Health reform in England: update and commissioning framework

**Key points**

- *Health reform in England* deals mainly with commissioning arrangements for hospital services covered by choice and payment by results.
- It outlines how practice-based commissioning is intended to empower GPs to develop new services that are flexible, reflect patients’ needs and are delivered closer to people’s homes.
- It describes the role of PCTs and SHAs and their relationship with GP practices.
- The commissioning framework is intended to strengthen practice-based commissioning by:
  - clarifying the approach to tendering for services
  - encouraging PCTs to set up local incentive schemes
  - seeking comments on a proposed governance and accountability framework.

Six years into the ten-year programme of NHS investment and reform, the Department of Health (DH) has published an update on progress in several important areas, particularly commissioning – *Health reform in England: update and commissioning framework*. The DH is asking for responses to certain proposals and questions contained in the document. This *Briefing* examines the aspects of the document that relate specifically to commissioning and the commissioning framework.

**Background**

As statutory bodies, primary care trust (PCT) boards are responsible for securing the best possible services for their population, within their allocated budget. PCTs cannot hand over accountability for the commissioning functions to others, but equally they cannot achieve their goals without close partnership with others such as local authorities.

*Health reform in England* says that practice-based commissioning will be key in enabling PCTs to achieve the best value for patients. Through it, practices will have indicative budgets and the freedom and incentives to exercise devolved responsibility for aspects of the commissioning and redesign of services. PCTs will support the development of practice-based commissioning by providing information, budgets, public health needs assessments, analysis of cost-effectiveness of interventions, and training and development for practices. Practices will develop, through their business plans, proposals for the redesign of services and for releasing resources.
The document says effective commissioning means effective engagement of patients and local communities.

The commissioning framework

The commissioning framework outlines how the DH expects commissioners to act where provision is either unavailable or fails to meet required standards. Commissioners are to be encouraged to use open tendering as a way of ensuring innovation, quality and value. Any provider will be free to compete in this process, including those from the public, private and voluntary sectors.

The document notes that stronger PCTs and the acceleration of practice-based commissioning, together with incentives introduced by health reform, provide the opportunity for more effective commissioning that will, over time, lead to:

• improvements in health and well-being
• reductions in health inequalities and social exclusion
• better access to a comprehensive range of services
• improved quality, effectiveness and efficiency of services
• increased choice for patients and a better experience of care
• improved integration of health and social care.

Effective commissioning

Health reform in England says that PCTs and their practices will need to work with their patients, local communities and local partners to ensure all the elements of commissioning described below and illustrated in Figure 1 are delivered effectively.

PCTs and practices will achieve effective commissioning through:

• information to support commissioners, including drawing on the skills of companies with particular expertise, for example in population risk assessment or social marketing
• better clinical engagement, for example through practice-based commissioning
• improved community engagement through a new prospectus, patient and community petitions and the work of the proposed new local involvement networks (LINks)
• incentives and contracts for commissioners
• increased choice for patients.

Elements of commissioning

• Assessing needs – based on rigorous analysis.
• Reviewing service provision – identifying gaps and the potential for improving existing services.
• Deciding priorities – the PCT should produce a strategic plan for the health community.
• Designing services – practices will work individually or in groups to develop strategies and service models to improve services.
• PCT prospectus – this will signal the strategic direction for local services, highlighting commissioning priorities.
• Shaping the structure of supply – PCTs will be clear about the services and service specifications needed and will agree contracts with local secondary care providers within a new national contracting framework.
• Managing demand and ensuring appropriate access to care – practices and PCTs will establish strategies for the use of care and resources.
• Clinical decision-making – individual practices and clinicians will undertake individual needs assessments, make referrals and advise patients on choices and treatments.
• Managing performance – practices will seek to manage their indicative budget to maximise the benefits from the resources available to them.
• Patient and public feedback – PCTs will be responsible for measuring and reporting on patients’ experience.
The Lawlor Report

In July 2006 the DH published the results of the independent review of the payment by results tariff-setting process for 2006/07. The review found that:

- not enough time was allowed to check and test the way the tariff was calculated
- the tariff was materially wrong – the DH intended the net impact of all the changes to increase the tariff by 1.5%, but the increase was more than this
- the NHS did not have enough time to plan on the basis of the new tariff as it was only published at the end of January 2006.

The report’s main recommendations include:

- increasing the number of staff working on the tariff calculation
- testing the tariff over a number of weeks, with a number of NHS organisations
- publishing the tariff by mid December at the latest
- strengthening consultation arrangements
- considering contracting out arrangements for calculating the 2008/09 tariff.

See: www.dh.gov.uk/assetRoot/04/13/73/42/04137342.pdf
### Roles and responsibilities

*Health reform in England* sets out the main roles and responsibilities for effective commissioning. These are shown in Figure 2.

#### The Department of Health

The DH is responsible for providing fair funding to commissioners.

Addressing concerns that organisational changes may lead to deprived areas losing out, strategic health authorities (SHAs) will monitor PCTs to ensure that they are correctly targeting areas of greatest health need. The funding formula is to be kept under review, but allocations made for 2006/07 and 2007/08 will not be changed. It is the responsibility of PCT boards to operate within the cash limit.

#### PCTs and practices

Commissioning cannot be regarded as a set of activities carried out in isolation. Instead, there are a number of roles and responsibilities which interact to ensure effective health and social care services are commissioned at all levels.

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### Figure 2. Roles and responsibilities

<table>
<thead>
<tr>
<th></th>
<th>Information</th>
<th>Practice-based commissioning</th>
<th>Prospectus</th>
<th>Community voice</th>
<th>Increased choice</th>
<th>Effective incentives and contracts</th>
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<tr>
<td><strong>Patients and the public</strong></td>
<td>Give feedback on service quality and experience</td>
<td>Give feedback on service quality and experience</td>
<td>Engage in development, including: • identifying need • assessing performance • deciding priorities</td>
<td>Views of the community and representative groups feed into commissioning</td>
<td>Choose the provider that is best for the individual</td>
<td>Give feedback on service quality and experience</td>
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<td><strong>Practices</strong></td>
<td>Help patients understand the information available about services and support choice</td>
<td>Engage with community in drawing together practice-based commissioning plans</td>
<td>Contribute to needs assessment</td>
<td>Represent patient views</td>
<td>Contribute to the development of priorities</td>
<td>Engage with community in drawing together practice-based commissioning plans</td>
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<td><strong>PCTs</strong></td>
<td>Ensure information on quality and patient experience is available to practices and the public</td>
<td>Support practices through provision of indicative budgets, clinical and management information, analysis of population needs and comparative data</td>
<td>Produce the prospectus</td>
<td>Manage the production process</td>
<td>Provide public health analysis</td>
<td>Actively facilitate community engagement and debate</td>
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<td>Develop data systems to monitor service quality and contracts</td>
<td>Provide governance for practices and report to SHA on all services developed in community</td>
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<td>Obliged to formally respond to community petitions</td>
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<td></td>
<td></td>
<td>Agree practice-based commissioning business plans</td>
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<td>Undertake review of services when asked to do so by overview and scrutiny committees or a community petition</td>
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<td><strong>SHAs</strong></td>
<td>Responsible for supporting and performance managing the implementation and operation of new commissioning arrangements</td>
<td>Ensure that relationships between PCTs and GPs develop in accordance with practice-based commissioning principles</td>
<td>Ensure that PCTs produce their prospectus</td>
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<td>Support practices in ensuring information is provided on services and choices</td>
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<td>Arbitrate where local agreement cannot be reached</td>
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<td>Ensure patients have a choice of providers for applicable services</td>
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Supporting practice-based commissioning

The document says that practice-based commissioning is a key element of the health reforms and will be crucial in enabling PCTs to achieve the best value for patients. It will be strengthened in a number of ways, outlined below.

Local incentive schemes
Currently, PCTs are required to introduce an incentive scheme to engage practices in redesign; the Directed Enhanced Service (DES) incentive scheme represents the minimum requirement. The document says PCTs should consider offering additional local incentive schemes, over and above the DES, that facilitate the provision of care in settings more convenient for patients, closer to home. Such schemes must be cash-releasing.

Guidance on procurement
Generally, existing primary care providers can develop services:

- by extending the management of patients before they are referred elsewhere, or discharging patients from outpatient follow-up back into practice (and the service becoming part of ‘essential’ GP services), or
- under a Local Enhanced Service (LES) agreement or within other General Medical Services or Personal Medical Services contractual arrangements.

Developments should be assessed against the criteria set by the PCT which should focus on local health need.

If the proposed service developments support the achievement of national or local targets and standards they are unlikely to need to be put out to tender.

Assessing proposals to develop primary care services
There are two levels of primary care provision against which proposals for service developments should be considered: services for a single practice population and services provided to a wider population.

Ensuring PCTs work together effectively

Co-ordinating commissioners
The DH’s aim is to avoid creating a system in which providers need to hold separate contracts with each PCT whose residents choose to be treated by them. A new model for contracting will be based on co-ordinating PCTs, which should reduce bureaucracy for PCTs without confusing governance and accountability. Most providers will have a single contract, agreed directly with one PCT – usually the geographical ‘host’ PCT. This PCT will act on behalf of all other commissioners whose patients choose to use the provider. The contract will specify care pathways and standards that represent the requirements of all interested commissioners. The co-ordinating PCT will also ensure that providers receive co-ordinated plans of activity to help plan their services, as well as acting as a focus for service redesign.

In some areas a number of PCTs may each be responsible for a significant proportion of a provider’s activity. In these circumstances the co-ordinating commissioner model will allow for SHAs to decide which PCTs should hold contracts with the provider. The requirements of all other commissioners will still be met through the co-ordinating PCT.

Shared commissioning business services
It is suggested that PCTs, or groups of PCTs working together, will want to consider how the private sector might be able to support them with functions such as data collection and analysis and elements of needs assessment such as risk stratification.

Specialised services commissioning
The risk to an individual PCT of having to fund expensive, unpredictable activity is reduced by PCTs grouping together to commission such services and share financial risk. The document sets out key commissioning requirements for specialised services; more detailed guidance will be issued in due course.

Themes for consultation
The DH is asking for responses to certain questions and proposals. These are shown on page 7.
Contracting for NHS care

Contracts will be the key accountability mechanism between commissioners and providers of NHS services. The DH proposes that contracts will work alongside the existing system-wide incentives of health reform, such as choice, payment by results and practice-based commissioning, to:

• specify the services to be provided
• ensure the delivery of national quality and performance standards
• drive improved quality and responsiveness of care
• secure a financial balance
• provide an agreed dispute resolution process.

The DH will introduce a national model contract, which all NHS commissioners and providers of services will be expected to adopt for services covered by payment by results. Commissioners may then include additional local content within their contracts.

The practice-based commissioning governance and accountability framework

These proposals aim to balance public accountability for the effective use of taxpayers’ funds with the freedom for clinicians to innovate to deliver improvements for patients. The aim is enhanced quality for patients, minimum bureaucracy for practices and proper accountability.

Proposals cover clinical and corporate governance, practice groups and the role of the primary executive committee (PEC).

Triggering community action

These proposals concern public petitions from members of the public in the area served by the PCT and/or users of the services commissioned by that PCT. The document sets out the principles that would apply to the design of public petitions. Petitions cannot be used to prolong debate on a proposed service reconfiguration following the outcome of a formal consultation exercise.

Confederation viewpoint

Health reform in England is one of a suite of framework documents expected from the DH over the next few months. The Confederation welcomes what appears to signal a more enabling approach to guidance, giving some local flexibility in its interpretation, although this will obviously become clearer as the other elements of the programme are published.

There are several positive areas:

• the definition of the commissioning cycle and of ‘effective commissioning’, which gives some clarity to a much used and misunderstood process
• the emphasis on the central role of shared working and relationship building with practices, the public and other stakeholders, such as NHS providers, local authorities, and the voluntary and independent sectors
• the clear definition of a series of tasks around commissioning and the lead responsibilities for each of these, clarifying in particular the relative roles of the SHA and PCT
• the positive response to the Carter Review recommendations for specialist commissioned services
• the further definition of governance and accountability arrangements for practice-based commissioning.

However, in our view there are also some points which require further development.

• It is regrettable that the framework covers mainly secondary care services. We look forward with interest to the promised document on joint commissioning as this will include those services where some of the issues covered are vital if transformational change is to be achieved.
• The document mentions the information needs of commissioners, but given the crucial role of information in delivering effective commissioning, further detail here would be welcomed.
• The extent to and methods by which the public and patients can be involved in the commissioning process require more clarity, particularly given recent legal challenges to the Section 11 duties of PCTs.
• The section in the framework on the future role and functions of the PEC leaves unclear the extent to which PCTs can change the constitution and responsibilities of
the PEC to reflect the new market and practice-based commissioning clusters present in most areas. We would like to see more work in defining the new role of the PEC in the commissioning of a fully-fledged provider market.

• The proposals for community petitions, which are part of the consultation, do not fully reflect the role of overview and scrutiny as the local democratic mechanism for accountability. Petition is already available as a mechanism to invoke scrutiny and it is unclear whether this has been effective for public accountability to date.

• The issues faced by some geographical areas, for example those with rural populations where the provider market may be more difficult to develop in a way that gives true choice, have not been addressed.

The potential strength of this document will become clear as the other parts of the system reform framework are developed. Overall, however, it is clear that the impact on the system will leave no part of it unchanged. The Confederation will continue to press for policy coherence and flexibility, to ensure that health and social care organisations can develop locally acceptable and cost-effective models of commissioning and provision which best suit their local populations’ needs.

Overall, the Confederation welcomes the framework approach but only if PCTs are allowed to retain the discretion to make it work, through greater flexibility and less central proscription of the detail of local arrangements.

Consultation questions

1. Contracting for NHS care
   Overall approach
   • Is the overall approach correct?
   • Are we seeking to include appropriate controls and incentives in contracts?
   • Is the proposed balance between contracts and other mechanisms (e.g. choice, regulation) appropriate?

National model contract
   • Will a national model contract be useful?
   • Is the three-level approach (standard mandatory requirements; mandatory requirements for local completion; content for local agreement) appropriate?

Content of the contract
   • Have we identified the right content?
   • Are there other issues we should address?
   • Is the balance of risk between commissioner and provider appropriate?
   • How do we ensure the contract is deliverable?
   • How should we best promote and enhance quality?
   • Would a national quality bonus be an effective approach to promoting quality?

Mechanisms
   • Do we need a dispute and arbitration scheme? If so, how should it work?

2. The practice-based commissioning governance and accountability framework
   • Will the proposals enhance quality for patients and ensure proper accountability for taxpayers’ money while providing freedoms for clinicians to innovate?

3. Triggering community action
   • Should petitions should cover only community and primary care services or the whole of PCT-commissioned activity, including acute services and specialised services?
   • Who can petition?
   • How can the voices of children and the excluded members of society be heard?
   • Regarding the threshold number of signatories to require a formal response from the PCT: what level of threshold should induce a review? For example, a response from 1 per cent of the public served by a PCT or 10 per cent of the users of a service?
   • What should the process be for PCTs to respond to petitions?
   • Which measures should be used to ensure a fair and robust process in all cases, but especially when the service to be reviewed is provided by the PCT and independence needs to be demonstrated?
   • What are the rights of challenge to the PCT’s decision?
   • Who will arbitrate if the response of the PCT is challenged?
Next steps

The DH has asked that comments on the issues raised in the document, and responses to the specific consultation questions, should be sent to nhs.reform.gsi.gov.uk by 6 October 2006.

Please also feed your views through to Jo Webber at jo.webber@nhsconfed.org, who can also update you about the NHS Confederation’s policy work in this area.

Healthways

Healthways’ long-term condition (LTC) management programmes currently support over 2.6 million LTC patients and are improving patients’ lives and reducing total healthcare costs.

Healthways’ proven approach integrates telephone-based services with self-care support to address the needs of LTC patients at all levels of the care triangle, and closely links these services with GP care and other primary care and social services.

For more information, please contact enquiries@healthways.com

Further information

Health reform in England: update and commissioning framework
www.dh.gov.uk

The NHS Confederation

The NHS Confederation brings together the organisations that make up the modern NHS across the UK. We help our members deliver better health and healthcare by:

• influencing policy and the wider public debate on the full range of health and health services issues
• supporting health leaders through information sharing and networking
• working for employers to improve the working lives of staff and, through them, to provide better care for patients.

Our work is driven by members, so member involvement underpins all our work.

Confederation Briefings

NHS Confederation Briefings are summaries of government policy development, with a viewpoint from the perspective of NHS management.