10 October 2010

The White Paper team
Room 601
Department of Health
79 Whitehall
London
SW1A 2NS

Dear Colleague

Re: Liberating the NHS: Commissioning for patients

The British Association for Counselling and Psychotherapy (BACP) would like to submit the following comments to the above titled consultation.

BACP is the leading professional body for counselling and psychotherapy in the UK, with a membership of over 35,000 practitioners across the UK, drawn from the various professional disciplines in the field of counselling and psychotherapy. A substantial proportion of our members work as mental health practitioners in the NHS.

General Comments

BACP welcomes this Department of Health (DH) document on commissioning for patients and believes that in broad terms GP commissioning at a local level will improve health outcomes. BACP also welcomes suggestions that the DH wish to work with the NHS and a range of stakeholders including professional bodies in the transition to the new arrangements to promote multi-professional involvement. BACP has a good body of knowledge and evidence on what has worked and what hasn’t worked in the area of psychological therapies commissioning and would welcome the opportunity to work with the DH.

BACP endorses the principles in the document which enable commissioning to be more patient focused and led by clinicians. BACP is also aware that local commissioning has in recent years been lead by PCT’s that have been significantly influenced by the DH, performance targets, NICE, Strategic Health Authorities and national programmes such as Improving Access to Psychological Therapies (IAPT). BACP suggests that a cultural shift is now required to enable local commissioning to be effective; this cultural shift will require the DH to be less prescriptive on the detail of provision and GP consortia to embrace the opportunity to lead the future of service provision.
Responses to consultation questions:

Responsibilities

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?

Assuming the NHS Commissioning Board will conduct some form of needs assessment before commissioning these services, BACP would suggest that they could consult GP consortia and relevant stakeholders (such as professional bodies, carer and patient groups etc) as part of this process.

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

BACP would suggest that the NHS Commissioning Board and the GP consortia work collaboratively to make decisions on the commissioning of low volume services based on GPs’ knowledge of what services are effective and an understanding of where the gaps exist in service provision.

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

No comments.

4. 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?

GP consortia could set up task and finish groups in order to involve other primary care contractors when developing proposals for the commissioning of services to which they refer patients. This would need to be included within the GP consortia governance.

Of the 300 million general practice consultations a year, it is estimated that a third are psychosocial, including patients with common mental health problems, relationship difficulties and stress. BACP would suggest that there should be an emphasis on involving contractors who deliver psychological therapies in primary care in the commissioning of the secondary care services that they refer to.
5. **How can GP consortia most effectively take responsibility for improving the quality of the primary care provided by their constituent practices?**

Collaborative working within the GP consortia is essential for a culture of continuous improvement to exist. GPs should work together on the points outlined in the document on improving the quality of primary care. The only constraint on this will be the time they have to build these relationships and work collaboratively.

6. **What arrangements will support the most effective relationship between NHS Commissioning Board and GP consortia in relation to monitoring and managing primary care performance?**

The document outlines an intention to consult GPs and the BMA on the QOF, which we agree is the best approach going forward.

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

BACP would suggest a transparent commissioning process that involves publishing appropriate documents and decisions in the public domain, including annual reports and local web updates.

BACP would also suggest that there is external scrutiny, the publication of outcomes and financial statements and the inclusion of the patient’s voice.

8. **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?**

There needs to be a culture of local decision making, so that contracts fit in with local needs. Quality standards such as those developed by NICE should not be presented as blueprint; otherwise this would lead to commissioning led by the centre. This would not take into account of local needs and priorities or clinical judgment.

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

Under 3.29 BACP suggests that in addition to the two points outlined a gap analysis is needed in terms of GP training. The analysis would need to look at whether they are equipped to do this work and what training is needed to ensure that they can. It may not just be the business process but also some training on
commissioning for whole community needs in relation to mental health, public health, social care, medically unexplained symptoms and possibly some work on equality and diversity because GP consortia will need to commission services that are accessible to all groups. After an analysis of training needs, training should then be provided.

Establishment of GP Consortia

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

BACP agrees with the statements made in 4.1 and 4.2, but in addition we would suggest that there is accountability at a local level to HealthWatch. HealthWatch should also have powers to report any concerns to the Commissioning Board.

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

BACP understands the need for GP consortia to have flexibility on which practices to include; however, BACP believes that such decisions should have a clear rationale that helps secure the best healthcare.

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

BACP would suggest that there shouldn’t be a minimum and/or maximum population size. A more effective way to manage the size of GP consortia should perhaps be based on using social demographics, as they might be more appropriate. GP consortia size should be guided by community so that GP practices in a consortia are meeting population based needs. For example it wouldn’t be appropriate to have just one consortia for a large city because this would make it more difficult to meet the needs of specific communities and populations.

Freedoms, controls and accountabilities

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

BACP suggests that GP consortia should be provided with appropriate guidance to support the recruitment of existing commissioners. If this were to happen in advance of 2013 when PCTs are dissolved this has the potential to save money, for example through reducing the numbers of people made redundant only to be recruited again at a later date. This would also help the NHS to retain some of the commissioning talent it has.
14. What support will GP consortia need to access and evaluate external providers of commissioning support?

Instead of expecting GP consortia to evaluate external providers, the Commissioning Board could take this role. We suggest that the Commissioning Board could vet/accredit providers of this support and produce a directory for GPs to choose from. This would help GPs easily access appropriate commissioning support.

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

No comments.

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

BACP would suggest that in order to demonstrate fairness and transparency, there needs to be transparency in all of the processes involved in investment decisions. Being well governed and accountable as a consortium with representation from HealthWatch and social care to provide some scrutiny would also be beneficial.

In terms of encouraging choice and competition, this might mean not always seeking one provider. For example in the context of psychological therapies it would be essential to keep contracts with the voluntary sector as well as with NHS provider arms such as IAPT services and existing local services in the NHS. This enables a choice of psychological therapies and can be more inclusive because often third sector providers are working with marginalised groups. Also as there is no monopoly there can be healthy competition and collaboration.

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

BACP welcomes the documents intention to consider both patient experiences and outcomes. Within the commissioning outcomes framework, BACP would suggest that patient choice is included as a key element.

On p 18 commissioning networks are suggested for patients with cancer, for ill and disabled children and so forth. We strongly suggest that mental health commissioning networks are included as a priority, across the age and condition range.
18. Should some part of GP practice income be linked to the outcomes that the practice achieves as part of its wider commissioning consortium?

No comments.

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

It is essential to include initiatives to make services more accessible, and which overcome language and cultural barriers, within commissioning arrangements. It is also important to consider what is offered by services, over and above the clinical component of their work when deciding whether they are commissioned. For example, some mental health charities provide a clinical counselling service but also have a wider remit, including raising public awareness, reducing stigma, peer support and outreach work in communities. Commissioning arrangements should enable this wider work to continue because it helps bring marginalised groups and individuals into services.

In addition, local charities that have grown because of gaps in services and that meet the needs of niche groups in their communities, need to be consulted and taken into account; because if commissioning is solely based on calculating average levels of need based on diagnosable conditions across populations this will not be accessible or equitable.

Partnership

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

BACP would suggest the need for formal regular consultations linked with the work of HealthWatch. We would also suggest that it is important to have lay representation on boards and committees.

21. 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 GP consortia need to consult with a wide range of community partners from the very beginning, with ongoing consultation and review to ensure that the GP consortia are accountable for their decisions. The reviews need to look in detail at whether the input has produced any changes/results.
22. How can we build on and strengthen existing systems of engagement such as Local HealthWatch and GP practices' Patients Participation Groups?

Existing systems could be strengthened by ensuring that there is some form of accountability. They could be built on by finding innovative ways of engaging all patients that see their GP. Patients Participation Groups could consult or survey other patients to find out their views.

23. 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?

BACP would suggest the need for training and the development of a culture of continuous improvement focused on the quality of patient care. There should also be a complaints procedure within the Commissioning Board.

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

BACP considers that this should be a two way process, with not all of the emphasis on GPs. GP practices and local authorities need to have locally agreed aims and objectives, bringing both sides together in a constructive engagement.

25. 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?

No comments.

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

BACP is pleased to see in point 6.13 that the DH wish to work with the NHS and professional bodies in the transition to the new arrangements to promote multi-professional involvement. BACP has many good examples of where commissioners have worked with our members on the commissioning of psychological therapies. Subsequently, BACP has a good body of knowledge and evidence on what has worked well and not, and how to engage clinicians and work with DH. BACP has produced ‘NHS commissioning – a toolkit for psychological therapy providers’. The toolkit aims to describe the developing NHS market for psychological therapies, provide a practical guide to support providers wishing to enter or remain in this market, and offer advice on how to engage with commissioners and the commissioning process.
We hope these comments will be of value. Please do contact me if you would like to discuss further any of the points our comments may have raised.

Yours sincerely

[Signature]

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