

# Memorandum

**From:** Lexington Communications

**Date:** 22 July 2010

**Re:** Health White Paper: GP Commissioning consultation

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## Overview

The Department of Health has today published two further consultations on specific aspects of the Health White Paper. Of particular interest to the pharmaceutical industry is the consultation on the detailed proposals around GP Commissioning, which is available [here](#).

The White Paper contained extensive detail on the broad principles underpinning GP Commissioning, the role of NICE in producing Quality Standards, the role and structure of the NHS Commissioning Board in setting the broad parameters for commissioning, and the formation of GP consortia.

As a result, this afternoon's document, while long, provides little actual new detail. The questions asked of stakeholders are all relatively broad, indicating that while the key decisions around the framework of the system have been made, the operational details are still open to influence. This is to avoid any appearance of an overly prescriptive system that prevents local structures from developing.

## Key additional detail contained in today's consultation

- The structure of GP consortia remains undefined. The consultation states that the Government expects all GP practices to fall under a consortium, but will not prescribe what size or geographical area they should cover. It is noted that as a last resort, the NHS Commissioning Board will step in to compel a GP practice to join a consortium.
- The question of how costs will be controlled under the system remains unanswered. The consultation restates that consortia will have freedom to use resources as they see fit. There will be a role for the NHS Commissioning Board and Monitor in ensuring competition in the commissioning process as a market mechanism to control costs.
- The consultation states that GP consortia will be able to take their own decisions on the vast majority of services. However, in a small number of defined areas, the NHS Commissioning Board will set commissioning and the proportion of budgets to be spent on services. The consultation proposes the following as areas that will need to be closely defined:
  - primary medical care;
  - other family health services: such as dental services, community pharmacy (and other dispensing services) and primary ophthalmic services.
  - national and regional specialised commissioning: such as heart transplants, spinal injuries, burns and renal dialysis;

- where appropriate and by agreement with consortia, hosting some commissioning networks, for example for cancer;
- maternity services; and
- health services for those in prison or custody.

### Questions for response

As noted above, the questions to stakeholders in the document are very broad, and so will enable respondents to make overarching comments on the policy, while drilling down into detailed asks will be more difficult. Questions that you may wish to consider responding to include:

- **How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?** This question will enable EMIG to highlight the importance any specific product-relevant add on services that benefit members' key disease areas, or niche disease areas that have particular importance.
- **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?** This question provides an opportunity for industry to argue for robust powers at the Board level to ensure as high a level of consistency of commissioning across consortia as possible under a devolved structure.
- **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?** Again, a robust line in response to this question will be important to ensure some consistency.
- **What are the key elements that you would expect to see reflected in a commissioning outcomes framework?** As with the two above questions, arguing for strong obligations with relationship to the outcomes framework will be crucial to ensuring that approaches to commissioning for particular disease areas are shared across consortia.

### Timeline

The deadline for submission is 11 October 2010.

The intention is to start to establish shadow GP consortia taking on responsibilities from PCTs in 2010/11 and accelerate that process in 2011/12.

The NHS Commissioning Board will be established in April 2011.

GP consortia will be formally established in 2012/13 and will fully functioning by 2013/14.