

The Functions of

GP Commissioning Consortia:
A Working Document

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Introductory message from Sir David Nicholson

This document has been developed in response to requests from GPs and others involved in the development of commissioning consortia. Its purpose is simple: to provide a clear and straightforward description of the key duties and powers of consortia as set out in the recently published Health and Social Care Bill.

It is of course important for prospective consortia to understand the statutory basis of their critical role in the new system, and the technical levers which will support them in discharging their functions. However, it is equally important that we focus our attention on the purpose of that system, thinking not just about the mechanisms for making change, but about what that change is seeking to achieve.

The core purpose of the new commissioning system is to improve health outcomes for NHS patients. Improving outcomes will be at the heart both of the mandate which the NHS Commissioning Board (NHS CB) is tasked with delivering, and of the way in which the Board in turn assesses and rewards the performance of consortia.

In order to achieve this, commissioners will need to be active leaders of change, pursuing a compelling vision for how healthcare should change. The commissioning system will need to take on the quality and productivity challenge right from the outset and get to grips with difficult challenges such as improving the management of long-term conditions and managing demand for urgent and emergency care. That is the ultimate purpose of the system we are creating: to improve quality and outcomes for patients and value for taxpayers.

Achieving this change will require commissioners to work in new ways, using informatics and technology to give patients greater choice and control. The commissioning system will need to understand the healthcare systems it funds by developing real insight into the needs and choices of patients and the public. And the system will need to support co-operation, particularly between commissioners and providers and between primary and secondary care.

These are ambitious and demanding goals, similar to the challenges faced by healthcare systems across the world. The levers described in this document are part of the story about how the new system will meet those challenges. But it is how the different parts of the new commissioning system work together, how we breathe life into the statutory levers in putting them into action, and how we shape mindsets and behaviours in the new system, which will be most important in shaping our success.



Sir David Nicholson KCB CBE
NHS Chief Executive

Foreword

Since the beginning of the discussions on the reforms to the NHS, we have been working closely together to ensure GPs and emerging commissioning consortia (referred to as “consortia” throughout the document) are supported and encouraged to think differently about how health care is commissioned, to improve outcomes for their patients.

Reflecting the clauses in the recently published Health and Social Care Bill, this document sets out:

- a) the proposed key statutory duties of consortia – the “must dos”,
- b) the proposed key statutory powers – i.e. the things that consortia have the freedom to do, if they wish, to help meet these duties, and
- c) illustrative examples of what this could look like in the future – to inform discussion through the Learning Network for emerging GP consortia (the Pathfinder programme).

This is not intended to be a substitute for the Bill, but as a helpful summary to which busy GPs and emerging consortia can refer. GPs – and those working with them to start developing emerging consortia – have been asking for clarification of the “must dos” so they can start to think about how consortia would carry out their responsibilities, what support they might want to put in place, and what this means for organisational development.


It is important to note that the duties and powers (together referred to as functions) set out in the Bill – and reflected in this document – do not simply replicate the current duties and powers of PCTs. In some cases, PCT functions will transfer elsewhere, for example to the NHS Commissioning Board or to local authorities. In other cases, the Bill proposes similar functions for consortia, but expressed in a different way. Some functions have been removed altogether. These may of course be modified as the Bill goes through Parliament.

Some sections of the document give examples of what this could mean in practice. These are only intended to be illustrative examples. However, we are keen that this is a living document that allows these sections to evolve over the coming months to reflect the ideas and learning drawn from pathfinders. We know that groups of practices, including pathfinders, are already considering new and innovative arrangements they would wish to put in place to deliver their functions.

We hope you find this document helpful in informing the planning and implementation of consortia commissioning responsibilities.

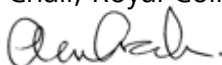
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National Managing Director of Commissioning Development Department of Health



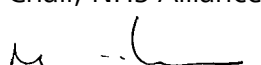
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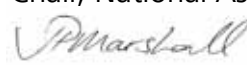
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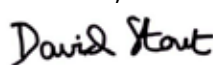
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Introduction

This paper sets out the proposed range of GP consortia responsibilities and functions, in relation to:

- scope of responsibilities
- general duties
- planning services
- agreeing services
- monitoring services
- improving quality of primary care
- financial duties
- governance
- specific duties of cooperation
- standard duties that fall on relevant public bodies.

The paper distinguishes between:

- the duties for which GP consortia are likely to be legally responsible (subject to Parliamentary approval of the forthcoming Health and Social Care Bill)
- proposed legal powers available to consortia to help them carry out their duties
- illustrative examples of activities that consortia might wish to carry out in practice to help fulfil these duties.

The duties and powers described in the document are those that will apply to consortia from April 2013 onwards, subject to the approval in the Health and Social Care Bill and subject to individual consortia being established as statutory bodies. Although there will be significant overlap, they are not intended to describe the functions that emerging consortia and (from April 2012 onwards) established consortia may carry out on behalf of PCTs in the period up until April 2013.

Consortia will have the flexibility to decide how far to carry out these functions themselves, in groups of consortia (e.g. through a lead consortium), in collaboration with local authorities, or through the use of external commissioning support.

Scope of responsibilities

- Consortia will be responsible for commissioning healthcare services across a range of clinical or service areas, including:
 - Community health services (except where part of the public health service)
 - Maternity services
 - Elective hospital care
 - Urgent and emergency care including A&E, ambulance and out-of-hours services
 - Older people's healthcare services
 - Healthcare services for children, including those with complex healthcare needs (except for those specialised services commissioned by the NHS CB)
 - Rehabilitation services
 - Wheelchair services
 - Healthcare services for people with mental health conditions
 - Healthcare services for people with learning disabilities
 - Continuing healthcare
- Consortia may agree to commission some health improvement services jointly with local authorities. This could include, for example, obesity, smoking cessation and drug/alcohol services. In some cases, the NHS CB may be asked to commission a service on behalf of Public Health England and may in turn arrange for consortia to commission the service on its behalf. These arrangements and the detail of the respective responsibilities of NHS and public health commissioners are subject to the outcome of the 'Healthy Lives, Healthy People: Our strategy for public health in England' consultation (which ended on 8 March 2011).

Services to be commissioned by the NHS CB

- The NHS CB will have statutory responsibility for directly commissioning GP services (including GP led health centres), but consortia will be expected to play a major role in improving the quality of primary care and will have a statutory duty to assist and support the NHS CB in doing so.
- The NHS CB will be responsible for commissioning community pharmaceutical services (including those provided by dispensing doctors and appliance contractors), but consortia will be financially responsible for the cost of prescriptions written by the GP practices in the consortium and may be responsible for the associated dispensing costs.
- The NHS CB will commission most dental services and NHS sight tests.
- The NHS CB will commission prison healthcare services, military healthcare services, high security psychiatric services and designated specialised services. Consortia will be expected to significantly influence the NHS CB's commissioning decisions in these areas.

Support for consortia

- The NHS CB will provide assistance to consortia to support them in the successful delivery of their commissioning functions. We will work with pathfinders to describe this further. This assistance may be financial and/or making available the services of the NHS CB's employees or other resources.
- Consortia may choose to buy in support from other external organisations including private and voluntary sector bodies.

1. General

Duties

- To commission healthcare to the extent the consortium considers necessary to meet the reasonable requirements of patients registered with the GP practices who are members of the consortium.
- To commission healthcare for other groups of patients, as defined in regulations, which it is intended will include:
 - people who live within the consortium's defined geographic area who are not registered with any GP practice
 - people present in the consortium's geographic area who need access to emergency care.
- To exercise their functions with a view to securing continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience.
- To co-operate with local authorities and participate in their Health & Wellbeing Boards.
- To co-operate with other NHS bodies.
- To have regard to the NHS Constitution.
- To have regard to commissioning guidance published by the NHS CB.
- To ensure that the consortium obtains advice from people with professional expertise in relation to people's physical and mental health.
- To involve patients and the public in developing, considering and making decisions on any proposals that would have a significant impact on service delivery or the range of health services available.
- To have regard to the need to reduce inequalities in access to healthcare and healthcare outcomes, promote patient and carer involvement in decisions about them ("no decision about me without me") and enable patients to make choices with respect to aspects of their healthcare.
- To pay providers (in specified circumstances) for the costs of healthcare commissioned by another consortium but provided to a patient for whom the consortium is responsible (e.g. for urgent care).
- To provide the NHS CB with specific information, if considered necessary by the Secretary of State for the purposes of carrying out his functions in relation to the health services (this is likely to be primarily financial information).

Powers

- Power to arrange for provision of services that aim to secure improvements in physical and mental health, or in the prevention, diagnosis and treatment of illness, for the people for whom the consortium is responsible.
- Power to enter into partnership arrangements (e.g. pooled budgets, lead commissioning) with local authorities.
- Power to enter into NHS contracts and to arrange for another health body to provide services.
- Power to act jointly with another consortium in exercising commissioning functions or for one consortium to exercise such functions on behalf of another, or, with their agreement, the NHS CB to exercise commissioning functions on behalf of a consortium.
- Power to make grants to voluntary organisations which provide or arrange for the provision of similar services to those in respect of which the consortia have functions.
- Power to conduct or commission research etc.

2. Planning services

Duties

- To contribute to the joint strategic needs assessment (JSNA) and the joint health and well-being strategy led by the relevant Health and Well-being Board(s) (HWB(s)) and to have regard to the JSNA and the joint strategy in exercising any relevant functions.
- To prepare and publish a commissioning plan before the start of each financial year, explaining in particular how the consortium intends to exercise its functions with a view to securing improvement in the quality of services and outcomes for patients and how it intends to fulfil its financial duties.
- To take appropriate steps to ensure that it is prepared to deal with relevant emergencies that might affect the consortium.

What this could include in practice

- Assessing people's healthcare needs and identifying likely trends in healthcare needs, building on the JSNA.
- Identifying inequalities in access to healthcare services, quality and outcomes.
- Working with the Directors of Public Health and their teams, to take account of public health advice in the development of commissioning plans.
- Identifying indicators in the Commissioning Outcomes Framework where there is scope for local improvement.
- Redesigning services and/or pathways to deliver improved outcomes and better meet patients' needs, involving patients and carers and engaging relevant health and social care professionals to co-produce and secure sustainable changes.
- Determining the nature, volume and range of services that will need to be available locally to meet needs as part of working with HWBs on the JSNA and developing a joint health and wellbeing strategy
- Identifying which services will be most effective and cost effective and planning both new investments and disinvestments, drawing on evidence and experience.
- Consulting with the public, and working with local Healthwatch and local authorities.
- Involving groups representative of patients and carers in the planning of services.
- Identifying which patient pathways (or stages) need to be co-ordinated across consortia (through lead commissioner arrangements) or across health and social care (using partnership flexibilities), to secure improved outcomes for patients, building on existing best practice, for example co-ordinated stroke care and cancer networks.

3. Agreeing services

Duties

- To adopt any 'standing rules' that may be required under the Bill in relation to the contracts to be used by consortia, e.g. specific terms and conditions that should be included in those contracts.
- To comply with any regulations that may be made governing procurement activities.

Powers

- Power to make payments to local authorities and voluntary organisations towards expenditure on services.
- Power to make direct payments to patients (instead of commissioning services for them), subject to the learning from the personal health budgets pilots.

What this could include in practice

- Developing service specifications and incorporating them into contracts, drawing on model contracts developed by the NHS CB.
- Determining how best to secure services and patient choice through the 'Any Willing Provider' model or competitive tendering in accordance with national guidance to enable patients to choose from any qualified provider that wishes to provide the service.
- Determining prices/payments for services (subject to tariffs that will be set by Monitor and the NHS CB).
- Determining any additional payments linked to quality and outcomes (e.g. through the CQUIN scheme).
- Ensuring arrangements are in place to enable patients to be reimbursed for treatment provided abroad, including any prior approval arrangements for certain treatments.
- Developing joint commissioning arrangements for locally agreed health and care services (e.g. for children, people with mental health conditions, or people with a learning disability), such as pooled commissioning budgets, lead commissioner arrangements and/or commissioning of integrated health and care services.
- Making arrangements for managing individual funding requests, e.g. to meet complex health care needs.
- Determining arrangements for making decisions on the funding of specific treatments including high-cost drugs and new interventions, taking account of guidance from NICE and the NHS CB and any specific legal requirements.

4. Monitoring services

Duties

- To exercise functions with a view to securing continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience.
- To provide information, where required, to the Information Centre which is necessary or expedient for the Centre to have for the purposes of its function e.g. to support publication of national data on healthcare services.

What this could include in practice

Ensuring arrangements are in place to:

- monitor performance against contracts, particularly in relation to:
 - quality and outcomes, including patient experience;
 - clinical standards;
 - activity levels;
 - financial expenditure.
- reconcile activity, invoices and payments.
- make arrangements to deal effectively with:
 - contract variations;
 - exceptions to the contract;
 - contracts that are under-performing, including agreeing and implementing recovery plans.
- Working with clinicians and patients to review the effectiveness of services and improve patient pathways.
- Managing relationships with a range of providers, potentially using lead commissioner arrangements.
- Assessing the quality of patient experience and using the information to inform local improvement activity and influence commissioning decisions.
- Handling complaints or issues raised by patients, or their elected representative and providing advice and practical support.
- Using the Commissioning Outcomes Framework and other intelligence to benchmark improvements in quality and outcomes.
- Providing information to the Care Quality Commission (CQC) where there are concerns about the basic quality and safety of service; conducting investigations and participating in Serious Case Reviews as needed.

5. Improving quality of primary care

Duties

- To assist and support the NHS CB as regards its duty to exercise its functions with a view to securing continuous improvement in the quality of primary care.

What this could include in practice

- Reviewing the quality and accessibility of services provided by GP practices that are members of the consortium and providing information to the NHS CB as requested.
- Drawing on comparative practice level information to understand the relationship between patient needs, practice performance (e.g. on chronic disease management) and wider quality and financial outcomes, and discussing with practices.
- Supporting practices in improving patient involvement in their own health and care and in planning how to improve GP practice services.
- Taking on delegated responsibility for some aspects of GP contract management including promoting continuous quality improvement, clinical governance, and clinical audit.
- Ensuring that GP practices can access prescribing advice and medicine management support.
- Supporting the NHS CB in arranging continuity of services for patients where, for instance, a GP becomes seriously ill.
- Identifying poor performance at practice and/or practitioner level and working with the NHS CB, the appropriate regulator (CQC and/or General Medical Council) and practices and Local Medical Committees (LMCs) to understand causes of poor performance and support remedial action.
- Potentially commissioning some enhanced primary medical care services on behalf of the NHS CB from GP practices or other providers, with appropriate safeguards to ensure fairness, transparency and competition.
- Influencing the strategy for commissioning primary care alongside broader commissioning plans.
- Determining how the proposed 'quality premium' for consortium performance on outcomes and financial management is shared between constituent practices.

6. Finance

Duties

- To break even on the consortium's commissioning budget (i.e. ensure expenditure in any financial year does not exceed the allocated budget and any other funding or other sums received).
- To ensure that revenue expenditure and capital expenditure do not exceed the separate limits set for each.
- To ensure that expenditure on administrative costs (i.e. costs relating to anything other than the healthcare services commissioned) does not exceed a specified proportion of the overall commissioning budget (the 'running costs allowance').
- To ensure that the use of resources in a given year (i.e. the expenditure incurred, which may not be the same as the cash payments made in that year, and changes in the value of assets) does not exceed a specified amount.
- To provide financial and other data to the NHS CB as required to allow in-year monitoring against budgetary and Parliamentary controls.
- To keep proper accounts and have these audited annually.
- To use a prescribed banking system (i.e. the Government Banking Service) to manage the consortium's funds.

Powers

- Power to pool commissioning funds with other consortia.
- Power to share financial risks.
- Power to pool running costs with other consortia.
- Power to pool resources with the NHS CB.
- Power to pool resources with local authorities.
- Power to raise additional income for improving health services.

What this could include in practice

- Developing and delivering plans to ensure the most effective and efficient use of resources, i.e. ensure quality, innovation, prevention and productivity ('QIPP').
- Developing arrangements to manage financial risk, including forms of risk-sharing and benefits realisation with other consortia, the NHS CB and other potential partners.
- Ensuring effective systems of financial governance, supervised by the Accountable Officer including adhering to Standing Orders and Standing Financial Instructions.
- Managing capital funding, e.g. for consortium premises and Information Technology.

7. Governance

Duties

- To have a constitution that sets out:
 - the name of the consortium and the GP practices that are members;
 - the area for which the consortium is responsible that is relevant to their commissioning responsibilities and to define which Health and Wellbeing Board(s) it is a member of;
 - how it carries out its functions (i.e. who will be responsible for day-to-day executive decisions about commissioning);
 - how the consortium makes decisions, how it deals with conflicts of interest, and how it ensures effective participation of all its members.
- To have an Accountable Officer, responsible for ensuring that the consortium carries out its functions in a way which ensures continuous improvements in quality and proper stewardship of public money.
- To publish an annual report on how the consortium discharged its functions in the previous financial year, with particular reference to how it has discharged its function in relation to quality improvement and patient and public involvement. To hold a meeting to present the annual report to the public.
- To have regard to the proper stewardship of patient and other personal information and manage information risk in line with guidance published by the NHS Information Governance Toolkit by assigning Caldicott Guardian and Senior Information Risk Ownership responsibilities.
- To provide information or explanation where the NHS CB has reason to believe that the consortium might have failed or might fail to discharge its functions.
- To offer NHS pension arrangements to staff employed by the consortium.

Powers

- Power to appoint staff and to decide on pay, terms and conditions for employees.
- Power to select an Accountable Officer, who can be a member of a GP practice in the consortium or an employee of the consortium and who is then appointed by the NHS CB as part of consortium authorisation.

What this could include in practice

- Developing the consortium so that all of its GP practices, and the other health and care professionals and public and patient groups are collaboratively engaged in commissioning, and are able to work together effectively and in an open and transparent manner.
- Developing arrangements to protect against conflicts of interest.
- Developing effective systems to assess and manage service and financial risks, and to ensure service and business continuity.
- Accessing communications support, including effective media handling.
- Acting as a good employer, including providing training and development opportunities for all staff and having fair systems for determining pay.
- Developing a constitution which reflects the 'Nolan principles' of conduct in public life.

8. Specific duties of cooperation

Duties

- To work in partnership to improve the wellbeing of children and, where necessary, support local authorities in arranging support for children and families.
- To help plan services for carers.
- To support local authorities, where appropriate, in community care assessments.
- To support local education authorities, where necessary (this could include, for example, supporting the statementing of children with special educational needs) .
- To co-operate as appropriate with the police, prison services and probation services (e.g. arrangements for assessing risks of violent or sexual offenders).
- To participate, where requested, in a domestic homicide review.
- To carry out specified duties under the Mental Health Act including:
 - make payments for medical examinations in connection with the Act;
 - provide a court on request with information about availability of hospital places;
 - notify local authorities of availability of suitable hospital places for emergency admissions and for under 18s;
 - work with local authorities to arrange after-care services for patients after detention under the Act.
- To consult with local authorities on matters to be set out in regulations. The equivalent regulations for PCTs require that they consult if they are planning a substantial variation in service, and that when necessary they provide relevant information, respond to local authority Overview and Scrutiny Committees (OSCs) reports and attend OSC meetings when requested.

What this could include in practice

- Working with Directors of Public Health and their teams, adult social services, children's services, other local government services and functions, and police/probation services to identify opportunities to work better together to improve people's health and wellbeing and to achieve more efficient and integrated delivery of services.
- Collaborating to provide effective multi-agency responses to safeguard vulnerable adults and children.

9. General duties falling on relevant public bodies

- To carry out functions effectively, efficiently and economically.
- To meet safeguarding duties, including:
 - having regard to the need to safeguard and promote the welfare of children;
 - following the requirements around employing members of staff;
 - being a member of the Local Safeguarding Children's Board(s).
- To meet the requirements of the Employment Rights Act.
- To act compatibly with the European Convention on Human Rights.
- To fulfil equalities duties, including:
 - not discriminating, harassing or victimising, either in commissioning of services or in treatment of employees, on grounds of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, or sexual orientation (collectively referred to as the protected characteristics);
 - advancing equality of opportunity;
 - fostering good relations between those who share a relevant protected characteristic and those who do not;
 - setting and publishing equality schemes;
 - publishing a range of equality data relating to their workforce and the services they provide;
 - producing equality analysis.
- To meet requirements of the Data Protection Act and Freedom of Information Act.
- To meet Health and Safety requirements, including duty of care towards anyone working for the consortium and towards visitors.