

COMMISSIONING FOR PATIENTS: FACT SHEET

1. Introduction

The Government's ambition is for an NHS that puts patients first and continually improves the quality and outcomes of care for everyone. This improvement will come from devolving power to professionals, patients and carers.

By April 2013, there will be a comprehensive system of GP commissioning consortia, supported by and accountable to a new independent NHS Commissioning Board.

2. The principle of GP commissioning

Key decisions affecting patient care should be made by healthcare professionals in partnership with patients and the wider public, rather than by managerial organisations.

GP commissioning builds on the key role that GP practices already play in coordinating patient care and acting as advocates for patients. It gives groups of GP practices financial accountability for the consequences of their decisions.

3. Granting GP consortia statutory powers and duties

The purpose of consortia being statutory bodies is to ensure that they have a separate identity from that of their member practices.

Being a statutory body means that consortia can have clear powers and duties. This will not affect the status of GPs and GP practices as providers of primary care.

The legislative framework will be designed to make sure that consortia are able to focus on improving quality of care within the resources available to them.

4. Composition of GP consortia

All holders of primary medical contracts will have a duty to be a member of a consortium for each contract they hold, i.e. for each GP practice.

Individual GPs or GP practices will not have to take commissioning and financial decisions on their own. The majority of GPs will continue focusing on providing primary care.

Membership of consortia will be flexible, with consortia able to expand, contract, dissolve or merge.

The precise size of a consortium is less important than the ability to scale up or scale down depending on the nature of the activity being undertaken.

The NHS Commissioning Board will need to be satisfied that prospective consortia, when applying to be established, have made appropriate arrangements to ensure that they can discharge their functions.

5. Robust governance arrangements

Commissioning decisions will need to reflect the healthcare needs of the practice's registered patients together with the needs of unregistered patients for whom the consortium is responsible.

All consortia should have an Accountable Officer who need not be a GP or clinician. However, strong clinical leadership is a critical component of successful

commissioning, and clinical experience will be essential in understanding how best to improve quality and outcomes.

The consortium's Accountable Officer will be responsible for ensuring that a consortium promotes continuous improvements in the quality of services it commissions, complies with its financial duties, and provides good value for money.

All consortia will be required to have a published constitution.

Consortia will be required to make remuneration arrangements and commissioning plans public, to hold an open annual general meeting, and to publish an annual report showing the results of patient and public consultations.

6. Partnership working and public involvement

There will be increasing focus given to partnership working and the importance of multi-professional involvement in commissioning.

The NHS Commissioning Board will hold consortia to account for financial performance and outcomes, but there will also be a stronger role for local authorities in helping shape commissioning priorities, and in promoting a joint approach to improving the health and wellbeing of local communities.

There is a commitment to greater patient and public involvement within emerging GP consortia. The Health and Social Care Bill will place a duty on GP consortia and the NHS Commissioning Board to ensure that people who may receive a service are involved in its planning and development. Local Healthwatch will strengthen the patient's voice, and the enhanced role of local authorities will increase the democratic legitimacy of NHS commissioning decisions.

7. The NHS Commissioning Board

The NHS Commissioning Board will be established in shadow form as a Special Health Authority in April 2011, and as a full non-departmental public body from April 2012.

The Board will be responsible for establishing GP consortia, and in doing so will ensure that there is a comprehensive system of consortia across England. The Board will hold consortia to account, but will only have the power to intervene where there is evidence that consortia are failing or are likely to fail to fulfil their functions.

The NHS Commissioning Board will have a vital role in providing national leadership for driving up the quality of care, including safety, effectiveness and patients' experience, and promoting choice and patient and public involvement.

The Board will need to be able to demonstrate good clinical evidence in support of its decisions, maintain effective relationships with professional bodies, and have strong internal professional leadership.

The Board will publish a business plan setting out how it intends to achieve its statutory duties, and the objectives or requirements that have been set for it by the Secretary of State. It will also publish an annual report setting out progress against both its duties and objectives and requirements.

8. Clear accountability

GP consortia will have a stronger focus on improving the quality and outcomes of care for patients. They will be under a statutory obligation to seek to reduce inequalities in access to healthcare.

The NHS Commissioning Board will draw on the national outcome goals in the Outcomes Framework to develop a Commissioning Outcomes Framework, to help hold consortia to account for promoting improvements in quality.

GP consortia will also be required to ensure that their expenditure does not exceed the commissioning budget allocated to them. There will be a clear line of financial accountability from consortia to the NHS Commissioning Board and in turn to the Secretary of State. The Board will have the powers to intervene where there is a significant risk of financial failure.

There is a need to ensure a fair approach to handling current deficits and surpluses. The expectation is that any debt will be fully resolved by the end of 2012/13. Further detail is included in the NHS Operating Framework for 2011/12.

9. Commissioning primary care

The NHS Commissioning Board will commission primary medical care services, but we are planning an explicit duty for all GP consortia to support the Board to improve the quality of these services.

The NHS Commissioning Board will be able to ask GP consortia to carry out some commissioning functions in relation to primary medical care on its behalf. This will mean that consortia have a core role in improving patient care across the system.

The NHS Commissioning Board will retain formal responsibility for ensuring that a practice is meeting its core contractual duties. The Care Quality Commission will be responsible for ensuring that GP practices are meeting standards of safety and quality.

10. Commissioning specialised and complex services

The NHS Commissioning Board will commission national and regional specialised services, drawing on engagement with GP consortia. The specialised services portfolio will be kept under regular review. There will be a criteria-based approach to deciding which services are 'specialised'.

The NHS Commissioning Board will have responsibility for health services for those in prison or custody, high security psychiatric services and the current PCT duties in relation to healthcare for the armed forces and their families.

GP consortia are likely to work collaboratively with each other on particular aspects of commissioning, such as commissioning low volume services. The NHS Commissioning Board will also be able to commission some services on behalf of consortia, where this is agreed by both parties.

Responsibility for commissioning maternity services will lie with GP consortia, but with a strong role for the Board in promoting quality improvement.

11. Autonomy for the NHS with national leadership

The functions of the NHS Commissioning Board will be defined in primary legislation, rather than being at the discretion of the Secretary of State through legal delegation.

Instead, the Secretary of State will set a mandate for the Board, which will include the totality of the Government's requirements and expectations for the NHS over a three year period, updated annually.

Each year the Secretary of State will be obliged to undertake a formal public consultation on the priorities within the mandate for the NHS Commissioning Board.

In the event of emergencies, it is vital for the Government to be able to act decisively. The Board will be under a duty to ensure NHS preparedness and resilience by assuring that clear arrangements are in place.

12. GP pathfinders and managing the transition to consortia

Consortia pathfinders will test out design concepts for GP commissioning and explore how emerging consortia will best be able to undertake their future functions.

Pathfinders and other emerging consortia will work closely with PCTs to deliver the QIPP agenda.

The NHS Commissioning Board will start to establish consortia from April 2012. Once established as statutory bodies, consortia will be able to employ staff directly from PCTs.

In the autumn of 2012, consortia will receive notification of the budgets for which they will be statutorily accountable in their own right from April 2013 onwards.

15. Conclusion

Our proposals for GP commissioning and the NHS Commissioning Board are intended to transform the quality of care and health outcomes for patients. Day-to-day decision-making will be more sensitive and responsive to their needs and wishes.

A clear framework established and developed by the NHS Commissioning Board will promote quality, choice, patient and public involvement, and effective stewardship of public resources.

The plans are intended to unlock the benefits of GP-led commissioning, focussing on achieving a step-change in the quality of patient care, delivering better value for the taxpayer and improving the health of local communities.