

NHS Chief Executive's Conferences, 23 July – 16 August 2010

Frequently Asked Questions

(A) Commissioning

- 1 As GPs are currently independent practitioners, how would the Commissioning Board and consortia groups hold GPs to account for the delivery of key performance and financial targets?**

It is our intention that GP consortia would be statutory public bodies. We have said that each consortium would appoint an Accountable Officer and a Chief Financial Officer who would have responsibilities and accountabilities as leaders of their NHS organisations. However, beyond this the governance arrangements would be a matter for the consortia themselves to determine.

The NHS Commissioning Board would also be responsible for developing an assurance process that would hold GP consortia to account for the outcomes they achieve, their stewardship of public resources, and their fulfilment of the duties placed upon them, for example in relation to promoting equality and working in partnership.

It is proposed that the NHS Commissioning Board would develop a commissioning outcomes framework that measures the health outcomes and quality of care achieved by consortia. The framework would allow the NHS Commissioning Board to identify the contribution of consortia to achieving the priorities for health improvement in the NHS Outcomes Framework.

GP practices already make a key contribution to the overall quality of patient care and to the effective use of NHS resources. 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 they achieve collaboratively through commissioning consortia and the effectiveness with which they manage financial resources.

We also propose to discuss with the BMA and the profession how primary medical care contracts can best reflect specific 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.

Subject to the outcome of the consultation, the primary legislation would need to allow for the NHS Commissioning Board to also intervene in the event that a consortium is unable to fulfil its duties effectively, for instance in the event of financial failure or a systemic failure to meet the health care needs of patients., or where there is a high risk of failure.

- 2 Would GP consortia be NHS bodies and NHS employers?**

Yes, GP consortia would be NHS bodies and NHS employers. The intention is that they would be statutory bodies, with powers and functions set out through primary and secondary legislation. We propose, however, that they would have flexibility in relation to their internal governance arrangements, beyond essential requirements for example, in relation to areas such as financial probity and accountability, reporting and audit.

Further detail on the arrangements for GP commissioning will be developed following the close of the consultation exercise

3 What plans are there to engage GPs with commissioning?

The proposed model does not mean that all GPs have to be actively involved in every aspect of commissioning, but a fundamental principle is that every GP practice would be a member of a consortium, as a corollary of holding a list of registered patients, and would contribute to its goals.

It is likely to be a smaller group of primary care practitioners who lead the consortium and play an active role in the clinical design of local services.

The Department will be working closely with key stakeholder organisations such as the NAPC, NHS Alliance and RCGP to engage with their members and as wide a clinical audience as possible, to explore how we can extend clinical leadership to respond to the opportunities presented by the forthcoming system changes.

SHAs and PCTs will have an important task over the next two years in supporting GP practices to prepare for the new arrangements. There are a number of practical next steps that they will need to take with GP practices and existing practice-based commissioning groups during 2010/11, which we will be discussing with the NHS and professions. This will include identifying the likely future shape of consortia and enabling them to start taking increasing responsibility for making commissioning decisions on behalf of PCTs. This would mean PCTs increasingly putting management resources at the disposal of shadow consortia and working with them during the transition to ensure that appropriate skills and knowledge are retained.

PCTs would also need to work alongside shadow consortia to forge relationships with patient and public groups and with a range of external partners, including local and national HealthWatch, local authorities and local voluntary organisations and community groups.

Our indicative timetable would see practice-based commissioning consortia taking on some responsibilities from PCTs, supported by indicative budgets, in 2010/11. By 2013/14 GP consortia would be fully operational, with real budgets and holding contracts with providers.

It is important to recognise that all General Practitioners would be commissioners, through their decisions on referrals and their involvement in a consortium.

4 Is there room for non-medical staff to be on the consortia?

Yes, just as there are non-medical partners in GP practices. A fundamental principle of the proposed new arrangements is that every GP practice would be a member of a consortium, as a corollary of holding a registered list of patients. Practices would then have the flexibility to form consortia in ways that they think will secure the best healthcare and health outcomes for their patients and locality.

5 What are a PCT's statutory functions and what items need a change in law before transfers can take place?

As explained in the White Paper, the Government intends to legislate in the forthcoming Health Bill to abolish PCTs from 2013, subject to Parliamentary approval. Until then, PCTs would continue to retain their existing legal functions.

6 Is it possible to merge or share PCT functions, to increase efficiency and help cut management costs?

It is not possible to merge or abolish individual PCTs without an order made by the Secretary of State, under existing powers in the NHS Act 2006.

However, PCTs have considerable flexibility in how they exercise their functions. They have power (under regulation 10 of the NHS Functions Regulations) to arrange for functions that they are responsible for to be exercised by another PCT or jointly with SHAs or other PCTs. SHAs can direct PCTs in how they do this.

For example, as already happens, PCTs are able to set up reciprocal arrangements where they delegate some of their functions to a different PCT, and act as lead organisation on other functions.

7 How and when would the management cost allowance for GP consortia be available?

We are currently developing the details of the financial regime post implementation of the White paper. The running cost allowance for GP consortia would be developed as part of the new financial regime.

We said in the 2010/11 revised Operating Framework that: 'As part of the ongoing reduction in SHA and PCT Management Costs, the NHS Operating

Framework for 2011/12 will set out how resources will be released from the infrastructure and running costs of SHAs and PCTs in order to provide a running cost allowance for the GP Commissioning Consortia.'

(B) Provision

8 Who would own the assets when Community Services transfer?

Senior officials are currently examining the implications for management and ownership of the estate following abolition of PCTs as announced in Equity and Excellence: Liberating the NHS. They are undertaking an option appraisal of the various alternatives before making recommendations to Ministers. The outcome of this process will be announced in the Autumn.

9 How would the new economic regulator work and why is Monitor taking this role?

We are developing Monitor's role as economic regulator for all providers of NHS service. Monitor's existing authorisation role for Foundation Trusts (FTs) would be duplicating the licensing function of the new regulator. Subject to legislation, Monitor's role would change significantly and, as a consequence, Monitor would not retain all of its existing powers as the regulator of FTs, but would extend its role in relation to providers more generally.

Monitor's overarching duty would be to protect the interests of patients and the public in the provision of health and adult social care services, by promoting competition where appropriate, and through regulation where necessary, including price regulation. The aim is to drive efficiency whilst supporting commissioners to maintain continuity of essential services, particularly where communities are highly dependent on one (or very few) providers.

Monitor would be required to take a consistent approach to licensing and regulation of all providers. There would be no separate Terms of Authorisation and intervention powers in relation to FTs. In particular, Monitor would not have approval rights over the decisions of FTs and would not have powers to remove FT Board members.

Monitor would license providers and set the tariff for NHS services in line with priorities determined by the NHS Commissioning Board and having regard to overall affordability constraints. Monitor would have powers to set conditions on a provider's license to ensure continuity of essential services. For example, to regulate disposal of key assets (or use of key assets as security for borrowing); and to levy contributions to a risk pool that would be deployed in the event of a provider becoming insolvent and used to sustain provision of essential services during a period of 'special administration'.

Monitor would also have concurrent powers with the Office of Fair Trading to enforce Competition Law within the health and social care sector. These would be statutory powers that could be enforced outside of Monitor's licensing regime and could, therefore, be applied throughout the sector, including in primary care, and to all types of provider.

(C) QIPP and transition planning

- 10 **Would there be a prescribed transition plan or would it be entirely down to local determination? What is the timetable for transition planning?**

We would set out nationally, what would be done at national and regional level, and then set out the framework within which local decisions can be taken, with the aim of allowing as much local determination and flexibility as possible.

This would be in the context of an overall national timetable which we set out in more detail as the legislative process progresses and overall plans become more detailed.

- 11 **In developing our QIPP planning, we need to influence many parts across the system. The commissioning/provision split is going to change the nature of that challenge, what is your take on how we do it?**

It is already a challenge in QIPP work to draw organisations together from within and beyond the NHS to lead the quality and productivity gains required – although it is being done well in many parts of the country. By seeking to integrate the QIPP and reform work, nationally, regionally and locally we are seeking to use QIPP as a vehicle to enable the new system players to identify and work together on key issues of local service improvement. Whilst this undoubtedly brings some challenges, it also creates important opportunities, for example the more direct linkage of the GP as referrer and commissioner to key QIPP objectives of changing the pattern of demand and treatment.

- 12 **Health systems are currently developing QIPP plans to deliver required levels of cost reduction. Are social care reductions factored into these plans on the scale they need to be?**

The financial challenge being faced in social care is very significant. There is a general view that nationally, regionally and locally this has been understated in QIPP processes to date. David Behan and Jim Easton are working with a group of national local authority and social care leaders to improve this nationally, and we encourage people locally to take similar steps to better

integrate social care issues into QIPP planning where this is not yet at the level needed.

13 What are your future plans for reconfigurations to get better services and lower costs?

It is vital that the NHS continues to modernise and improve, and to meet the challenges of QIPP. But this must go hand-in-hand with an NHS where improvements are driven by local clinicians, patients and their representatives, and be bottom up, not top-down.

The NHS has always changed and adapted to new technologies, medicines and treatments and must continue to do so. The goal of any change to services must be to ensure patients get the best care possible, delivered to the highest standards in the most effective, efficient and personalised way.

The Secretary of State has identified four key tests for service change, which are designed to build confidence within the service, with patients and communities.

The tests require existing and future reconfiguration proposals to demonstrate:

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

The Secretary of State has also made it very clear that GP commissioners would lead local change in the future. With that in mind, I have asked local GP commissioners, in conjunction with PCTs, to lead this process locally and assure themselves, and their SHAs, that proposals pass each of the tests.

(D) Engagement

14 What is planned nationally to ensure that GPs and consultants stay aligned?

We recognise that this is a real issue, and one that would require careful attention. Given their role in co-ordinating care, GP practices are well placed to lead on commissioning care for patients. However we recognise that there are issues around the interface of primary care with other sectors. We would expect consortia to involve relevant health and social care professionals from all sectors in helping design care pathways or care packages that achieve more integrated delivery of care, better quality, better patient experience and more efficient use of NHS resources.

The GP practice and the registered patient list should form the essential building block of commissioning consortia, but successful commissioning would clearly also be dependent on the wider involvement of other health and care professionals. Subject to the consultation process, we propose to work with the NHS and professional bodies in the transition to the new arrangements to promote multi-professional involvement.

15 What plans are there to engage with Local Government to ensure we have a joined-up approach to transition?

We recognise that the elements of the new system for delivering health and care taken together would have a major impact on Local Government and the wider delivery of public services and necessitates a major re-shaping of the way that DH engages with Local Government and its partners. In alignment with the Government's commitment to decentralisation and local democratic engagement, we aim to establish mechanisms for in-depth discussion and co-production with the Local Government Sector around both the system design and system build stages of the new system. We are discussing with Local Government and Whitehall partners what the best mechanisms to achieve this would be.

(E) Workforce

16 Would there be changes to junior doctor training and the way new consultants work to support the new ways of working we need?

Professor Sir John Temple's independent review of the impact of EWTD on the quality of training, *Time for Training*, made important recommendations about junior doctors' training and the way consultants work. Sir John concluded that high quality training can be delivered in 48 hours but traditional models of training and service delivery waste training opportunities and would need to change. The report recommended that more consultant involvement is needed to safeguard patient safety and improve patient experience and that this will lead to better training and supervision. This could be done through stronger job planning with an emphasis on clinical service and the role of the consultant in the delivery of 24/7 patient care.

The Secretary of State asked Medical Education England (MEE) to consider with the profession, the service and medical Royal Colleges, how best to implement training practices that will meet these aspirations.

At the same time, the Secretary of State has made it clear he will support the Secretary of State for Business, Innovation and Skills in taking a robust approach to future negotiations on the European Working Time Directive to achieve greater flexibility.

In addition:

- the Centre for Workforce Intelligence has been commissioned to undertake a review of the shape of the workforce which will consider productivity, substitutability and alternative ways of delivering services. Their analysis will inform healthcare policy and service developments and enable change. The first stages of the project will focus on the future shape of the medical workforce and will be reporting later this year.
- Medical Education England is undertaking a review of the future shape of postgraduate medical training.

Colleagues can follow progress and may wish to contribute to these through the relevant websites (www.cfw.org.uk and www.mee.nhs.uk).

17 **How will education and training develop over the next period?**

The White Paper makes it clear that it is time to give employers greater autonomy for planning and developing the workforce alongside greater professional ownership of the quality of education and training. A public consultation on the future education and training system is planned for later this year. It would be based on the principle that the system should be driven by healthcare provider decisions, underpinned by strong clinical leadership. It would be set within the context of delivering appropriate investment in workforce education and training, whilst ensuring better outcomes for patients and value for money. It would also need to ensure appropriate checks, balances and accountability. The arrangements for education commissioning and delivery would be transparent and more efficient.

18 **What is MARS?**

A national Mutually Agreed Resignation Scheme (MARS) has been developed in partnership with the Social Partnership Forum. A MARS is a scheme under which an individual employee, in agreement with their employer, chooses to leave employment in return for a severance payment. A Mutually Agreed Resignation is not a redundancy or a voluntary redundancy. MARS has been designed to support the flexibility of the organisation to address periods of rapid change and service re-design.

The duration of the national scheme is planned to be from mid September 2010 until the end of October 2010. During this timeframe no other Mutually Agreed Resignation Scheme (MARS) will be available. Key features of the scheme include:

Payment Terms: Employees with from 1 to 6 years of reckonable service would receive a MARS scale of payment of 3 months basic salary. Any employee with over 6 years of reckonable service will receive an extra half months basic salary for every year of continuous service, up to a capped maximum of 12 months basic salary.

Clawback: Where an employee returns to work for the NHS in England within 6 months and before the expiry date of the period for which they have been compensated (as measured in equivalent months/part-months salary), then an employee would be required to repay any un-expired element of their compensation. The clawback would be reduced to take account of any appointment to a lower grade and reflect net salary.

The Department also commissioned NHS Employers to negotiate with the NHS Trade Unions a set of principles for future MAR Schemes. The intention is that these principles can be used by NHS organisations to develop their own future MAR schemes which are tailored to local requirements. Guidance for the National MAR Scheme will have been published by September and the set of principles for MAR schemes will follow soon after.

19 What would be the role of non-executives during the transition process and how are future non-executive appointments to be handled?

Currently, PCT chairs and NEDs are prohibited from serving on more than one PCT board at any time. There may be occasions during the transition where more flexibility is needed to set up shadow or transition arrangements or merely to share non-executive resource. We are seeking the appropriate changes in regulations to provide the flexibility for a PCT chair or NED to serve on more than one PCT board.

We have learned from previous changes within the NHS, that the role played by chairs and non-executives (NEDs) and the effective continuation of good board governance is vital. The Appointments Commission have been advised by the Department of Health and with the agreement of the Commissioner for Public Appointments, that:

- Where necessary, re-appointments, or in a more limited number of cases, extensions to appointments should be made for SHA and PCT chairs and NEDs up to the latest abolition date for the body.
- Otherwise, either a vacancy would be carried (as long as the board can function effectively) or a temporary appointment would be made.
- Temporary appointments would not normally be made through open competition, but from for example, an identified pool of people well-placed to take on the task.

Chairs of NHS Trusts would need therefore to look carefully at how best the board prepares for Foundation Trust status, and consider the board composition required to achieve this. The Appointments Commission would support this by extending appointments or re-appointing where appropriate, or by making new appointments where different skills are required.

20 **How would the proposed changes impact on equality and diversity in the NHS?**

The new Equality Act comes into force during the period of transition and all NHS organisations will need to understand what this means for both services and staff. Compliance with both the spirit and letter of the Act will be an important aspect as we move through the transition.

There are existing legal requirements to consider how men, women, disabled people and ethnic minorities are affected by changes at a local / regional level. Moreover, it is recommended that organisations do the same in relation to older people, Lesbian Gay Bisexual and Transgender people, and people of different religions, as the new Public Sector Equality Duty in the Equality Act 2010 will extend this requirement to all groups, when it comes into force in April 2011.