Gateway number: 14833

**Liberating the NHS: Commissioning For Patients**

**FAQ**

**1. *GPs will not be ready for this enormous change - how will they cope?***

Our proposals are clear that consortia would be formed from a bottom up basis. It is envisaged that over the next two years, Primary Care Trusts (PCTs) will have a role in working with proposed consortia to ensure a smooth transition. PCTs should provide support for this process and empower consortia to take on new responsibilities quickly when they are ready to do so, but it is important that solutions develop from the bottom up and are not imposed from above. We would support professionals, and the wider NHS, to help these changes to happen. We will discuss these next steps with the NHS and the profession in due course.

Once established, consortia would be supported by the NHS Commissioning Board. The board would, for example, develop commissioning guidelines and model contracts.

**2. *What should GPs be doing now?***

The focus should be on taking part in the engagement activities that are taking place. If GPs wish to go further at this stage, they may wish to start thinking through how they may go about forming consortia locally, building on practice-based commissioning arrangements should they wish to do so, and working with PCTs to shape current commissioning decisions. Now is the time to be thinking about goals for the future and for co-operating practices to start thinking about how they might work together in consortia, bearing in mind that the legislative framework is still being developed.

**3. *Will different consortia be able to work together to commission certain services?***

Consortia would be likely to carry out a number of commissioning activities themselves. In other cases, they may choose to act jointly, for instance by adopting a lead commissioner model to negotiate and monitor contracts with large hospital trusts or urgent care providers. As well as joint working between consortia to commission certain services, consortia may also choose to buy in support from external organisations, including Local Authorities and private and voluntary sector bodies. This could include, for instance, analytical activity to profile and stratify healthcare needs, procurement of services, and contract monitoring. We would want to enable

new organisations, and particularly GP consortia, to have the maximum possible choice of how they operate and who works for them.

**4.** ***What about GPs who do not want to do this?***

We have proposed that it would be a requirement for every GP practice to be part of a consortium and to contribute to its goals. However, our proposed model will mean that not all GPs have 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 GPs who would lead the consortium and play an active role in the clinical design of local services.

**5.** ***How would GP consortia be held to account?***

We have proposed that the NHS Commissioning Board would be responsible for holding consortia to account for stewardship of NHS resources, and for the outcomes they achieve as commissioners. Subject to the outcome of the consultation, the primary legislation would need to allow for the NHS Commissioning Board to 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 needs of patients, or where there is a high risk of failure.

Subject to the engagement activities that are currently taking place, the Health and Well-Being Board of the Local Authority could offer a formal means through which Local Authorities and consortia work together and bring democratic accountability to the consortia's work. Our proposals for strengthened patient and public voices through national and local HealthWatch will further this accountability to patients and local communities.

Of course, the first accountability of everyone working in the NHS is to the patients and public that use NHS services. These reforms are about placing the power and responsibility to change health services in the hands of NHS professionals who see and talk to patients every day and know most about their patient's health needs. Clinical and financial decisions will be more closely aligned.

**6.** ***How do you intend to ensure that Local Authorities and GP consortia cooperate?***

We have proposed that a new Health and Well-Being Board of the Local Authority could offer a formal means through which Local Authorities and consortia work together. If Health and Wellbeing Boards were created, under our proposals there would be a statutory obligation for the Local Authority and commissioners to participate as members of the board and act in partnership on these functions. We would also expect there to be strong informal links between Local Authorities and consortia. Clearly, much of this will be about local leadership and relationships. As part of the current engagement activities, we have specifically asked for views on what support might be needed to empower commissioners and Local Authorities to work together effectively.

Where disputes over commissioning priorities arise, the test of the new arrangements would be the ability of the proposed Health and Wellbeing Boards to resolve them locally through compromise and negotiation.

For a minority of cases, there would still need to be a system of dispute resolution beyond the local level. If a dispute cannot be resolved at a local level, we envisage the Health and Wellbeing Board would have a power to refer commissioning decisions to the NHS Commissioning Board. This should only happen in exceptional cases.

**7. *How would consortia be responsive to the needs and wishes of the public?***

We propose that Commissioners would need to establish and develop new relationships with the proposed local HealthWatch and the national body HealthWatch England, a new independent consumer champion that we propose to establish as part of the Care Quality Commission. It is expected that Consortia will also want to engage with Patient Participation Groups, Local Authorities and local voluntary organisations and groups.

We would want to ensure that the focus is on developing behaviours and cultures that will encourage and facilitate public participation and patient voice.

**8. *What would happen if a GP consortium fails - would they go bust? What about their patients?***

We propose that consortia would be made up of GP practices and would be separate legal entities. GP practice income would be separate from consortia budgets. Membership of a commissioning consortium would not make individual GPs financially liable for any overspends.

We propose that the NHS Commissioning Board would be responsible for ensuring consortia are accountable for the outcomes they achieve, their stewardship of public resources, and their fulfilment of the duties placed upon them. The NHS Commissioning Board would intervene in the event that a consortium is unable to fulfil its duties effectively or where there is a significant risk of failure.

**9. *What is intended to happen to Primary Care Trust staff?***

There will need to be significant reductions in management costs, and this will inevitably mean fewer jobs within commissioning. As part of the transition towards the new commissioning bodies, work will be carried out to identify which PCT functions transfer where and which come to an end. David Nicholson's letter of 10th September[1] asserted that we want to support current employees of Strategic Health Authorities (SHAs) and PCTs through the change, to treat them well and, where it is the right thing to do, support them in moving into new roles, minimising the cost and complexity, and ensuring we retain essential talent and capability through the

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_119311

transition. To this end, an HR framework would be developed to support the change process.

**10.** ***Would GP consortia be NHS bodies and NHS employers?***

The intention is that GP consortia will be statutory bodies, with powers and functions set out through primary and secondary legislation. However, we propose 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 consortia will be developed following the close of the consultation exercise.

**11.** ***Would GPs still be independent contractors?***

Yes. We propose that consortia will be new statutory bodies. Consortia would be made up of GP practices and would be separate legal entities. GP practice income would be separate from consortia budgets.

**12.** ***GP consortia - just a PCT by another name?***

No. Commissioning has been too remote from the patients it is intended to serve. Our proposals for GP commissioning mark a fundamental break with the past. Most commissioning decisions would 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 would push decision-making much closer to patients and local communities and ensure that commissioners are accountable to them. Making GP consortia responsible for commissioning decisions would ensure that those decisions are underpinned by clinical insight and knowledge of local healthcare needs. These reforms would enable consortia to work closely with secondary care, other health and care professionals, and with community partners to design joined up services that improve the health and care of patients and the public.

**13.** ***How would this be different from fundholding?***

Consortia would operate in a different NHS environment to that of the GP fund-holding era. Critics of GP fund-holding point to high transaction costs as a major weakness of the scheme. The subsequent introduction of a standard pricing mechanism for hospital-based care and template provider contracts should lead to lower transaction overheads for GP commissioners. In addition, the sources of data on the quality and effectiveness of services are now much richer and more readily available, allowing GP consortia to take more sophisticated action.

**14.** ***Would consortia be able to commission GP and other primary care services from themselves?***

The NHS Commissioning Board would be responsible for commissioning primary medical care and holding contracts with individual GP practices in their role as providers. There would be a key role for consortia in driving up the quality of general

practice, as the performance of consortia as commissioners will be closely bound up with the quality of services provided by their constituent practices.

Consortia would have the freedom to make the great majority of commissioning decisions about NHS services in order to achieve the best outcomes with the financial resources available to them. They would need to do so in a way that ensures transparency, fairness, and patient choice. This will be particularly important where a consortium proposes to commission services from one or more of its constituent practices.

**15.** ***How do you propose ensuring transparency and fairness in consortia's commissioning decisions?***

We propose that consortia would have the freedom to make commissioning decisions that they judge will achieve the best outcomes within the financial resources available to them. At the same time, the economic regulator and NHS Commissioning Board would develop and maintain a framework that ensures transparency, fairness and patient choice. Wherever possible, services should be commissioned that enable patients to choose from any willing provider.

**16.** ***How would consortia deal with the non-registered population?***

Individual consortia would be responsible for meeting the healthcare needs of the people who are registered with each of its practices. A consortium would also need to have sufficient geographical focus to be able to commission services for people who are not registered with any GP practice but who live or are present in the consortium's geographical area of responsibility.

The NHS Commissioning Board would also be responsible for establishing a comprehensive system of GP consortia.

**17.** ***How would you ensure that they will spend their commissioning budget on patient care? What is to stop them awarding themselves massive pay rises?***

With the exception of the management allowance, which is to cover management costs, the intention is that a consortium's commissioning budget must be used exclusively for the commissioning of patient care.

It would be distinct from the income that GP practices earn under their primary medical care contract, from which they both meet their practice expenses, and derive their personal income.

**18.** ***Won't all this new responsibility mean GPs are so busy commissioning they are spending less time with their patients?***

No. The proposed model will mean that not all GPs have to be actively involved in every aspect of commissioning. Their predominant focus would 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.

**19.** ***GPs are getting all the power and money at the expense of other health professionals - what about other clinicians? Why are they being excluded?***

Given their role in co-ordinating care, GPs are well placed to lead on commissioning care for patients. However, 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 document, *Liberating the NHS: Commissioning for Patients*, explicitly invites views on how best to promote this collaborative working across a range of health and care professionals. We propose to work with the NHS and professional bodies in the transition to the new arrangements to promote multi-professional involvement.

**20.** ***How does the judicial review affect the commissioning proposals?***

*Commissioning for Patients* sets out our proposals for new commissioning arrangements for the NHS. We are engaging on these proposals and consulting on specific questions highlighted in the document. A response to the consultation will be published, and will inform the Health Bill to be introduced into Parliament later this year.

**21.** ***Where can I find further information*****?**

A series of engagement events on the White Paper and its supporting documents are taking place nationally and regionally. The White Paper and supporting documents can be found at http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm. Views on the questions in the White Paper should be sent by 5th October. Responses to the questions in the supporting documents, including *Commissioning for Patients* can be sent directly to NHSWhitePaper@dh.gsi.gov.uk by 11 October. Responses to the views on the White Paper will be made available on the Department of Health website. Responses to the consultation, *Commissioning for Patients*, will be made available on the Department of Health website and will help shape the Health Bill later this year.