

Commissioning support

February 2012

NHS REFORM

Introduction

For the benefits of clinician-led commissioning to be realised, clinicians will need the freedom to decide how to fulfil their commissioning responsibilities and what support they will need to do so. In November, the Government published a first draft of their proposals for commissioning support ('Developing Commissioning Support: Towards Service Excellence'). The BMA General Practitioners Committee (GPC) raised serious concerns that the Government's proposals for commissioning support threatened to restrict this freedom by making it difficult for Clinical Commissioning Groups (CCGs) to host or share their own commissioning support.

A further draft was published at the end of January. The changes made to the document to a certain extent addressed some of the GPC's concerns (Appendix A details the changes to the later draft) however some very serious issues remain.

This document:

- Summarises the Government's plans in more detail;
- Outlines the GPC's concerns;
- Discusses principles underlying good commissioning support;
- Suggests models for CCGs who wish to host or share NHS commissioning support.

What is commissioning support?

The Health and Social Care Bill aims to put clinicians at the heart of the commissioning process through the establishment of CCGs. However, GPs and other clinicians involved in CCGs will need support to commission effectively. Commissioning support encompasses a range of functions, from transactional services such as payroll and IT services, to equipping CCGs with the complex population level data required to inform commissioning decisions.

The Government's plans

Many Primary Care Trust (PCT) clusters are developing commissioning support services (CSSs) for their local CCGs. The NHS Commissioning Board will host these services until 2016, although from as early as 2013 (when PCTs cease to exist) these support services will be encouraged to form social enterprises or to partner with other organisations, including the private sector.

Once they become legal entities, CCGs will either provide their own commissioning support through directly employing staff, use the PCT cluster offering, or may tender for their commissioning support services from a range of providers, including social enterprise, third sector bodies and private enterprises. The procurement processes will be governed by criteria to ascertain the competence and commercial viability of potential CSSs.

The GPC's view

GPC believes that the Government's proposals for commissioning support have potential to undermine the purported aims of the Health and Social Care Bill of empowering clinician commissioners and reducing bureaucracy. Implementing a market in commissioning support during a period of major structural overhaul and financial pressure will be a complicated process, something the Government itself has acknowledged. These proposals have potential to erode a public health and public sector ethos which the GPC believes should underpin NHS commissioning.

- The GPC has received reports of emerging CCGs being pressured to make decisions about commissioning support within unrealistic timescales in order to achieve authorisation, raising concerns about the future of the CCG if they do not comply. Rushed and ill-considered decisions about the structure and development of support services will be difficult and costly to reverse in the future.
- We are concerned that CCGs are being compelled to enter into protracted procurement processes *prior* to their establishment as statutory bodies and before they have a firm grasp of their commissioning responsibilities. CCGs should be free to choose which services are provided in-house, shared between CCGs, delivered by clusters or by external providers.



- The Government's proposals emphasise the advantages of seeking commissioning support from external providers, without acknowledging the benefits that NHS commissioning support would offer – for instance continuity of skills and expertise through-out the transition period.
- There is potential for an imbalance of power between the CCGs (locally responsive and accountable) and large commercial support providers thus undermining locally-focussed and genuinely clinician-led commissioning. Whilst some services benefit from delivery at scale, experience of large-scale, outsourced shared services by private providers has been very poor. Problems include a lack of awareness of local policy and procedure resulting in serious issues with list cleansing exercises, delays in payments and concerns about the security of patient data to provide a few examples.

The principles of good commissioning support

Clinically-led commissioning has the potential to benefit patients and the NHS. Skilled commissioning support services will be necessary to ensure that CCGs are genuinely able to lead the commissioning agenda and form strong relationships with the bodies to which they are accountable (for example, the NHS Commissioning Board) and those they will negotiate with (for example, large acute trusts).

'Developing commissioning support: Towards service excellence' discusses in depth the advantage of procuring commissioning support from external organisations. However, less emphasis is given to the benefits of CCG-hosted support models. The GPC believes that CCG-hosted, NHS commissioning support would:

- Empower CCGs to be intelligent commissioners, not just intelligent customers;
- Retain and develop existing skills and expertise;
- Provide a patient (not profit) focussed approach, remaining accountable to a local population;
- Support clinician-led commissioning from within the NHS, with managers and staff accountable to the clinically-led CCG;
- Allow CCGs to procure specialist or niche support services from alternative providers where necessary, but not as the norm;
- Enable co-operative working across services and geographies to provide economies of scale where necessary.

Commissioning support in the new structures

CCGs have a range of options available in terms of whether they host, share or contract out their commissioning support services. The GPC believes that a CCG-hosted or shared model of commissioning support (with external support procured where necessary) would best empower clinicians leading the commissioning process and would minimise the need for costly procurement and contract management.

Possible models

1. CCGs in an area could form an overarching statutory governance and administrative structure, but retain strong devolved local groupings. This would enable CCGs to be sufficiently large to develop their own commissioning support services providing support to each local grouping and remaining locally responsive and accountable.
2. Smaller CCGs could group together to establish and share NHS commissioning support services. This model would require consideration of how HR, legal obligations and financial risks are shared between organisations.
3. One CCG in an area could establish a commissioning support service and contract this out to other CCGs. How the host CCG can avoid becoming the dominant partner would need to be fully considered.
4. CCGs in an area could partner with the Local Authority to share public sector commissioning support services.


To retain expertise currently in the system and avoid costly procurement processes, CCGs should work co-operatively with PCT clusters to identify likely support requirements (acknowledging that these needs will change through the transition period), with a view to the PCT cluster becoming subsumed within the CCG structures once the PCT cluster ceases to be a statutory body.

Cambridgeshire and Peterborough PCT cluster

Cambridgeshire and Peterborough PCT cluster is not setting up a freestanding CSO, but is working co-operatively with the CCG. The emerging CCG covers a population of population of 856,000. The CCG will be able to take advantage of its larger size and accompanying economies of scale. In-house support will be able to be provided through the running cost allowance. Its locality commissioning groups will then be supported with devolved budgets.

What to do now?

- CCGs must not be coerced into prematurely signing up to any configuration or commitment to external support. Authorisation of CCGs begins this year, with a view for the majority of CCGs to be authorised by April 2013. However, this is not a deadline and CCGs should resist pressure to agree to ill-considered structures.
- Commissioning support arrangements must be developed with the full involvement and support of local practices, GPs and LMCs. CCGs and Local Medical Committee (LMCs) are asked to inform the GPC secretariat (by emailing info.commissioning@bma.org.uk) of any instances where shadow CCGs are being put under pressure to make decisions about commissioning support either before they are ready, or before GPs and practices have been informed and involved, as required under the proposed legislation.



If you have any questions or concerns about how the new commissioning structures are developing in your area, please email the GPC at:

info.commissioning@bma.org.uk

APPENDIX A

'Developing Commissioning Support: Towards Service Excellence'

Key changes with respect to BMA concerns

Overview

- Addition to state: 'It is critical that we do retain the skills which have been developed within both the NHS and other sectors' (p. 3).
- Addition to state (in italics): 'At present, commissioning is undertaken predominately by NHS staff working in PCT clusters *from where we expect the majority of this support to be sourced*' (page 3).
- Addition to mention of the possibility of CCGs hosting their own support in-house (page 4);
- Addition to state that the NHSCB should ensure that support services have 'sufficient input and buy in from local CCGs' (page 4).
- A new paragraph about joint working with local authorities (page 5).

Chapter 2: Developing the evidence

- Reduction in estimated running costs from '£25-35 a head' to '£25 a head' (page 15).
- Refers to commissioning support organisations as 'customer focussed and responsive' entities, not 'customer focussed and commercially adept entities' (page 21).
- Additional mention of working with local authorities (page 22).

Chapter 3: The strategic direction for commissioning support

- In the introduction, a removal on the emphasis to ensure CCGs are ready 'as soon as possible' to procure commissioning support services (page 24).
- Additional paragraphs stressing that local authorities will have a key role to play both as partners in health commissioning and in providers of commissioning support (page 26).
- 'Developing the NHS Commissioning Support offer' (page 26) reworded:
 - Addition to emphasise 'giving NHS staff enough time to develop the best and most efficient commissioning support models'
 - Additions to state: 'The NHSCB will work with pathfinder CCGs to ensure that services are developed in line with their needs and requirements, including supporting choice of NHS commissioning support supplier in supporting CCGs through authorisation. CCGs will be able to choose their local NHS commissioning support ahead of April 2013. SHAs will work with CCGs on a case by case basis to ensure that decisions are made carefully and sensitively and that HR and other operational implications can be worked through and handled appropriately' (page 28).
 - 'CCGs may also wish to host their own commissioning support and/or share it with other groups through collaborative arrangements. Where CCGs choose to operate in this way these services will be tested through authorisation process to assure both the NHS CB and CCGs that these embedded or shared commissioning support arrangements do not pose financial or operational risks for CCGs or the NHSCB.' (page 29).
- In section 'Managing Risk' (page 29): Amended wording to say that CCG hosted commissioning support will be assessed by the same 'or similar' criteria to other commissioning support organisations (page 30).

Chapter five: What happens next?

- Addition to state that NHS commissioning support services should focus on supporting CCGs through authorisation (page 44).
- Change from stating that commissioning support should have 'commercial awareness' to customer focus' (page 44).
- Addition to state that SHAs should inform the BDU where CCGs wish to host their own support or secure provision from an NHS commissioning support services or 'any non-NHS products and services' so that 'alternative strategies can be put in place' (page 44).
- Additions to state that PCT clusters should:
 - 'Work with CCGs to agree their do/buy/share options and ensure that emerging commissioning support offers truly meet CCGs' needs before the end of January';
 - 'Ensure that emerging CCGs have the necessary commissioning support services to support them through authorisation and consider where CCGs may want or need access to additional support beyond the scope of the existing NHS offer';
 - 'Co-ordinate the development of commissioning support with Local Authorities to ensure that any arrangements strengthen existing joint commissioning processes' (Page 45).
- Addition to state that CCGs should:
- 'Prepare to put in place SLA arrangements with their choice of NHS CSS by the end of March 2012';
- Flag any intentions to host commissioning support to SHA clusters as soon as possible, with a view that these will go through similar assurance tests as part of the commissioning support business review or CCG authorisation' (Page 46).