

All Change in The NHS Where Now for Practice Managers?

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Declaration of Interests

Dr Jenner received an
honarium to prepare and
deliver this presentation



GP Commissioning A Brief History

- 1990 purchaser provider split in NHS
- 1991 GP fundholding started
- 1997 GP fundholding abolished
- 1999 PCGs
- 2002 PCTs (c300)
- 2003 HA's go SHAs begin (30)
- 2003 New GMS contract
- 2004 Foundation Trusts
- 2005 Payment by results
- 2005 PBC



A Brief History cont.

- 2006 PCTs merged (150)
- 2006 SHAs merged(10)
- 2010 Liberating the NHS
- 2011 Health Bill
- 2011 shadow GP consortia begin
- 2011 June PCTs to work in clusters
- 2012 SHAs abolished (now 2013)
- 2012NHSCB established
- 2013 PCTs abolished
- 2013 GP commissioning consortia take over (?)
- 2015 May –final date for next General Election



Where Are We Now?

- GP practices in England primarily providers of care
- All hold contracts for provision
- No statutory responsibility for commissioning
- PBC has brought a lot of noise and some action
- But benefits hard to gauge nationwide

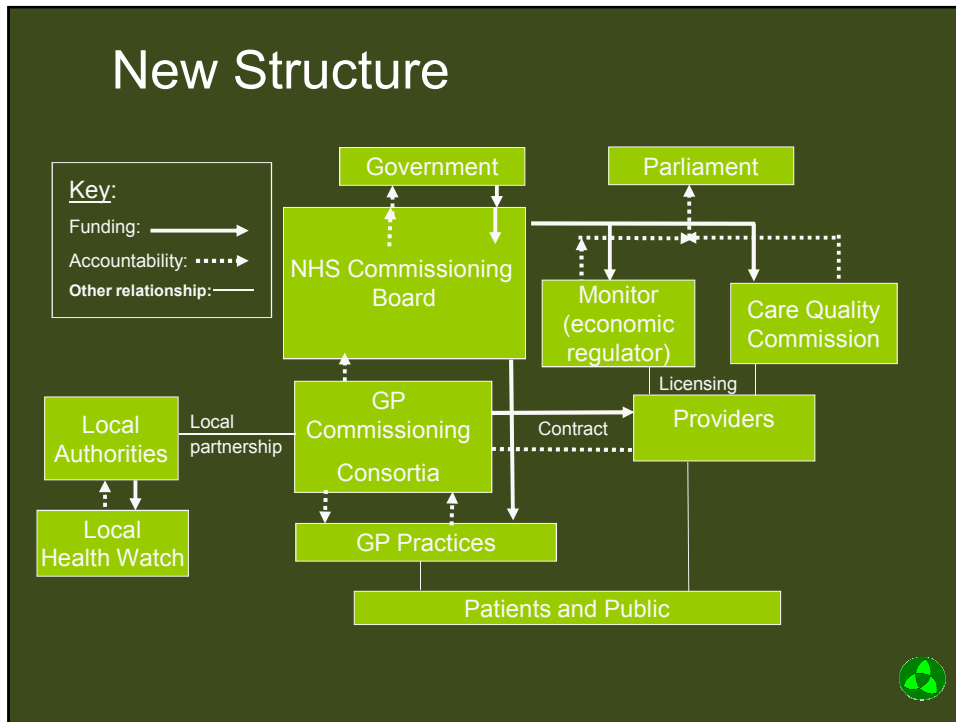


“Liberating the NHS”

- Radical in scope and timelines
- But has it been thought through?
- Note the differences between initial coalition plans and the White Paper
- PCTs are removed at a stroke!
- Nothing between No 10 and front line apart NHSCB
- Few NHS managers left to mitigate the policy-but is this the plan?



New Structure



Six Months Ago

- Consultation on White Paper just finished
- Coalition still harmonious
- Many GPs, BMA and RCGP still in support of GP commissioning
- PCTs unaware they would be “clustered by June”
- Industry unsure who are the power brokers at present
- Most NHS managers think it’s a bad dream and they will wake up to find it gone

And Right Now

- Health Bill in Parliament (paused!)
- PCTs to form clusters with single executive team from June 2011
- 90%+ of country covered by “pathfinders” (most announced the day before Health Bill published – politics pure politics!)
- Likely future consortia emerging as shadow forms
- Still need to make massive efficiency savings
- Futures Forum have reported
- Government has responded



And This Week -Future Forum Report

- SOS to remain accountable for NHS
- Monitor to have primary duty to promote choice, integration and collaboration not just competition
- GP Consortia to become clinical consortia and only become authorised and established when “ready and willing”
- NHSCB to take responsibility in April 2013 where consortia are not ready PCTs will go
- Consortia to have clinical senates to inform commissioning



And This Week -Future Forum Report

- Consortia Boards to have independent members to protect against conflict of interest
- Consortia boundaries should not normally cross Local Authority boundaries to aid integration
- Consortia Boards should meet in public (as should Foundation Trusts)
- NHSCB to become established as soon as possible and also include clinical senates



And This Week -Future Forum Report

- Private providers should not be allowed to 'cherry pick' patients and the Government should not seek to increase the role of the private sector as an end in itself. Additional safeguards should be brought forward.
- Commissioners to have a new duty to promote the NHS constitution and be required to report on this in their annual reports.
- Experienced NHS managers will be essential and should be retained.



And Cameron's Response 14/06/2011

- We will not endanger universal coverage - we will make sure it remains a National Health Service.
- We will not break up or hinder efficient and integrated care - we will improve it.
- We will not lose control of waiting times- we will ensure they are kept low.
- We will not cut spending on the NHS - we will increase it.
- And if you're worried that we are going to sell-off the NHS and create some American-style private system - we will not.
- We will ensure competition benefits patients.



“The Biggest Change Will Be”

Bureaucrats to work for Doctors
Not
Doctors for Bureaucrats!



And the Biggest Uncertainty Is

Will it be compulsory eventually for GPs to commission

Tories suggest yes

Lib Dems suggest NO!



Government Response

- We will make clearer that NHS care must be free at the point of use and that charges for patient services could only be introduced by legislation; and we commit not to introduce any new charges during this Parliament.
- The policy is that the Secretary of State will be responsible – as now – for promoting a comprehensive health service.
- We will also make clear that the Secretary of State will also retain ultimate accountability for securing the provision of services
- GP consortia to be called clinical commissioning groups



Government Response

- Consortia not to cross L.A boundaries unless agreed by NHSCB and show clear benefit to patients
- Clinical commissioning groups will be expected to have a name that uses the NHS brand and has a clear link to their locality.
- But as public bodies, they will be unable to delegate their statutory responsibility for commissioning decisions to private companies or contractors.
- We will [soon] publish further details on the processes for authorising and assessing clinical commissioning groups and on the accountabilities and relationships between the NHS Commissioning Board, commissioning groups and Health and Wellbeing Boards.



Government Response -Consortia

- Boards to have two lay members ,one to be Chair or Vice Chair
- One nurse and one hospital Dr on board (but not from local provider!?)
- Boards to meet in public
- Quality premium –issue fudged –more regulations on their way but it wont be cash for cheap care!



Government Response

- Primary Care Trusts will cease to exist in April 2013. However, clinical commissioning groups will not be authorised to take on any part of the commissioning budget in their local area until they are ready and willing to do so.
- By April 2013, GP practices will be members of either an authorised clinical commissioning group, or a 'shadow' commissioning group, i.e. one that is legally established but operating only in shadow form, with the NHS Commissioning Board commissioning on its behalf.
- This will be determined through a robust process of authorisation, run by the NHS Commissioning Board, with input from emerging Health and Wellbeing Boards and local clinicians.



Government Response

- Where a clinical commissioning group is not able to take on some or all aspects of commissioning, the local arms of the NHS Commissioning Board will commission on its behalf,
- The primary care trust "cluster" arrangements will be reflected in the local arrangements of the NHS Commissioning Board.
- The ten Strategic Health Authorities will remain in place as statutory bodies until April 2013, but we will form them into a smaller number of clusters later this year
- We will take steps to boost the quality of management and leadership: for example, by retaining the best talent from PCTs and SHAs in the new system, and through a commitment to the ongoing training and development of managers.



Government Response

- We will enable doctors, nurses and other professionals to come together in “clinical senates” to give expert advice, which we expect clinical commissioning groups to follow, on how to make patient care fit together seamlessly in each area of the country.
- Both clinical networks and clinical senates will be hosted by the NHS Commissioning Board; they will not be organisations or new forms of bureaucracy.



Government Response

- The Bill will make clear that HWBs should be involved throughout the process as clinical commissioning groups develop their commissioning plans, and there will be a stronger expectation, set out in statutory guidance, for the plans to be in line with the health and wellbeing strategy. Though they will not have a veto, HWBs will have a clear right to refer plans back to the group or to the NHS Commissioning Board for further consideration.
- They will be given a formal role in authorising clinical commissioning groups and the NHS Commissioning Board will have to take HWBs' views into account in their annual assessment of commissioning groups.



Government Response Monitor

- Monitor will have a new duty to carry out appropriate public and patient involvement in the exercise of its functions.
- We will also place Monitor under a new duty to obtain appropriate clinical advice.
- Monitor's core duty will be to protect and promote patients' interests.
- We will remove Monitor's powers to "promote" competition as if it were an end in itself.
- Monitor will be required to support the delivery of integrated services for patients



Government Response

- The NHS Commissioning Board, in consultation with Monitor, will set out guidance on how choice and competition should be applied to particular services, guided by the mandate set by Ministers. This includes guidance on how services should be bundled or integrated
- We will remove Monitor's powers to open up competition by requiring a provider to allow access to its facilities to another provider.



Government Response

- Competition will be on the basis of quality not price. We will create additional safeguards against price competition and “cherry picking”.
- So that providers cannot “cherry pick” the profitable, “easy” cases, services will be covered by a system of prices that accurately reflect clinical complexity, except where this is not practical. Commissioners will be required to follow “best value” principles when tendering for non-tariff services, rather than simply choosing the lowest price
- We will outlaw any policy to increase the market share of any particular sector of provider



Government Response

- This will prevent current or future Ministers, the NHS Commissioning Board or Monitor from having a deliberate policy of encouraging the growth of the private sector over existing state providers – or vice versa.
- In addition to revising Monitor’s core duty, we will create a new duty for clinical commissioning groups to promote integrated services for patients,
- We will introduce a “duty of candour”: a new contractual requirement on providers to be open and transparent in admitting mistakes



So Where Does That Leave Us?

- Practices have to join consortia
- But only commission if they are ready and willing!
- NHSCB gets more powers
- Monitor loses loads of powers
- HWBs more powerful
- Patients and public get more powers
- Consortia get more bureaucracy
- SHAs live another year
- The Health Bill Survives for now



But This is Now A Major Rework of a Flawed Design

Have we just compounded the problems?

What Incentives are there for GPs to commission?

Has a poisoned chalice even lost the wine within?

Alan Milburn describes as biggest train wreck ever!



And Then There Are the QUIPP Savings

- £20 billion by 2015
- According to James Kingsland
- (national clinical commissioning lead)
- 40p per pt per day
- £2400 per 6000 patients (average practice) per day
- And an ageing population
- And 40% reduction in management costs



Consortia Unresolved Issues

- Running costs
- Who are successor bodies to PCTS?
- (vital for TUPE and legal liabilities)
- HR framework
- Where several key legal duties of PCTs will go in future
- The authorisation process
- Future of GP contracts



Consortia Unresolved Issues

- The allocation formula and pace of change
- A mass of secondary legislation
- Cash incentives to GPs as providers for commissioning success?
- How Monitor will interpret it's brief!
- Whether quality premium funded from GP provider budgets



But the Biggest Uncertainty Is
When and Whether the Bill Will
be Passed!

And if it is will the rules change yet
again?

It now looks likely but more changes still
possible in legislation



The Pathfinder Dilemma

- Push ahead regardless and assume Bill will be passed (DH message)
- Concentrate on the QUIPP challenge and flex the structures to keep the office open!
- Form new organisations when money is tight
- Recruit and retain NHS managers or look to private sector
- (but often recycled NHS talent)



PCT Sub Committee Looks Best Bet

It's an each way bet!

Could even survive total failure of the Bill!

Allows shadow consortia to offer NHS terms

Aligns commissioning responsibility with accountability

Saves on legal and accountancy fees!



NHSCB Powers

- Hold GPCC to account
- Approve their constitution and establishment
- Allocate practices to and from a consortia
- Appoint and dismiss the accountable officer
- Dissolve the consortia
- Take a top slice from the consortia budget for a contingency fund
- Allocate a performance bonus to consortia
- Allocate to, (or remove from) any functions from consortia as it sees fit



“But if the aim is genuinely to see clinically-led commissioning, the international experience suggests that’s best achieved through coalitions-of-the-willing, not conscription.”

Simon Stevens
President United Health



Other Challenges for Practice Managers

- Falling income and no obvious new money from consortia for providers
- Inexorable increase in patient demand
- CQC registration
- Revalidation
- Raid on GP Pensions
- Recruitment and locum issues
- End to practice boundaries April 2012?



Engaging with Commissioning

- Don't ignore it –your future survival could be at risk
- Be aware of your NHS resource footprint and look to explain any variation or eliminate it
- For now concentrate on the QUIPP challenge 4% a year is enormous
- No consortia will get authorised if it isn't controlling costs
- The form can follow the functions!



NHS Resource Footprint (compare against benchmarks – local and national)

- GMS/PMS/APMS core income
- QOF income
- Enhanced service income
- Prescribing spend per Astro PU
- PbR spend (elective and non elective)

- Where do you sit?
- Look at NHS comparators
- PBC budget setting toolkit



The Commissioning Challenge

- If we don't control costs –our own worth will be questioned
- Clinical commissioning does give us chance to influence change
- We need to spend more in primary and community care
- And less in hospitals
- But rationing is not overt –yet!



And Are Most GPs Going to Do This?

We Need You to Make It Work !

Great providers are usually great commissioners

And for now your contractual responsibilities is as providers of care



So In Summary

- We would not wish to start from here!
- We can however help save the NHS
- Quality provision is important
- But the 4% challenge is paramount
- Keep to the issues
- Whilst others argue over structures
- Commissioning responsibility unlikely to go away



And This Is a Risky Strategy!

