

## COMMISSIONING A PATIENT-LED NHS

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To all:

Chief Executives of NHS organisations  
Chief Executives of Local Authorities  
Directors of Social Services  
Primary Care Trust PEC Chairs

### INTRODUCTION

This brief document builds on the *NHS Improvement Plan* and *Creating a Patient-Led NHS*. Its focus is on creating a step-change in the way services are commissioned by front-line staff, to reflect patient choices. Effective commissioning is a pre-requisite for making these choices real. It does so in the overall context of improving the health of the whole population.

This will require:

- better engagement with local clinicians in the design of services;
- faster, universal roll-out of Practice Based Commissioning;
- developing PCTs to support Practice Based Commissioning, and take on the responsibility for performance management through contracts with all providers, including those in the independent sector;
- reviewing the functions of SHAs to support commissioning and contract management.

Delivering these changes is an essential part of creating a patient-led NHS. They complement the policies of choice of provider, payment by results, and the commitment to press on with the NHS Foundation Trusts programme.

The changes will also prepare the NHS to implement improved care outside of hospital, following the White Paper on which we will be consulting throughout the autumn.

Improvements in commissioning, the determination to make progress on working with Local Authorities on *Choosing Health*, and the commitment to make £250 million of savings in overhead costs, require NHS organisations to change and develop.

These changes in function will mean that the NHS will want to reconsider the optimal configuration of PCTs, and where appropriate Care Trusts, and SHAs and their fitness for purpose. This will be done alongside the reform in the provision of ambulance services described in *Taking Healthcare to the Patient*.

The pace of change will be for local consideration and consultation. However, the Department expects that PCTs will make arrangements for universal coverage of Practice Based Commissioning to be in place by December 2006, that PCT changes will be in place by October 2006 and that SHA changes will be complete by April 2007. Changes to PCT service provision will be complete by December 2008. Some areas may choose to go faster. However, the Department will not approve proposals for restructuring unless proposals satisfy the criteria set out in this document.

As the NHS moves from being a provider driven service to a commissioning driven service, the Department of Health will review its own commissioning and provider support functions over the next few months to ensure fitness for purpose.

The purpose of these changes is to see improvements in health and in services. Reconfiguration is not an end in itself. This process is about ensuring organisations are properly configured and fully prepared for their new role. The Government's main priorities remain the delivery of PSA targets for this year and looking forward to 2008; and effective implementation of a patient-led NHS, so that improvement becomes embedded in the fabric of the NHS.

It is very important that as we make these changes we support the people who will be affected and ensure continuity of service for the public.

**SIR NIGEL CRISP**  
Chief Executive of the NHS

28 July 2005

## THE PROGRAMME - DEVELOPING COMMISSIONING

1. This process falls into two stages:
  - the first stage is about getting the right configuration for commissioning and the right people in the right places. This will involve a review, coordinated by the SHAs and engaging PCTs, other stakeholders including local government and NHS staff;
  - the second stage is about enhancing the ability of Practices, PCTs and SHAs to do their new job.

### Stage 1

2. Strategic Health Authorities will be responsible for coordinating the exercise locally, working with local people and patient groups, NHS organisations, local government, MPs and other stakeholders. They will be expected to consider Practice, PCT and SHA functions to deliver a fit for purpose health system with an effective and objective commissioning function able to deliver high quality care and value for money alongside the improvement of health promotion and protection. This may or may not involve mergers and reconfigurations. Any such changes will be subject to local consultation and assessment by the Department.
3. Proposals will be assessed against the following criteria of the PCT's ability to:
  - secure high quality, safe services;
  - improve health and reduce inequalities;
  - improve the engagement of GPs and rollout of Practice Based Commissioning with demonstrable practice support;
  - improve public involvement;
  - improve commissioning and effective use of resources;
  - manage financial balance and risk;
  - improve coordination with social services through greater congruence of PCT and Local Government boundaries;
  - deliver at least 15% reduction in management and administrative costs.
4. As a general principle we will be looking to reconfigured PCTs to have a clear relationship with local authority social services boundaries. This does not need to mean a rigid 1:1 coterminosity – big Local Authorities might have more than one PCTs whereas a number of small Unitary Authorities might fit into one PCT.
5. Most PCTs currently provide services. As PCTs focus on promoting health and commissioning services, arrangements should be made to secure services from a range of providers – rather than just through direct provision by the PCT. This will bring a degree of contestability to community-based services, with a greater variety of service offerings and responsiveness to patient needs.

In some types of services, there may be a range of providers – for instance, in the voluntary sector – already able to deliver. In other areas, no obvious alternative providers may exist. One of the purposes of the forthcoming consultation and White Paper on health and care services outside hospital will be to consider how to develop a wider variety of local services and models of provision in response to patient needs.

6. In the proposals that they develop locally and put forward by 15 October, Strategic Health Authorities should show how:
  - commissioners will be actively seeking new and innovative ways to improve new services with a range of providers;
  - they have assessed what services should move away from direct PCT provision and at what pace;
  - where PCTs continue to manage services, decision-making on commissioning and on provision will be separated in order to enhance contestability.
7. The White Paper will undoubtedly explore different service models. This may mean that SHAs and PCTs will want to refine these proposals on service provision. However the direction of travel is clear: PCTs will become patient-led and commissioning-led organisations with their role in provision reduced to a minimum. We would expect all changes to be completed by the end of 2008.
8. We are also looking to reconfigured SHAs to move towards alignment with Government Office boundaries where appropriate, though SHAs may make a case that that is not appropriate in their particular area. SHAs will be expected to deliver a significant reduction in management and administrative costs through their configuration proposals.
9. SHAs are asked to submit proposals at the latest by **15 October 2005** which show how they will meet the criteria detailed at paragraph 3. This will include:
  - their proposals for future organisational configurations (covering PCTs, SHAs and reflecting proposed changes to Ambulance Trusts which are moving to a faster timetable);
  - proposals on changes to PCT – managed service provision, recognising that some of these proposals may need to be developed further following the publication of the White Paper into the end of the year;
  - a plan for the roll-out of Practice Based Commissioning;
  - a business continuity plan to ensure financial balance, delivery of short term targets and no loss of momentum towards 2008 targets;
  - evidence of the views and contributions of all the relevant parties they have consulted.
10. The Department will then test proposals – including those where no change to the current PCT configuration is deemed necessary. The aim is to agree with each SHA by the **end of November 2005** that they may proceed to consultation – or where this is not necessary, that the plan can be implemented.

11. Statutory consultation will be undertaken locally and completed by the end of **March 2006** at the latest. Whilst there is no requirement for all SHAs to undertake their consultation simultaneously and the Department would not wish to slow fast movers down to the rate of the slowest, there are practical advantages in a small number of clustered consultations, which the Department will facilitate.
12. All legal, staffing and recruitment processes will be handled locally, though the Department will seek to cluster SHAs moving at a similar pace to provide support and offer redeployment opportunities to staff. SHAs should consider the advantages of running parallel processes with other local SHAs to offer staff the maximum opportunity to find the right job. The Department will work with SHAs to ensure that human resource policies are consistently and fairly applied across the country.
13. All PCT reconfigurations should be complete by **October 2006** with SHA changes completed by **April 2007**. Changes to PCT service provision will be complete by **December 2008**.

## Stage 2

14. This second stage is about identifying the development support that organisations will need to be successful in future.
15. SHAs will have already reviewed the appropriate organisational design of PCTs and themselves to discharge their new roles and changes in provider responsibilities as part of the configuration exercise in stage 1. This second stage will therefore focus on internal capacity and capability to discharge new functions, and particularly leadership ability. It will be as rigorous as that for NHS Trusts applying for NHS Foundation Trust status where strengthening the composition of Boards and improving governance systems have featured strongly. It should also learn from the experience of local government as it has developed its role as a commissioner of social care services.
16. As part of this process, PCTs and SHAs across the country will undergo an independent diagnostic and benchmarking assessment, which will ensure that the resultant development programme will be appropriately targeted and consistently applied.

## **ROLES AND RESPONSIBILITIES IN COMMISSIONING**

### Practice Based Commissioning

17. The Government is committed to Practice Based Commissioning as a way of devolving power to local doctors and nurses to improve patient care. It is also a way of aligning local clinical and financial responsibilities.
18. Under Practice Based Commissioning, GP practices will take on responsibility from their PCTs for commissioning services that meet the health needs of their local population. Commissioning practices, or groups of practices will have the following main functions:
  - designing improved patient pathways;
  - working in partnership with PCTs to create community based services that are more convenient for patients;
  - responsibility for a budget delegated from the PCT, which covers acute, community and emergency care;
  - managing the budget effectively.
19. Under Practice Based Commissioning GPs will not be responsible for placing or managing contracts. That will be done by PCTs on behalf of practice groups, with back office functions including payment administered by regional/national hubs. GP Practices will also receive management support, the size of which will be dependent of the numbers of practices involved. Further details on these arrangements will be set out in October following discussion with relevant stakeholders.
20. There is a strong desire in general practice to make rapid progress in rolling out Practice Based Commissioning more rapidly. In line with this desire, and given the strategic importance of commissioning to the system reform agenda, the Department can confirm that it expects to see PCTs make arrangements for 100% coverage of Practice Based Commissioning by no later than the end of 2006. Individual practices will have the option to take on commissioning to a greater or lesser extent depending on their wishes and their capabilities.

### Primary Care Trusts

21. PCTs will ensure access and choice to a range of high quality health services and ensure that the Government's commitments to health, reducing health inequalities and health services are delivered for local people.
22. As custodians of their population's health budget, they are responsible for ensuring prioritisation and value for money in ways which have maximum impact on health and secure all necessary health services.

23. Their functions, which can be provided by external agencies, partners and consortia working on their behalf, will remain as follows:

- improving the health of the community and reducing health inequalities;
- securing the provision of safe, high quality services;
- contract management on behalf of their practices and public;
- engaging with local people and other local service providers to ensure patients views are properly heard and coherent access to integrated health and social care services is provided;
- acting as provider of services only where it is not possible to have separate providers – and with arrangements for separating out decisions on commissioning from provider management;
- emergency planning.

24. As proposed in paragraph 3.20 of *Creating a Patient-led NHS*, the need for PCTs to be involved in contract negotiation will be reduced by the development of national and regional standard contracts, with the ability to tailor locally. This will allow them to focus on health improvement and securing high quality services and reduce costs.

25. PCTs will be accountable to their local communities and to the Secretary of State through Strategic Health Authorities.

### Strategic Health Authorities

26. SHAs will focus on the following functions:

- performance managing the NHS local public health function and working closely at a regional level (with the Department's Regional Directors of Public Health in the Government Offices of the Regions) recognising the latter's cross-government multi-agency roles in improving population health and reducing health inequalities as well as health protection;
- ensuring successful delivery through:
  - performance management of PCTs;
  - strategic planning and the oversight of major investment and reconfigurations;
  - supporting research, innovation, education and training and ensuring its integration with service commissioning;
  - tertiary level commissioning when this cannot be undertaken by PCTs;
  - overseeing and managing the system in association with the regulators;
- ensuring robust and integrated emergency planning;
- taking their NHS Trusts to Foundation status.

27. Strategic Health Authorities will be accountable to the Secretary of State through the NHS Chief Executive.

## NHS Foundation Trusts

28. NHS Foundation Trusts will have the following main functions:

- deliver service agreements with PCTs on a contractual basis, making the best use of available resources;
- work with PCTs, Practice Based Commissioning groups and clinical networks in the redesign of services to ensure that they are patient centred and integrated across the continuum of primary and secondary care;
- work with PCTs and other partners to contribute to health improvement in the local community, recognising their contribution to employment and economic development locally;
- provide a good environment for training, development and research;

29. NHS Foundation Trusts will be expected to deliver these functions through the empowerment of clinical teams and patients, by working across institutional boundaries, reaching out and providing services as close to local communities as possible. Focusing on the redesign of services to make them more patient centred, they will encourage innovation and creativity and maximise the benefit of NHS resources across the whole health community.

30. NHS Foundation Trusts are accountable to an Independent Regulator (known as Monitor) for compliance with their terms of authorisation. The terms of authorisation sets out the business of the NHS Foundation Trust. They are also accountable to local people through their governance arrangements and to PCTs for the delivery of contracted services. NHS Foundation Trusts are required to consult with Overview and Scrutiny Committees and Public and Patient Forums in the same way as other NHS organisations and are subject to inspection by the Healthcare Commission.

## NHS Trusts

31. The implementation of *Commissioning a Patient-led NHS* for NHS Trusts is about successfully preparing them all to move towards NHS Foundation Trust status by April 2008.

32. To help NHS Trusts prepare, Monitor, the Department and the SHAs will lead a rigorous development programme to identify areas where NHS Trusts need to develop to reach the standard required for foundation status. This programme is currently being piloted in Birmingham and the Black Country and Cheshire and Merseyside SHAs. Roll-out across the country is scheduled to be completed by the end of 2006 at the latest. The existing NHS Foundation Trust community will be asked to support the roll-out process.



33. The diagnostic process covers:

- financial health and delivery track record of Trust;
- leadership and governance;
- risk assessment of local health economy covering PCTs and SHA.

34. The development interventions identified as needed as a result of this process will be coordinated by the SHA in conjunction with Monitor and the Department.

#### Other providers

35. Alongside this programme for NHS Trusts, there will be a progressive move towards greater use of other providers, including those from the independent sector.

#### Ambulance Trusts

36. The review of ambulance services published on June 30 (*Taking Healthcare to the Patient*) proposed to strengthening ambulance services with an associated reduction of a least 50% in the number of ambulance trusts.

37. Ambulance Trusts will also be supported in preparing themselves to move towards Foundation status.

#### Next Steps

38. The Department stands ready to offer advice and assistance on request through John Bacon for SHA issues, Peter Bradley for Ambulance Trusts and Duncan Selbie for all other organisations.

## **TIMETABLE**

### Commissioning Functions

- August – mid October 2005: SHAs to review their local health economy's ability to deliver the commissioning objectives and submit plans to ensure they are achieved, including reconfiguration plans where required
- March 2006: all statutory consultation completed
- By October 2006: all reconfigurations undertaken
- October 2005: commissioning development support programme launched (2 year programme)
- March 2006: first wave of enhanced Practice Based Commissioning implemented
- December 2006: PCTs have in place arrangements for universal coverage of Practice Based Commissioning
- April 2007: SHA reconfiguration complete
- December 2008: Changes in PCT service provision complete

### Trusts

- mid September 2005: Monitor and SHAs to publish diagnostic tool for NHS Trusts
- January – June 2006: SHAs conduct NHS Trust diagnostic process
- July 2006: SHAs to report back on NHS Trust review, scheduling Trusts for transition to Foundation status

### Ambulance

- September - November 2005: formal consultation to elicit patient and public views
- December 2005: Ministerial decision and announcement
- from January 2006 onwards: legal (establishment orders, TUPE, transfer of assets and liabilities) and board recruitment processes begin
- April 2006: implementation begins – first trusts established in shadow form with the option of moving to statutory status from July 2006
- by March 2007: implementation complete – all Trusts in place and fully operational