

HEALTH AND SOCIAL CARE BILL

KEY AREAS

- The white paper was published 12/07/10 and the Bill was presented to Parliament on 19/01/11. It is currently making its way through the House of Commons.
- Several consultation documents:
 - Commissioning for patients
 - Transparency in outcomes
 - Regulating healthcare providers
 - Local democratic legitimacy

Provides for:

- an independent NHS to allocate resources and provide commissioning guidance
- increases GPs' powers to commission services on behalf of their patients
- strengthens the role of the Care Quality Commission
- develops Monitor to oversee aspects of access and competition in the NHS
- cuts the number of health bodies to help meet the Government's commitment to cut NHS administration costs by a third, including abolishing Primary Care Trusts and Strategic Health Authorities.

- GP led commissioning consortia
- Abolition of PCTs 2013 and SHAs 2012
- Any willing providers to be welcomed
- Public health to be under Local Authorities
- Introduction of maximum price for procedures

- DOH reduced in size
- DOH contracts with three bodies
 - NHS commissioning board (GP contracts)
 - Monitor – economic regulator – sets prices and rules and encourages competition
 - Care Quality Commissioning – to supervise provider quality

NHS commissioning board

- Responsible for
 - Assessing GP commissioning Consortia
 - Holding them to account
 - Holding GP contracts
 - Established in shadow in April 2011
 - Live April 2012
 - SHAs abolished in 2012/13

GP commissioning consortia

- Consortia to replace PCTs and become statutory NHS bodies (not Limited Company, CIC or LLP)
- Will need an accountable officer and chief financial officer
- Responsible to the NHS commissioning board
- Commission most services including emergency and OOH
- Will not commission:
 - GMS/PMS
 - Pharmacy/dental/opticians
 - Specialised regional services
 - All practices will be required to join.
- Will hold contracts with providers
- Have a duty to determine local health needs

- Have a duty to promote equalities
- Have duty to work with local authorities
- Duty of public and patient involvement
- Each consortia must ensure that expenditure (capital, revenue and administration) does not exceed that allotted by the Commissioning Board
- Will need skills in tendering, consulting and budgeting
- Commissioning budgets will be separate from practice budgets
- Need to enhance working relationships with secondary care clinicians
- GP Consortia will be required to have regard to commissioning guidance
- The Commissioning Board will have primary responsibility for tariff structure and develop model contracts
- Some staff and property will transfer from PCTs to consortia.

Timetable

- Shadow consortia 2011/12 taking responsibility from PCTs
- There are now 177 GP commissioning consortia given pathfinder status covering two thirds of the country and 35 million people
- Consortia responsible for commissioning from 2012/13
- Financial allocation to consortia late 2012
- Full responsibility April 2013
- PCTs abolished April 2013.

Patient Choice

- Choice of 'any willing provider'
- Choice of consultant led team
- Extended maternity choice
- Choice of mental health service
- Choice of treatment in long term conditions
- Choice of any GP practice – not limited by where a patient lives or practice boundary.

Improvement of use of NHS resources

- 'Consortia to work with practices to drive up quality'
- Peer pressure
- Benchmarking practices (scorecards)
- Could expel a practice from a consortium.

A new GP contract 2012

- 'Proportion of GP practice income linked to the outcomes that practices achieve collaboratively in consortia and the effectiveness with which they manage NHS resources'
- Quality premium paid to consortium and they decide how to apportion it to practices
- QOF to focus more on health outcomes not process
- All funded from existing resources
- One contract in future.

Implications for the future

- Clinical leadership
- Real involvement in redesigning services and improving services for patients
- New OOH services
- Developing practices
- Developing partnerships between consortia, LA, hospital trusts and consultants

Implications for practices

- Duty on each partner to ensure their practice is member of Consortium
- Duty on each partner to act with a view to enabling the Consortium to discharge its functions
- Role of clinicians in Consortia
- Treatment of time/liabilities of those on GPCC boards – practice or personal business?
- Ensuring that the practice earns its share of performance payments
- Implications of removal of practice boundaries
- CQC Regulation
- Revalidation
- Patient feedback