



Faculty of Public Health

of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

FPH response to *Liberating the NHS: Commissioning for Patients*

The UK Faculty of Public Health (FPH) is the standard setting body and the leading professional body for public health specialists in the UK. It aims to advance the health of the population through three key areas of work: health promotion, health protection and healthcare improvement. In addition to maintaining professional and educational standards for specialists in public health, FPH advocates on key public health issues and provides practical information and guidance for public health professionals.

FPH welcomes the opportunity to respond to this consultation, and to recommend collaboration between GP consortia, commissioners and public health experts that will not only ensure better commissioning for patients, but also improve the health of the wider population.

1. In what practical ways can the NHS Commissioning Board most effectively engage GP consortia in influencing the commissioning of national and regional specialised services and the commissioning of maternity services?

Specialist commissioning should be integrated with the work of GP consortia by the establishment of national subgroups for the relevant specialities of the NHS Commissioning Board. The relevant National Clinical Directors should sit on these groups, and the groups should provide guidance for consortia. GP consortia should have leads for specialised commissioning who link up with the relevant clinical subgroups. These leads would meet regionally/subnationally and would engage with secondary care colleagues and public health specialists. Specialist public health and commissioning advice would also be essential to ensure that specialised commissioning is responsive to local need, is prioritised appropriately and takes into account the primary prevention aspects of the clinical conditions for which it is responsible; and to ensure that commissioning plans integrate prevention, primary and secondary healthcare and social care. Resource allocation decisions should be scrutinised to ensure that they are consistent with priorities for health and wellbeing. Specialist public health advice will ensure that only cost and clinically effective interventions are commissioned and that appropriate account is taken of overall population health.

Q2. How can the NHS Commissioning Board and GP consortia best work together to ensure effective commissioning of low volume services?

This can be achieved by using specialised service arrangements and extending them to cover other low volume services or by asking GP consortia to work collaboratively across a large population to commission low volume services. Access to specialist public health and commissioning advice will also be necessary.

Q3. Are there any services currently commissioned as regional specialised services that could potentially be commissioned in the future by GP consortia?

No. Devolving commissioning of these services to smaller commissioning units runs the risk of duplication of effort, inconsistency, an increase in financial risk, creeping developments of highly expensive but marginally effective treatments and a possible increase in inequalities.

Q4. How can other primary care contractors most effectively be involved in commissioning services to which they refer patients, e.g. the role of primary care dentists in commissioning hospital and specialist dental services and the role of primary ophthalmic providers in commissioning hospital eye services?

Note: We have included Community Pharmacy in this question

Primary Care Dentistry

GP consortia should continue to use dental practice advisors who are General Dental Practitioners, to work with them, in consultation with the Local Dental Committee. In addition, to avoid conflict of interest and to ensure the breadth of expertise needed, dental public health advice (provided by dentists who have trained in public health) will be needed along with dental commissioning staff. This will ensure needs based value for money commissioning that takes account of the needs of vulnerable and deprived populations for hospital and special care dental services.

Lead GP consortia arrangements may be needed.

Primary Ophthalmic Providers

In our view ophthalmic providers are currently underutilised in the commissioning of eye services. Ophthalmic practice advisors or similar should be developed and work with the local ophthalmic committee to inform commissioning. In addition, to avoid conflict of interest and to ensure the breadth of expertise needed, public health advice will be needed along with commissioning advice. This will ensure needs based, value for money commissioning that takes account of vulnerable and deprived populations need for hospital services.

Lead GP consortia arrangements may be needed.

Community Pharmacy

Community pharmacists have a role utilising their knowledge and skills in pharmacology, their understanding of the pharmaceutical industry and their desire to take on an increased clinical role. Most community pharmacists derive their income from a prescription written by a general practitioner. It is important that the general practitioner has the most up to date knowledge about the drugs and the cost of these drugs that s/he is prescribing and pharmacists are well-placed to offer advice. Pharmacists taking on clinical or health improvement services need to work closely with general practice to obtain the required clinical support and develop the skills and experience required for the provision of services e.g. responsibility for hypertension review clinics.

A patient should have their prescription dispensed as close as possible to the source of the prescription. However, there should be a complete separation of prescribing and dispensing so that there is no conflict of interest. The above proposals help to ensure that these functions are kept close but separate.

For these arrangements to work effectively and equitably across the population, pharmacy advice to consortia is essential.

Q5. How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?

The Commissioning Board and the National Institute for Health and Clinical Excellence (NICE) must set quality standards for primary care

The Consortia should monitor practice performance. Potential conflicts of interest should be addressed by stipulating that GP Consortia must establish a robust and transparent system with HealthWatch representatives and public health support to ensure a well informed and impartial understanding of quality in primary care and effective action to drive up quality. It is particularly important that consortia are given a duty to reduce inequalities in access to high quality primary care and to achieve a reduction in the inequalities of outcomes from primary care. There should be a statutory duty for GP Consortia to report to the Health and Wellbeing Board on the quality of primary care, action to improve quality and action to reduce inequalities in outcomes from primary care. This must include information on quality of health improvement and prevention services provided in primary care.

The funding of each practice should be equitable and based on a weighted funding formula so that there can be no reasonable justification why every practice should not provide high quality care and equitable outcomes.

Q6. 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?

The Commissioning board, advised by NICE, must set standards for primary care access and quality. GP Consortia should have a statutory duty to report to the Health and Wellbeing Board (the NHS Commissioning Board is a member of the Health and Wellbeing Board) on quality of primary care and action to improve inequalities in access to and outcomes from primary care. This must include information on the quality of health improvement and prevention services provided by primary care. Effective engagement of HealthWatch in the process must also be demonstrated. Public health involvement will be needed to ensure that there is effective and impartial work to drive up quality.

Q7. What safeguards are likely to be most effective in ensuring transparency and fairness in commissioning services from primary care and in promoting patient choice?

The GP Consortia should have a duty to cooperate in production of the Joint Strategic Needs Assessment and should commission services that are consistent with the health strategy and priorities laid out by the local Health and Wellbeing Board. Commissioning plans, including those for primary care should be signed off by the Health and Wellbeing Board and must demonstrate HealthWatch engagement, and that the needs of vulnerable and disadvantaged groups have been taken into account. Commissioning plans must also demonstrate that they support patient choice.

Q8. 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?

Consortia with large populations will be more able to afford the management and public health infrastructure needed to understand local needs and to provide the support GP commissioners will need to effectively use the quality standards frameworks, tariffs and commissioning networks. Small GP consortia will not have the management capacity to do this and scarce GP commissioner time will be spent inefficiently getting to grips with the

commissioning tools. Their time and expertise should be used to make real changes to benefit patients.

GP consortia will also need access to their own public health advice to assist GP commissioners in understanding the quality standards and evaluating how well services meet these standards. Public health will also identify where inequalities in quality of services exists and assist GP commissioners to tackle these unacceptable variations.

We believe the local Health and Wellbeing Board should have a central role in joining up and informing local commissioning. The NHS Commissioning Board, as a member of the Health and Wellbeing Board will also be able to ensure that GP Consortia are using the necessary tools to support their commissioning.

Q9. Are there other activities that could be undertaken by the NHS Commissioning Board to support efficient and effective local commissioning?

Local Health and Wellbeing Boards should have the responsibility for laying out health, health service and health improvement priorities and strategy locally. The NHS Commissioning Board will need to set national standards and outcome frameworks for the NHS and, through the Health and Wellbeing Board, ensure that these are delivered.

The NHS Commissioning Board should support GP Consortia to collaborate together where it makes more sense to work across a larger population or to make best use of time and resources. The NHS Commissioning Board should offer a development programme to GP commissioners.

The NHS Commissioning Board will need its own public health specialist advice if it is to ensure that GP consortia are commissioning evidence based, clinical and cost effective services that join up with social care and support health improvement. This specialist advice will also be crucial in ensuring that the NHS Commissioning Board is able to assess and support GP consortia to reduce inequalities through their commissioning and quality assurance work.

Q10. What features should be considered essential for the governance of GP consortia?

GP consortia will be responsible for the large majority of NHS services and for NHS resources. There is a potential for conflict of interest as GPs will be both provider and commissioner of services. GP consortia governance arrangements must be transparent and robust and need to include:

- A Board or similar structure that adheres to existing best practice standards
- A risk management and assurance process
- HealthWatch involvement
- Regular reporting to the NHS Commissioning Board
- An annual report for the public that is first considered by the Health and Wellbeing Board
- The annual report must include sections on governance, remuneration and finances. The report must also include sections on delivering priorities agreed with the Health and Wellbeing Board, health improvement and emergency planning and protection of population health. The report must also demonstrate that the needs of vulnerable and disadvantaged groups have been considered and report on progress in reducing inequalities in outcomes. It is particularly important, given potential conflict of interest, that a section on quality of primary care is included.

Q11. How far should GP consortia have flexibility to include some practices that are not part of a geographically discrete area?

They should have very limited flexibility and, ideally, none. In order to work effectively with Health and Wellbeing Boards and ensure a joined up approach to service commissioning, child protection, emergency responses etc, it would be impractical to have geographically separated practices, especially if they served populations in another local authority with another Health and Wellbeing Board. Similarly, in terms of information collection, assessment and quality assurance, it would prove impractical.

GP consortia may include practices that are based or work across local government boundaries, but GP consortia with these configurations will need to work with more than one Health and Wellbeing Board, Children's Trust, Public Health Service and local NHS Commissioning board.

There also need to be clear arrangements in place to cover those patients who are not registered with a GP practice, who are often the most vulnerable e.g. the homeless or travellers.

Q12. Should there be a minimum and/or maximum population size for GP consortia?

Yes. Larger GP consortia are preferable. This is because GP Consortia have major responsibilities and will need a management infrastructure that is able to effectively serve GP commissioners so that they can make best use of their time in commissioning services effectively. Smaller consortia will not have the range of skills and capacity needed and will also result in fragmented partnership working that may fail patients and public. Smaller consortia are less likely to effectively engage in child protection, emergency responses, and crucial partnership work to ensure joined up services with social care.

Q13. How can GP consortia best be supported in developing their own capacity and capability in commissioning?

There are many capable NHS managers and public health staff who should be transferred to GP consortia to support GP commissioners in their commissioning role. This will ensure that scarce and costly GP time is used most effectively to make the changes in services that will make a difference.

Very few GPs have experience in commissioning services at a population level. It is suggested that existing PCT commissioning and public health staff should be employed by GP consortia to provide information, analysis and support to complement the skills and experience of GP commissioners. GP commissioners will then be able to focus their efforts where changes are needed. NHS managers and public health staff will also be able to use the commissioning tools and mechanisms on behalf of GP commissioners to transact these commissioning decisions. These staff will also provide support to GP commissioners in their work with the Health and Wellbeing Board, the NHS Commissioning Board and with the Public Health Service to ensure that safe, joined up services are commissioned and statutory duties and emergency responses effectively delivered.

Training should be provided to GP commissioners. We are aware of one such training initiative, in Derbyshire, which has been very well received by local GPs. Similar models need to be rolled out as a matter of urgency around the country. FPH would be happy to assist.

Q14. What support will GP consortia need to access and evaluate external providers of commissioning support?

GP consortia will need sufficient management and public health infrastructure of their own to be able to make sure they contract the right commissioning support from external providers and get value for money.

External commissioning support can be good value, usually when it offers expertise in specialist areas. However, for their core responsibilities, GP consortia should use their own staff, which is the most usual model in private industry.

A standard national policy should be developed for working with external providers to ensure that there is transparency and competition and to ensure that any conflict of interest is appropriately recognised.

Q15. Are these the right criteria for an effective system of financial risk management? What support will GP consortia need to help them manage risk?

Insurance risk – there is significant risk within programme areas (such as cancer drugs or complex packages of care). However, overall the insurance risk to GP consortia with a total population over 150,000 is really quite small. This is because adverse movements in one programme of care will tend to be balanced by favourable movement in another. Insurance risks should not be overestimated as this will lead to excessive risk pools and GP consortia labelling ‘service risk’ as ‘insurance risk’ and failing to take responsibility for effectively acting to improve the cost-effectiveness of care, drive up efficiency and drive down poor and wasteful practice (e.g. poor prescribing and referral behaviour from its constituent practices).

Service risks are those which will arise from GP consortia failing to be effective commissioners and failing to drive up quality.

In order to manage risk and incentivise good financial management GP consortia will need to:

- Work effectively with the local Health and Wellbeing Board to prioritise spending and ensure plans are within budget
- Have their own expert management and public health capacity so that they can analyse risk and make well informed decision on the commissioning of clinically effective and cost-effective care
- Have their own expert management and public health capacity so that they can undertake objective analysis of GP practice performance and effectively target poor clinical quality (which is usually also wasteful) and drive up quality and efficiency
- Maintain structures such as Area Prescribing Committees, Individual Funding request Panels and commissioning policy processes on thresholds and eligibility criteria by working collaboratively.
- Any risk pool should be small and governed by clear rules on what constitutes an ‘insurance risk’
- Funding to each GP practice should be calculated using a weighted capitation formula, so there can be no reasonable reason why any practice in a GP Consortium is offering poor quality, inequitable, inefficient or wasteful care.

Q16. What safeguards are likely to be most effective in demonstrating transparency and fairness in investment decisions and in promoting choice and competition?

Commissioning decisions must be consistent with the overall priorities for population health, health services, health improvement and inequalities laid out by local Health and Wellbeing Boards working in partnership with the GP consortia and the NHS Commissioning Board. GP consortia commissioning plans must be signed off by the Health and Wellbeing Board. HealthWatch should be involved and engaged in GP consortia commissioning decisions.

Joint commissioning with the Local Authority in key areas of common interest (e.g. children's services, services for vulnerable groups and the elderly) will help to ensure that there is fairness in investment decisions.

Local Authority scrutiny should also ensure that decisions are transparent and fair.

The NHS Commissioning Board, through the local Health and Wellbeing Board should ensure that decisions promote choice and competition, take account of inequalities and meet national standards.

Q18. What are the key elements that you would expect to see reflected in a commissioning outcomes framework?

GP practices should be incentivised and rewarded, on addressing outcomes of the care they provide, and for achieving equitable outcomes.

Deep rooted inequalities are socially driven and the responsibility for overall inequalities in outcomes (such as mortality) must be a responsibility of the Health and Wellbeing Board and GP Consortia. The Commissioning Board should consult on appropriate health inequality indicators.

The commissioning outcomes framework should include NHS elements of prevention and lifestyle improvement. For example, vaccination and immunisation, stop smoking outcomes and management of illness related to incapacity and worklessness.

The five domains as listed in the proposed NHS outcomes framework are appropriate but too limited in scope. As detailed in our response to the separate consultation, there should be a further sixth domain on prevention of ill health. This objective should be integrated in any commissioning outcomes framework.

There is also a need to include measures of cost effectiveness and affordability in the framework. An example would be to include prescribing indicators.

Q19. Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?

Yes.

Q20. What arrangements will best ensure that GP consortia operate in ways that are consistent with promoting equality and reducing avoidable inequalities in health?

Consortia should have a statutory obligation through the local Health and Wellbeing Board to ensure NHS outcomes contribute to population health outcomes and reduction of inequalities. Equitable access to high quality primary care and prevention services will make a significant impact. The contributions that GP practices and local community services make to ensuring that children have a healthy start to life and identifying people with, or at risk of,

chronic disease (such as diabetes, heart disease and respiratory disease) and then systematically monitoring these patients and providing high quality evidence based interventions, including lifestyle interventions, save many lives and prevent much disability and ill-health. If there is equitable provision then inequalities are reduced.

Smoking remains the single biggest cause of early death and mortality inequalities in the UK. Therefore GP consortia must ensure that smoking prevalence is recorded in general practice and that practices act to systematically offer support to help patients quit and drive down the prevalence of smoking within their practice boundary.

Ensuring equity across populations requires a population perspective at every level. Without that, health inequalities will grow. Consortia should have access to public health advice which in turn, will be linked to the national Public Health Service. The role of Directors of Public Health (DsPH) will be also be crucial. The Director of Public Health should be required to report at least annually, in public, on the health needs of the local population and the extent to which these are being met. This report should include explicit consideration of local inequalities in health, the success of current efforts to address them, and the action needed by GP consortia, those from whom they commission and other local organisations. This will be invaluable to GP commissioners in identifying local issues and how best services can be developed to address them.

Q21. How can GP consortia and the NHS Commissioning Board best involve patients in making commissioning decisions that are built on patient insight?

We expect all commissioning proposals to be informed by HealthWatch and signed off by the Health and Wellbeing Board with its local democratic legitimacy.

Q22. How can GP consortia best work alongside community partners (including seldom heard groups) to ensure that commissioning decisions are equitable, and reflect public voice and local priorities?

The Health and Wellbeing Board should lay out the overall strategy for health, health service and health improvement and the priorities locally. The Joint Strategic Needs Assessment will be at the core of making sure this strategy is well informed. HealthWatch will have a key role in the Health and Wellbeing Board and should have a duty to ensure that it engages with 'seldom heard' groups and reflects their need and views.

Both tier1 and tier 2 local authorities have well established public consultative process, which should be used and will complement the work of HealthWatch.

Q23. How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patient Participation Groups?

Local Authorities have considerable experience of partnership working. Consortia will require public health and management expertise to ensure effective engagement and that they have the right skills to work effectively in partnership.

Q24. What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients and, where appropriate, staff?

It will be essential that the Health and Wellbeing Board takes an overall strategic lead and is made responsible and accountable for ensuring that inequalities are recognised, effective action is taken and that outcomes are improved. The NHS Commissioning Board will also

have a key role in ensuring GP Consortia are reducing inequalities and achieving equitable outcomes from health services.

There is a significant risk that expert staff who are currently working in commissioning – particularly those in PCTs and SHAs – will feel that the current proposals imply that their skill and expertise is not valued and may not be required in the future. This will be exacerbated by a long period of uncertainty with regard to the new system and their personal future. In the meantime, the effort needed to put in place the new arrangements, coupled with personal anxiety, will at best distract them from the work that is needed today - and every day - to improve the health of the population and important momentum will be lost; at worst, staff will leave and/or existing networks and services will be disrupted or even destroyed. Early piloting and scenario testing would help to maintain staff confidence, as would rapid clarity about their personal futures.

Q25. How can GP practices begin to make stronger links with local authorities and identify how best to prepare to work together on the issues identified above?

The Health and Wellbeing Board will be at the heart of achieving this. The Health and Wellbeing Board should be statutory and require that GP Consortia, the NHS Commissioning Board and tier 2 local authorities are represented.

The Board will need to devolve responsibilities to local communities as appropriate and GP Consortia should also engage at this level.

The Director of Public Health will also be a key player. The DPH should be a senior director of the Local Authority, accountable directly to the Chief Executive and able to influence colleagues across the local authority and NHS to ensure integrated working.

In the current preparatory phase, the local DPH, who will normally have a joint appointment with the local authority, should engage actively with GPs and LA colleagues to support and enable the development of relationships and understanding.

Q26. Where can we learn from current best practice in relation to joint working and partnership, for instance in relation to Care Trusts, Children's Trusts and pooled budgets? What aspects of current practice will need to be preserved in the transition to the new arrangements?

Local Authorities have considerable experience of partnership working. Consortia will require public health and management expertise to ensure effective engagement and that they have the right skills to work effectively in partnership.

Q27. How can multi-professional involvement in commissioning most effectively be promoted and sustained?

By giving GP consortia the freedom and the resources to employ the public health and management staff they need, and to engage a range of clinicians and other specialists from primary and secondary care; by requiring the DPH to provide oversight and support; by offering training now for clinicians and specialists who wish to be involved; by providing clarity as soon as possible about future opportunities for those currently involved in multi-professional commissioning; and by populating the outcomes frameworks appropriately.

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