Changing NHS Commissioning System

Purpose

To outline some of the changes taking place in terms of the NHS Commissioning system and structure. It is the first overview briefing for the Healthwatch network on the changing commissioning landscape.

Action Required

For information only

Enquiries

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Overview

The NHS commissioning system is undergoing change driven by national leadership, efforts to address weaknesses and financial constraints.

NHS England is passing on significant parts of its responsibilities to CCGs, and will allow well performing CCGs more autonomy.

NHS England is also taking a different approach to specialised health services and to struggling CCGs and local health economies.
Key timings

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Changes taking place in 2014 and 2015

A number of significant changes are taking place in the commissioning system. The main drivers of change to the commissioning system are:

- The reformed commissioning system has been in place since April 2013. After less than one year in operation there are concerns about some of its shortcomings (e.g. limitations of NHS England commissioning primary care services) and the need to make adjustments.
- Simon Stevens has been appointed as Chief Executive of NHS England in April 2014 and his approach differs from those of predecessor Sir David Nicholson
- The Health Secretary has changed since September 2012.
- There will be substantial reductions in the government-set running cost allowance of the commissioning system in 2015-16.
Legislative Reform Order

The Legislative Reform (CCG) Order 2014 (came into effect 1st October 2014) enables:

1) Two or more CCGs to form joint committees to exercise their functions jointly.

2) One or more CCGs and NHS England to form joint committees so that the CCG(s) and NHS England can exercise functions jointly.

Healthwatch England has written to the Secretary of State using our statutory powers to highlight concerns raised by local Healthwatch regarding the impact of the Legislative Reform Order. The concerns relate to reduced local accountability arrangements around joint commissioning (see Healthwatch England Letter to Secretary of State and also Revised Legislative Reform Order briefing for local Healthwatch for further details).

NHS England Structure and Priority Changes

The changes to operational commissioning are to NHS England’s regional and area teams and to specialised commissioning:

- Area teams will be reduced from 27 to 15, with all area teams working more closely with their regional teams (North, South, Midlands and East, and London).
- Changes to area teams will be in place by April 2015 but in practice staff are likely to be working to proposals earlier in the year.
- There will be reductions in regional and areas staff, particularly in senior managers in these teams and they will cover a larger geographical area.
- Simon Stevens wants to empower strong CCGs and give them more responsibilities (see co-commissioning and assurance below and devolving specialised commissioning services).
- A new national team will be created with nearly 40 staff but they will be doing a lot less on specialised commissioning.

Co-Commissioning of primary care and specialised services

Following Simon Stevens’ appointment, NHS England announced it wanted to give CCGs substantially more involvement in commissioning services that the national body had previously been directly responsible for.
Primary care

NHS England is expected to delegate extensive responsibility for the commissioning of core general practice and the corresponding budgets to many CCGs for 2015-16. Some concerns have been highlighted including: the potential conflict of interest for GPs involved in CCGs; the new CCGs’ ability and capacity for the role; and additional running costs and budgets.

As a result of these concerns, some CCGs have said that they do not want formally delegated responsibility, but that they are prepared to share responsibility through joint committees with NHS England or to be less formally involved in tasks and decision making (see Revised Legislative Reform Order briefing for local Healthwatch).

There are three primary care co-commissioning models that CCGs can take forward:

- Greater involvement in primary care decision making - an invitation to CCGs to collaborate more closely with their area teams to ensure that decisions taken about healthcare services are strategically aligned across the local health economy.

- Joint commissioning arrangements - A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or “committees in common”.

- Delegate commissioning arrangements - Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services.

During summer 2014, more than 190 of the total 211 CCGs expressed an interest in some form of primary care co-commissioning. CCGs have been asked to resubmit, in January 2015, details of primary care responsibilities they would like to take on. Approval decisions will be made by NHS England during February-March 2015 for implementation in April 2015.

Arrangements under primary care co-commissioning are likely to include more cross-CCG arrangements in which groups from the same region would share responsibility, more decisions would be made by senior CCG figures who are not GPs (e.g. senior managers, lay members, nurses or other professional members) and there would be greater involvement of the NHS England area team and other local authorities/Health and Wellbeing Boards.

It is for CCGs to agree the full membership of their primary care commissioning committee. CCGs will be required to ensure that it is chaired by a lay member and have a lay and executive majority.
A standing invite is required for representatives from Healthwatch and the Health and Wellbeing Board to attend meetings of joint committees1 and delegated commissioning committees. In other words, local Healthwatch would not be mandated to attend but invited to attend as an observer (see Next Steps on Primary Care Co-Commissioning).

Specialised services

Overview

Specialised commissioning2 is currently commissioned nationally and is being reviewed to include co-commissioning and other (delegated) arrangements. Whilst the specialised commissioning taskforce still exists, another set of groups has been set up including the communication and stakeholder engagement subgroup. All specialised commissioning is assured on behalf of patients and the public through the Specialised Commissioning Patient and Public Voice Assurance Group (PPVAG), established in June 2014 and chaired by Jason Stamp. Healthwatch England has a direct relationship and an open observational seat on the group.


The first four services that we know of that will be devolved to CCGs are renal services, bariatric surgery, specialised wheelchair services, outpatient neurology. A public consultation on two of the services being delegated to CCGs (renal services and surgery for morbid obesity) is currently taking place and will close at 9 January 2015 (see A Consultation on Arrangements for the transfer of Commissioning Responsibility from NHS England to CCGs).

1 A joint committee is a single committee to which multiple bodies (e.g. NHS England and one or more CCGs) delegate decision-making on particular matters

2 Specialised services are those services which are provided from relatively few specialist centres. Conditions treated range from long-term conditions, such as renal (kidney services), mental health care in secure settings and neonatal services, to rarer conditions such as uncommon cancers, burn care, medical genetics, specialised services for children and cardiac surgery.
For those services being devolved to CCGs, accountability is with CCGs and there is concern that this will lead to postcode lottery as there is no requirement for CCGs to commission these services if they do not see them as a priority.

**CRGs**

In April 2013, Clinical Reference Groups (CRGs) were established by NHS England for specialised commissioning to give clinical advice to the Board. At the same time patient and carer members were recruited to be part of the CRG membership, bringing a patient and carer perspective to the work of the groups. Patient and carer members were recruited to bring patient and carer insight, valued expertise and knowledge through experience and some useful challenge. CRGs have been operating over 18 months and focused on delivering on policy and service specification as well as other areas of work.

A recent NHS England survey (not yet published) has highlighted some concerns from patient and public members about their CRG. These concerns include: patient voice is often lost in the meeting; meetings short notice with poor admin; range of issues associated with telecom meetings and face to face and clarity needed on scope of CRGs.

**Prioritisation framework**

The prioritisation framework sets out NHS England’s legal duties and the principles that it has chosen to follow in order to demonstrate that it is making appropriate decisions on specialised commissioning policies put to it by CRGs, based on sound judgement. Following a threat of judicial review, the Commissioning Priorities Advisory Group meeting that was due to decide whether to take forward specialised commissioning policies, including the gender identity specification and clinical commissioning policy, has been cancelled and postponed. There is a high level of uncertainty on how and when these policies will be taken forward. A paper will be going to the NHS England Commissioning Board on the 17th of December 2014 proposing a way forward on the prioritisation framework for specialised commissioning. It is likely that a new framework will go out for public consultation after the board meeting.

**Health and Wellbeing Boards and the Better Care Fund**

The creation of the Better Care Fund (BCF) means that Health and Wellbeing Boards (HWBs) have become an important locus of commissioning decisions. The BCF, while a small proportion of CCG’s overall spending, has been subject to intensive planning during summer-autumn 2014, and has incorporated wide reaching strategic decisions about both the future of out-of-hospital services and the impact on secondary care.
The BCF budget has not been confirmed beyond 2015-16 and the role of HWBs and local authorities in healthcare commissioning will depend on political decisions subject to the outcome of the general election (see Better Care Fund website).

CCG mergers

Law and regulations allow CCGs to merge fairly easily in that they must propose it and gain approval from NHS England. Factors likely to drive mergers: large number of CCGs within a HWB (upper tier local authority) area; overlapping HWB boundaries; serving a small population; and serious performance/finance problems.

Gateshead, Newcastle North and East and West Newcastle CCGs will merge from April 2015 as has been approved by NHS England. The groups have been working closely in alliance since they were established and have already shared senior staff.

Development of the CCG oversight and assurance role

The CCG authorisation framework run by NHS England put a significant focus on which organisations could be approved to take on the full range of commissioning responsibilities (see CCG assurance framework).

In late 2013, a formal assurance framework was introduced under which CCGs are reviewed quarterly by their NHS England area teams. There is a more substantial review at the end of the financial year. This formal framework has generally been applied in a light touch way, and resulted in very little public information indicating CCG’s success or failure. The 2013-14 end of year assessment was published in October 2014.

NHS England conducts an annual performance assessment of CCGs. The process is set out in the CCG assurance framework. The annual assessment may conclude that the CCG is assured, or is not assured in which case intervention will be required.

At the end of their first year of operation 210 CCGs have been judged to be assured. One CCG, Barnet has required the exercise of intervention powers in order to secure future performance in respect of one issue.

In August 2014, we used our statutory powers to write to Simon Stevens at NHS England to request an assessment of the assurance of Clinical Commission Groups (CCGs) involvement of local Healthwatch and the public in decisions about service change, as set out under the CCG Assurance Framework and Operational Guidance.

We have asked NHS England to assess CCGs’:

- Involvement of local Healthwatch and the public in decisions about service change.
- Compliance with the legislation and statutory guidance on public involvement
We have asked them to send the results of this assessment to the Secretary of State and for Parliament to have access to the findings before it debates the proposed changes.

In summer-autumn 2014, NHS England has been considering important changes to the CCG assurance regime which will be implemented for April 2015.

The **NHS Five Year Forward View** signals a firm shift towards “a whole system, geographically based intervention regime”, coordinated by NHS England, Monitor and the NHS Trust Development Authority. This would focus on whole health economies rather than individual organisations and could see health economies, rather than individual organisations, placed in ‘special measures’.

Likely changes to the CCG assurance and intervention regime are:

- Labelling of CCGs which have severe problems in their areas, as being in “special measures”.
- A greater focus on CCG achievement in performance, finance and care quality, less emphasis on capability and leadership - judged on performance of providers rather than as standalone organisations.
- Less regular and distant assurance of well performing CCGs.
- Assurance of powers delegated to or shared with other CCGs under new co-commissioning arrangements.

**Next steps**

There is a lot of uncertainty about how the commissioning system will develop over the next year to 18 months. Potential directions include:

- Greater diversity in commissioning structures - there is already variation in CCG size and involvement of NHS England in CCG assurance. Simon Stevens has emphasised that diversity and experimentation should be encouraged rather than avoided.
- Increasing local government role - both Labour and Liberal Democrats have said they want HWBs to have a growing role in commissioning. Legislation could be introduced to give them more independent powers, e.g. hold budgets.
- Increase of people with personal and health budgets - this is set to increase and local commissioning leaders are apparently enthusiastic for change e.g. commissioners have less control of budgets.

We will be providing regular updates and briefings to the Healthwatch network between January and April 2015 on these changes to commissioning once there is further clarity.

If you have any queries, the commissioning and accountability lead at Healthwatch England is Phil Brough (email phil.brough@healthwatch.co.uk or call 0207 972
8044) and the specialised commissioning lead is Zoe Mulliez (email zoe.mulliez@healthwatch.co.uk or call 020 7972 8053).

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