

APRIL 2007

# Framework for procuring external support for commissioners

BMA briefing and position statement (England only)



## 1 BACKGROUND

The framework for procuring external support for commissioners (FESC) is a relatively new development, first announcements of which were made in June 2006 and then again in July 2006 (originally termed as the 'commissioning services framework') in the Department of Health (DH) document 'Health reform in England: update and commissioning framework'. Essentially it will comprise of a list of private sector companies from which PCTs can buy in the necessary services in order to fulfil their commissioning function.

At the end of the ongoing national procurement exercise currently underway and which began in 2006, it is anticipated that the details of a number of companies or 'suppliers' will be released at the end of May 2007.

A policy statement on the FESC from the DH (February 2006) can be found online at the following address:

[www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4143055&chk=y3WUAY](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4143055&chk=y3WUAY)

## 2 HOW IT WILL WORK

The following summary has been informed by the DH policy statement referred to above:

- (i) It is for PCT Boards to decide whether or not to buy in any of the skills secured via the framework (paragraph 5).
- (ii) Commissioning remains a statutory responsibility of the PCT Board and the range of procured services do not extend to provider services (paragraph 13).
- (iii) If the PCT does wish to access services under the framework, they will conduct a locally managed competitive bidding process for which all suppliers (where appropriate) are required to bid. The subsequent contract between PCT and successful supplier will be referred to as an External Support Services Agreement (ESSA) (paragraph 12).
- (iv) The four categories of services built into the FESC are: (1) Assessment & Planning; (2) Contracting & Procurement; (3) Performance Management, Settlement & Review and (4) Patient & Public Engagement (paragraph 16).
- (v) There are three levels of service that a PCT can access: (a) a single service ('micro'); (b) one or more related group of services ('macro') and (c) a complete package ('end-to-end'). An 'end-to-end' package should only be bought in 'exceptional circumstances', with SHA approval and final sign-off by the Director General of Commissioning (paragraphs 20-21).
- (vi) The management of contracts with suppliers will be overseen by PCT Boards. This will include financial management, analysis of the quality of services being provided by the supplier and clinical standards. A specific group should be set up within the PCT, with clinical representation, to report to the Board accordingly (paragraph 25).
- (vii) The framework will outline five different payment models from which PCTs will determine the most appropriate for any procurement of services. [Note that further detail on these payment models has yet to be made available.] For 'end-to-end' services, only two of these payment models, those transferring the least risk to the supplier, will apply (paragraph 27).
- (viii) Where a payment model includes the potential for the supplier to take a share of savings, this will be dependent on the achievement of Operational Performance Indicators (OPIs), which will reflect national performance (paragraph 28).

- (ix) Four areas where potential conflicts of interest may arise are identified; the most relevant being where suppliers may be contracted to commission services when they already provide clinical services in the PCT area. Where such a conflict exists, the supplier in question will be excluded from the local procurement process (paragraphs 32 & 34).
- (x) Where other material conflicts of interest are identified, mitigating actions should be agreed and adopted. PCTs will have a right to exclude any supplier from bidding for a contract where no other appropriate mitigating actions can be taken (paragraphs 32-33).
- (xi) Suppliers under the FESC will be required to encourage practice based commissioning (PBC) participation and will work within existing demand management protocols as agreed with GPs and the PEC (paragraphs 28-29).
- (xii) Payment of savings made by GP practices and/or suppliers through commissioning activity will not be duplicated (paragraph 29).
- (xiii) The DH policy statement makes reference to the latest DH guidance on PBC ('Practical implementation' November 2006) which places renewed responsibility on PCTs to provide adequate management support to practice based commissioners. It goes on to say that GP 'practices, in agreement with PCTs, may wish to obtain support in particular functions by using the FESC' (paragraph 9).

### **3 IMPLICATIONS AND CONCERNS**

The services provided under the framework may enable some PCTs to buy in pockets of expertise that are otherwise lacking among existing PCT personnel. This may then lead to an improvement in the overall standard of PCT commissioning which in turn would facilitate more successful development of practice based commissioning (PBC), ultimately to the benefit of patient care.

However we believe that the negative implications of the framework will outweigh any potentially positive outcomes as outlined below.

#### **(i) Privatisation of commissioning**

The framework appears permissive of privatisation and in view of the extensive nature of a complete package of or 'end-to-end' services this may be seen by some PCTs as an opportunity to contract out large portions, or even almost all of its existing commissioning management functions to the private sector. Although the FESC stipulates that this must only happen in 'exceptional circumstances' it is yet to be seen how this will be defined and managed in practice.

The gravest consequence of any move towards privatisation of PCTs' commissioning management functions would be the potential for a private company to commission/purchase services from itself without check, regardless of the clinical appropriateness and cost-effectiveness of those services and without consideration of other commissioning and/or provider arrangements in the area. Again, the FESC seeks to set out some measures which will avoid such a situation arising, which we welcome, but whether or not these will be effective and adequately stringent in practice is also yet to be seen.

(ii) Validity of private sector involvement

Lessons from secondary care show that purchasing from the independent sector is not necessarily better, or cheaper, and in some cases, can prove detrimental<sup>1</sup>; there has been similar experience at a primary care level, for example with PCT 'turnaround teams'. We are also unaware of evidence to suggest that organisations with little or no experience of the NHS are able to do improve on the outcomes of the NHS.

(iii) Timing and compatibility with PBC

It could be argued that until the current transition of a large portion of commissioning responsibility from PCTs to GP practices is complete, it will not be possible to identify areas of real need for additional, third party involvement.

The ordinary functioning of PCTs is still in a state of disruption, particularly following PCT reconfigurations in 2006 and any further distractions preventing PCTs from working effectively with GP practices in order to put in place PBC arrangements should be avoided. In addition, it is likely that the introduction of suppliers through the FESC will give rise to new areas of disagreement between GP commissioners and PCTs. In the first instance, there may be a difference of opinion as to whether or not there is actually a need for PCTs to use the framework or disagreement over the level of services that should be bought in.

By introducing a third party into the commissioning process, further complications could arise. For example, it may prove difficult to determine whether a budgetary under-spend can be attributed to the work of local PBC groups and decisions of local GPs or that of suppliers under the FESC. In addition, there is a danger that suppliers will not adhere to or be mindful of the commissioning arrangements being put in place by local practice based commissioners, which would undermine PBC.

(iv) Extra demand on limited resources

PCTs will need to find resources within existing allocations in order to use the FESC and therefore we are concerned about the effects of resulting, additional budgetary pressures. Whether or not this can be seen as a legitimate use of limited NHS funding is also questionable.

It is as a result of these uncertainties and from a belief that the commissioning of patient care is a key function of the NHS<sup>2</sup>, that the BMA has major concerns over the introduction of the FESC.

## 4 PRINCIPLES AND SAFEGUARDS

The BMA was not consulted on any aspects of the FESC and as stated earlier in this document, we currently anticipate the list of suppliers to be released towards the end of May 2007. The stronger the local commissioning arrangements, the less of a need there will be for PCTs to access the services under the FESC. However as there will be some areas

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<sup>1</sup> Audit Commission and National Audit Office (2005) *Financial Management in the NHS* London: The Stationery Office Limited; House of Commons Health Committee (2006) *Independent Sector Treatment Centres* London: The Stationery Office Limited.

<sup>2</sup> The BMA produced a position statement '*BMA principles for effective and successful commissioning*' issued in November 2006, which sets out these views in more detail (see appendix 1).

where PCTs will wish to make use of the framework, we have set out the following principles and safeguards which, if adhered to, may help to minimise the risks associated with contracting out aspects of the commissioning process to the private sector.

- (i) There is close working with LMCs and GP practices undertaking practice based commissioning and, where appropriate, secondary care clinicians, in order to ensure that the services that are bought in are fit for purpose and compatible with other local commissioning arrangements.
- (ii) The buying in of services is done openly, transparently, is a cost-effective use of NHS funding and should only take place where such intervention is essential.
- (iii) Any purchasing and management details should be in the public domain.
- (iv) There must be no political pressure or even passive expectation on PCTs to make use of this resource and the DH must not make any guarantees, financial or otherwise, to suppliers under the framework.
- (v) Any contracts PCTs put in place with suppliers under the framework should be flexible in order to avoid their being tied-into long-term arrangements for services that are no longer required.
- (vi) The latest DH guidance on PBC sets out that all aspects of the PCT budget should be devolved indicatively to GP practices. Practices will then hand back elements of this notional, whole practice allocation to PCTs, including clearly identified funding for a central (PCT) management team. By virtue of the process of handing back to the PCT funding for central management, practices have legitimate authority over how these resources are used. Therefore, if the PCT wishes to use part of this funding to buy in services from the FESC, the agreement of practices should be sought accordingly.
- (vii) PCTs must ensure that good relations are developed between local GP commissioners and any contracted suppliers under the framework and that any potential areas of cross-over or conflict are clearly set out, discussed and resolved.
- (viii) In the long-term, any use of services under the framework should seek to build and develop skills within the NHS rather than de-skill the NHS.
- (ix) Measures are put in place at a local level to ensure that conflicts of interest, especially those relating to the commissioner/provider conflict, are avoided at all costs.
- (x) A package of 'end-to-end' services is reserved for *genuinely* 'exceptional circumstances' and the agreement of local clinicians that this is the only option is sought accordingly.
- (xi) Where the contract of a supplier under the framework gives access to personal and/or population data, there must be safeguards in place that ensure that this will not be harnessed in the commercial interests of that company in the future. Essentially, if a private company is to handle NHS data, ordinary commercial freedoms must not apply and the duty of confidentiality that binds the NHS must apply equally to the independent sector.

### **BMA principles for effective and successful commissioning November 2006**

The BMA views the commissioning of patient care as a key function of a National Health Service seeking to balance the clinical needs of patients with the finite resources that society is prepared to make available via general taxation. Most importantly, effective commissioning has the potential to improve the range and quality of health services available to patients.

This document outlines a series of principles which the BMA would wish to see upheld as the role of commissioning develops.

#### *Promoting clinical engagement and creating the right environment*

Engendering meaningful clinical engagement from and with both primary and secondary care is central to successful commissioning. In particular, increased attention should be paid to engagement with clinicians in secondary care and public health and more careful consideration paid to existing engagement with clinicians in primary care.

There are a number of ways to encourage clinical engagement, but these are quickly and easily overshadowed by the numerous disincentives which discourage involvement. For example, reducing commissioning to a demand management or 'rationing' mechanism acts as a major disincentive to primary care clinicians from becoming involved in the process, as does stifling innovation. Using negative incentives to drive engagement of secondary care, such as fear of destabilisation, is both inappropriate and ineffectual. Another major disincentive for both sectors arises from targets being set, whether local or national, which are unachievable and/or unrealistic. In order to promote clinical engagement, the terms of involvement should be fair, reasonable and equitable, an adequate resource should be made available to support the work involved and where there is a need for clinicians to develop particular skills, this should be identified and addressed.

The landscape of national policy heavily influences the cultural environment within which commissioning takes place. Effective commissioning is central to the Government's current reform programme, other key aspects of which include patient choice, plurality of providers, contestability, moving care closer to home and payment by results. Within this programme of reform there is inherent conflict and the BMA would wish to see a reappraisal of Government policy which results in the establishment of a coherent and shared vision. Commissioning cannot be viewed out of context and in order to succeed, both within the current financial climate and amidst all other change underway in the NHS, it must be properly supported as outlined above.

#### *Enabling cross-sector collaboration*

As clinical engagement does not only apply to GPs and primary care clinicians, the BMA wishes to see the establishment of effective and meaningful clinical networks across both primary and secondary care and public health. Public health doctors offer an invaluable role in supporting good quality commissioning. Their input includes needs assessment, critical appraisal of the published evidence, clinical effectiveness, priority setting, developing service models and service specifications, setting service standards, monitoring clinical outcomes, and service review and evaluation. Public health input into commissioning will make it possible to determine the optimum affordable basket of health care. Only through a collaborative approach, together with an intimate knowledge of both local and national health priorities, can commissioning be effective and produce patient-centred outcomes.

A number of the current reforms have the potential to erode relations between the primary and secondary care sector. Payment by Results in particular creates a tension between primary care commissioners, who are encouraged to refer less, and those in secondary care, who are incentivised through the national tariff to carry out more procedures in hospitals. This sets up a potential clash that discourages the collaboration that is needed to develop co-ordinated services and deliver best care for patients. Consequently, there is an urgent need to reform Payment by Results, including refining and unbundling the tariffs. In addition, effective collaboration will only be achieved where there is promotion of and support for clinicians across all sectors of healthcare to work together and the BMA wishes to see incentives in place for such cooperation to be achieved.

#### *Ensuring an appropriate balance between cost-effectiveness, quality and long-term sustainability of the health economy*

The current emphasis on commissioning to achieve immediate and short-term financial aims needs to be rebalanced to give equal importance to commissioning to achieve high quality patient services and long-term sustainability of the health economy. Financial balance, whilst important, must be achieved over a timescale that allows the continued delivery of real clinical need whilst the process of more effective and efficient re-provision of services takes place. Ill-thought-out, unsupported and short-term commissioning changes whose prime function is simply to reduce costs are likely to result in long-term problems and not ultimately achieve financial stability.

Commissioning decisions, whatever the level/scope, need to be considered within the wider context of the local NHS economy and should consider the implications of service redesign such as destabilisation of existing services and/or a depletion in the opportunities available for education and training.

#### *Effective dialogue with patients and the public*

The BMA believes that patient care should be at the heart of commissioning yet there is little confidence left among patients and the public in terms of their views being heard, both at a national and local level. There must be an open and honest debate with the public so that they are intimately involved in the development of commissioning decisions, feel that their needs and choices are being fully recognised and have realistic expectations of the services that can be delivered within finite resources. Rather than an adversarial approach, the fullest and widest possible public and patient participation in collaborative decision-making should be encouraged.

#### *Development of information systems*

In order to support commissioning, data must be accurate, timely, quality-checked and validated. This area needs urgent attention and investment to enable robust commissioning, to inform service redesign and to monitor the effects of any service changes put in place. There is a joint benefit in ensuring accurate data upon which to base commissioning decisions and planning which relies heavily on engagement and collaboration with secondary care.

#### *The future of commissioning*

In addition to patient care, the BMA believes that the overarching ethos and ethics of a publicly provided health service should also be at the heart of commissioning. Enabling non-NHS, commercialised, private companies to be heavily involved in commissioning has the potential to put these fundamental principles at risk. Where commercial gain takes priority over regard for the patient experience, the process of commissioning will inevitably be compromised. We would therefore wish to see commissioning remain a core function of the National Health Service and call for the appropriate support to be given to clinicians in order to enable them to succeed in the commissioning role.