?

A1 The issues we believe that need to be addressed are,

- Resource allocation - the commissioning portfolio has to be defined and split between specialized and other services
- A robust GP consortia allocation model agreed with GPs has to be developed and ownership of the model established
- The rationale for GP consortia commissioning Maternity services has to be explained in more detail.
- Service specific issues focused on clinical specifications, evidence based best practice and improved outcomes need to be taken forward

The first three points can be addressed by asking GP consortia to nominate a representative to sit on the NHS Commissioning Board where they have a special interest in national and regional specialties and maternity services. Membership should be focused on those consortia that host the specialised services

With regard to service specific issues GPs with a special interest in particular services should be invited to be members of the same service advisory groups.

Q2 How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?

A2 Assuming that this is referring to non-specialised services a lead Commissioner and risk pooling approach could be considered

Q3 Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?

A3 On a day to day basis – many specialised services could be commissioned by GP consortia within nationally agreed guidelines.

An important issue to be addressed is how change in specialized services is handled.

The majority of commissioning activity around these services is about change management and this can/should only be done by expert commissioners with the skillset and resources to do the job.

The government is already committed to the principles of the Carter report which confirms these principles.

An example would be Renal Dialysis services – given an adequate capital infrastructure, an agreed tariff and adherence to agreed clinical and access standards, then GP consortia could commission these services – with the proviso that they would need to be monitored in this task in order that country wide equity of provision could be demonstrated.

Q4 How can other primary care contractors most effectively commissioning services to which they refer patients? i.e primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?

A4 GP consortia can establish clinical groups or networks to include Primary Care Professionals and specialists to input into the development of specifications and commissioning volumes.

A preferred approach would be that this is completed once at a national level and then tailored to local services.

Given the management costs ceiling “off the shelf “solutions which can be adopted locally should provide a cost effective solution.

Duties and responsibilities of GP consortia

Questions

Q5 How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?

A5 Best practice guidelines developed within primary care, benchmarking of performance and development of improvement plans could be appropriate tools to deliver this objective

- Q6** 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?
- A6** A Single source of information for all GP consortia with one format for reporting is recommended accompanied by a small number of meaningful output measures and clear levers for changing behaviors.
- Q7** What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?
- A7** CIPFA would recommend clear rules re the costing and pricing of these services and subsequent sign off by auditors and;
- Published tariffs (and therefore an agreed currency)
 - Declaration of interests when taking decisions.
 - Oversight by the Local Authority.

The role of the NHS Commissioning Board

Questions

- Q8** 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?
- A8** Consultative processes should be established in a similar way to those established by NICE to seek views and comments before formal adoption.
- Q9** Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?
- A10** The following points are recommended
- Initial and on-going training programmes for local consortia will be important in establishing the skills required to support efficient and effective local commissioning
 - Promotion of shared service models for delivery – including joint appointments –

- Appointment of high calibre staff –
- Benchmarking of costs and performance
- Sharing of best practice.

Establishment of GP consortia Organisational form

Questions

Q11 What features should be considered essential for the governance of GP consortia?

A12 Development of staffing structures within management cost limits and;

- Job descriptions for all staff
- Standing Orders
- Standing Financial instructions
- Protocols that show how consortia manage business on behalf of all practices
- An approved scheme of delegation
- Robust commissioning, financial and support systems
- Systems covering under and overspending of resource limits
- Risk pooling at the appropriate level
- Statutory roles and the requirement for DoFs to be Members of CCAB bodies.

4. Establishment of GP consortia

Forming consortia

Questions

Q13 How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?

A13 It will be very difficult to reconcile the role of LAs if there is not a coterminous geographic boundary as they can only reflect the needs and views of their population.

Also, financial allocations (some of which will be to LAs) need defined boundaries.

Q14 Should there be a minimum and/or maximum population size for GP consortia?

A14 There is a balance between natural local communities that allow for close integration of health and social care and potentially very large GP consortia that will benefit from advantages of economies of scale, particularly in relation to management costs and the cost of support services.

Consortia should be of sufficient size to be able to receive an accurate financial allocation, be able to influence the development of local services and providers and be able to manage risk effectively.

A general reflection would be that commissioning can only be effective (not only being cost effective) if it is undertaken at the appropriate population level. Therefore, the NHS needs to clarify what the appropriate population levels are for effective commissioning. This links with questions about the level of risk pooling, reserves and availability of competent staff within the available management costs.

5. Freedoms, controls and accountabilities Freedoms

Questions

Q15 How can GP consortia best be supported in developing their own capacity and capability in commissioning?

A15 A comprehensive training programme will need to be developed to facilitate this objective

It would be helpful to articulate to GPs;

- the size of the task ahead of them.
- approaches which have proved to be successful in the past,
- options for delivering the agenda – e.g. shared services (CIPFA has significant expertise in this area)
- the role of Local Authorities and their expertise,
- PCT staff and expertise that could be transferred into the new organisations.

Q16 What support will GP consortia need to access and evaluate external providers of commissioning support?

A16 A comprehensive training programme will need to be developed to facilitate this objective and;

- Intelligent commissioning is key to success, GPs cannot possibly have this skill yet.
- The FESC programme is not the solution in isolation – it still requires an informed “intelligent” commissioner who is capable of defining what

Managing financial risk

Questions

Q17 Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?

A17 A comprehensive framework and training programme will need to be developed to facilitate this objective covering

- Concepts of risk pooling at the appropriate level (otherwise too many reserves),
- Control of activity levels (when FTs are incentivized to act in the opposite way!),
- Clarity re how any savings will be handled.

[There will need to be clarity that savings can only begin to accrue once the GP consortia have met all other financial targets and met the costs of transition.]

Transparency and fairness in investment decisions

Questions

Q18 What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

A18 Current guidance for investment decisions could be adapted to suit GP consortia and;

- The development of better information systems to provide comparative information on providers in line with commercial internet systems that compare financial products might provide an answer to this.
- Costing/pricing and tariff policies including audit re compliance.
- Transitional costs to be included within assessments

Accountability to patients and the public

Questions

- Q19** What are the key elements that you would expect to see reflected in a commissioning outcomes framework?
- A19** Information on the current level of attainment in respect of outcomes, target profiles to reflect an achievable level of improvement and inputs from Social Care / Housing / Education that contribute towards these improvements
- Q20** Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?
- A20** Yes within the existing resource envelope – not as an additional payment.
- Q21** What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?
- A21** Strong links with and challenge from LAs and the public health function.

6. Partnership Patients and the public

Questions

- Q22** How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?
- A22** GP Consortia and the NHS Commissioning Board could look to draw from the current pool of patient representatives across their area, in addition concerted work with leading health charities can improve patient engagement particularly for long term conditions.
- Q23** 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?
- A23** Working with Community leaders, particularly those from Ethnic minorities can increase the input from seldom heard groups, and developing the LA role re Health watch
- Q24** How can we build on and strengthen existing systems of engagement such as Local Health Watch and GP practices' Patient Participation Groups?

A24 Service users should be offered engagement at times that are convenient to them, meetings during the day tend to attract the more elderly who may not have work or childcare commitments

Q25 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?

A25 Publishing the positive outcomes of patient and public consultation can motivate service user input.

Post project evaluation needs to incorporate research on whether groups or individuals have been disadvantaged as a result of the new proposals

Local government and public health

Questions

Q26 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?

A26 GP consortia should work with existing patient engagement forums and their PCT to develop new arrangements, it is critically important that the contribution to service development from current forums is not lost where it can be attributed to new GP consortia area. It is also important to

- Build on existing links between PCT DoH, PH and LAS.
- Map out services, financial investment and activity levels/intervention rates at present and learn from Total Place pilots etc on how change can be promoted by organizations working across boundaries.

Q27 Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts,

A27 Wales are doing this – possibly others too.

Other health and care professionals

Questions

Q28 How can multi-professional involvement in commissioning most

effectively be promoted and sustained?

A28 Include these functions in the mapping exercise suggested above – then make a plan for them!