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THE INTELLIGENT COMMISSIONER

THE SKILLS NEEDED TO BE AN EFFECTIVE COMMISSIONER

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Commissioning comprises a complex set of activities. While Clinical Commissioning Groups (CCGs) cannot delegate or subcontract their responsibility for overall commissioning, it is inevitable that both CCGs on a local level, and the NHS Commissioning Board at a national level, will need some support so that they can make the right commissioning decisions, and that these decisions lead to better outcomes for patients. ‘Commissioning support’ will bring the specialist skills and knowledge to the non-clinical elements of commissioning so that clinicians can use their strengths to focus on leading change and improvement locally.

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ABOUT THIS REPORT

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This paper is based on a full report *A New Commissioning* by David Colin-Thomé which explores these themes in more detail and is available online at www.dctconsultingltd.co.uk

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Executive summary

We are facing a future where general practitioners through Clinical Commissioning Groups (CCGs) are poised to play a much greater role in the way that healthcare services are delivered. This presents GPs with an opportunity to drive change and improve outcomes for patients and their local populations.

There are concerns CCGs will not live up to these expectations and, indeed, that they will not be given complete control over commissioning which some fear may only be tokenistic. This report assumes that CCGs will assume responsibility for the majority of commissioning decisions in health care and asks what good commissioning looks like, what are the attributes of an effective CCG, what skills GPs can bring to the table and what they are likely to be missing.

The report discusses four areas where CCGs should focus their efforts over the coming years. They are: becoming the people's organisation; developing new relationships within the wider public health system; becoming healthcare system leaders and developing new relationships with providers. In each of these areas, GPs will have something to offer to complement the skills of others. They are clinical professionals who are at the interface between patients and the wider NHS, and, as a result, have knowledge and experience that will be invaluable in driving CCGs forward.

Where expertise and skills are lacking in each of these four areas, CCGs must consider the best way to acquire them. The way that the NHS is being re-organised is freeing up talent in primary and secondary care but CCGs must remember it is their choice — they should not feel pressured into picking up the pieces and 'making do'. This is an opportunity that requires them to seek out the best talent.

Introduction

Whatever emerges from the parliamentary passage of the Health and Social Care Bill and any subsequent political fallout, one thing is clear — we need a fresh approach to commissioning. The need for change was brought into sharp relief by the Health Select Committee report into commissioning 2009/10[1]. The Committee said: "Commissioners [primary care trusts] continue to be passive, when to do their work efficiently they must insist on quality and challenge the inefficiencies of providers, particularly unevidenced variations in clinical practice...[they] do not have adequate levers to enable them to motivate providers."

General practitioners through Clinical Commissioning Groups (CCGs) now have an opportunity to show that they have the levers to drive change and improve outcomes for patients and people in their communities. In order for CCGs to be effective, there are four areas where they should focus their efforts. First, they need to become the 'people's organisation'; second, they must develop new relationships and partnerships within the wider public health system; third, they have to become the healthcare system leader across organisations, and; fourth, develop new relationships with providers of care.

Being the people's organisation requires a focus on public and patients — everyone within the area covered by the CCG, whether they are registered at member practices or not. Having general practitioner-led clinical commissioning within CCGs presents an opportunity for all clinicians to shape the system and encourage a better focus on outcomes and value for public and patients. The starting point must be the citizen with the aim to deliver a good experience of easy-to-access, high quality co-ordinated care. The overarching relationship for CCGs must be with

the public as citizens and the overall defining culture must be one of sustainability. Making hard decisions is a core commissioning task, so commissioners need to ensure both a public transparency and the effective involvement of the public.

Developing new relationships within the wider public health system is a key role and CCGs will have to create and foster relationships that ensure sustainable partnerships. Although Local Authority-led Health and Well Being Boards will need to ensure that the individual agencies are held to account for delivering their part of the local public health strategy, there are several facets of improving the public's heath that the NHS will lead, particularly around successful health promotion and disease prevention. CCGs will have to take this further and develop a public health system-wide role in enabling and ensuring that all their providers deliver appropriate services to the local community.

The third area of focus for CCGs is becoming healthcare system leaders. They should acknowledge that commissioning takes place at many levels, whether it is by clinician in the act of referral to other services, by small organisation (e.g. general medical practice), or by a body with a non-statutory yet central role in commissioning. It is the responsibility of the statutory commissioner not to subsume that activity but to support, challenge where necessary, co-ordinate and give the strategic lead.

Successful commissioners will think in terms of sustainable, transparent and accountable relationships. In a complex adaptive system such as the NHS, linear approaches to management are of limited value and rarely achieve any effect, especially when it comes to commissioning. Effective commissioners must exhibit clarity of purpose in a multiplicity of relationships within a complex system.

To gain maximum support, CCGs must view themselves as the customer and identify the appropriate support, possibly in conjunction with other groups. Providers of support apart from PCT clusters could include local authorities, acute and other NHS providers, public health observatories and the private or third sector. CCGs have to pursue a role as system enabler, encouraging an approach which avoids the current situation where we have a series of stand-alone services contracted separately.

The fourth area of focus is around provider relationships. Relationships between providers and former practice-based commissioners have been varied. In some parts of England they work together well, in others it is nothing short of pure hostility. However CCGs have to enlist providers by working collaboratively, describing outcomes and not prescribing processes. Relationships and power dynamics will need to change radically in order that the individual provider organisation, not the commissioner, is clearly and explicitly accountable for its care quality and population focus.

What does effective commissioning looks like?

We are facing a set of circumstances that have until now driven commissioning in a linear direction. Commissioning has been mired in our preoccupation with setting contracts. Even within that narrow contractual focus there is a paucity of effective clinically-oriented contract review. It is little wonder that large swathes of clinicians from across the healthcare spectrum are disengaged from and disinterested in the commissioning process.

Much of the improvements in NHS care, whether in access to services or clinical improvements in cancer and cardiovascular care, have been achieved by national targets or direction. The input locally has majored on delivering national priorities, but why has that predominately administrative function required such huge resources? What has been the extra achieved through locally-based commissioning leadership whether managerial or clinical? There are, as always, the exceptions, but too few it seems to have made a local specific sustained and sustainable difference.

The government's NHS reform package is a response to the lack of engagement and involvement of clinicians at a local level and an attempt to produce better outcomes with fewer resources. It is, after all, clinicians and particularly doctors who spend the money by their deployment of clinical resources.

The hope is that we can re-define and extend the concept of commissioning without adding layers of complexity and lessening the potential benefits. The reforms should support this process by removing the NHS commissioner's responsibility for provision of community services — a process begun by the previous administration. Further, the prime leadership for improving the public's health is to be the remit of local government.

However, it is already clear that this fresh approach to commissioning is bringing with it a host of duties and responsibilities on the part of new CCGs. The issue is how should they should discharge their responsibilities, and what skills and experience can GPs lend to CCGs?

A key initial task is to decide on board membership. It must be clear that the responsibility of the CCG board is chiefly about the governance of that organisation. This is quite a separate responsibility to the very important task of engaging local clinicians and others in service design and review. In some cases, the two separate responsibilities have been unhelpfully conflated. Of greater concern is that in some instances board membership is seen as conferring higher status on its members.

The current confusion and ambiguity will not help deliver the necessary governance that the public need from their statutory organisations. It is also clear that in the past formulaic composition of NHS boards has obfuscated the

identification of major problems arising in the organisations. Thus, it is important to bring on board individuals who possess technical skills, experience, and the appropriate behavioural attributes.

CCGs are effectively taking on the statutory functions of the primary care trust (PCT). It is a wide agenda that encompasses safeguarding young people, children and vulnerable groups. Until now, this is something that most GPs will not have considered and it means complying with the relevant legislation, for example, the Equalities Act. Even though CCGs will not be providing care directly in all instances, they will need to operate within the law.

Managing conflicts of interest is an issue that has already provoked attention. Some GPs have become specialists in areas like dermatology. When CCGs commission such services they will need to show that they have managed any potential conflict of interest. This goes beyond assertions and guidelines set out in the written constitutions. There is no check list for CCGs and they are being given a very short run up.

Governance issues are already on the mind of Dr Mark Spencer, a GP in Fleetwood, Lancashire. Dr Spencer is chair of a pathfinder CCG called the Fleetwood Community Commissioning Group. He says: "CCGs will undoubtedly need good governance — we all want to improve the service we provide to our communities and want to work with our peers in primary and secondary care. However, if there are problems with a particular practice then we need good governance arrangements to pick this up."

"We must also have robust governance around conflicts of interest. We have an interest in seeing that our own practices flourish, but in one sense CCGs have an opportunity to be very democratic because CCG members are elected."

Wider system management is at the heart of the CCGs function and covers clinical and non-clinical aspects of care. In most areas, a larger number of CCGs will replace a smaller number of PCTs. This presents an inherent challenge as CCGs will have to work together to coordinate a multi-agency approach, especially when it comes to areas such as mental health provision.

Julie Wood, Director, NHS Alliance Clinical Commissioning Federation refers to the build/buy/share approach: "The build aspect is about service redesign over which they will need complete ownership, sharing will require an assessment of which functions could be owned jointly by CCGs and buying will entail a separate assessment of what the CCG requires in terms of commissioning support."

THE FOUR AREAS OF FOCUS

Becoming the people's NHS organisation

First and foremost CCGs need to define themselves as the visible NHS organisation for their populations. That is their defining role but, as such, is not what the public recognise whether evidenced in a previous Picker Institute review[2], or the much-quoted survey where the public thought refuse collection was in the top three of primary care trust activities.

Statutory commissioners are the predominant funders of the local healthcare system and given that responsibility, they must become the system leader across the healthcare system on behalf of their citizens and be transparently accountable to them. CCG leadership has to enable better health and ensure better health care with a strongly enhanced focus on individual patient's and the public's population needs, rather than the needs of NHS providers.

Dr Mark Spencer says that becoming outward-facing organisations will present some challenges. "We are very good at understanding patient's needs on a one-to-one basis but on a much wider level community engagement is more alien to us. When you stand up in a public meeting with 200 people, you will be asked some awkward questions," he says. However, Dr Spencer is convinced GPs can use their knowledge of individual patients to broaden this to the wider community, even when it comes to hard-to-reach groups.

Communication also extends to understanding the way the media works and who the local influencers are in the healthcare system. Dr Spencer says: "Not many stories in the local press will be positive — in fact, GPs have to some extent

Skills and experience needed — becoming a people's organisation

The extent to which communities are engaged with health care and consider themselves owners in the healthcare system could be a measure of the success we have had in engaging local communities. For CCGs to succeed in becoming a people's organisation they must begin to understand their local communities, listen to their concerns and encourage them to
feel ownership.

- Ability to develop a vision for the healthcare system
- Ability to segment the local population and tailor this vision so that it makes sense to everyone
- Ability to deliver on accountability and transparency
- Ability to engage with and listen to a diverse population
- Understanding of the basic tenets of good communication
- Good understanding of the local media and networks of influencers

been sheltered from the bad news by PCTs." CCGs will therefore have to cultivate relationships with local media to help them understand the commissioning and the hard choices that have to be made.

However, becoming a visible and accountable entity also relies on having a transformational relationship with an active community — citizens who are not merely 'done to'. We have so far been slow at divesting meaningful power and responsibility to the public. Some might argue that patients and the public have become accustomed to the NHS exhibiting a didactic approach, which, in turn, has created a dependency culture.

So at the same time as being visible and accountable, CCGs will have to engender a sense of membership and a culture of belonging. Although membership can be achieved through structural arrangements (as with foundation trusts), communicating a vision and encouraging local community buy-in is a harder task requiring a different skill set. Nick Goodwin, Senior Fellow, King's Fund talks about developing social capital and says the first thing CCGs must do is to focus on the 'narrative' and then work on following that through.

Communicating this narrative will be complex. No two CCG populations are exactly the same and this narrative, or vision, will have to be tailored to take into account socio-economic factors and different existing attitudes to health services. In Public Services at the Crossroads[3], The Institute for Public Policy Research argued that the better-off receive superior health and education services to the poor. The report found that that higher socio-economic groups access healthcare more frequently as elective, planned admissions, while lower socio-economic groups typically enter as emergencies. The report also shows that, across a disparate and wide range of conditions, lower socio-economic groups tend to present to clinicians at more advanced and severe stages of illness.

To be 'of the people' entails both a community leadership and community facilitative approach at the early stages of the journey. This requires softer skills which are harder to come by: communicating a vision for local healthcare services goes beyond slick slogans on a website. GPs do not traditionally have these skills and will have to rely on support which could come from a range of organisations, although NHS bodies are largely unaccomplished in this area.

THE FOUR AREAS OF FOCUS

Developing new relationships within the wider public health system

The reforms to the public health system give Local Authorities the lead role locally for improving the health of their population. It can be argued that their services and influence have a greater impact on sustainability and the social determinants of health than the NHS. That said, the NHS has a role to play and a multi-agency approach involving the public is essential for successful health promotion and disease prevention.

The proposed Local Authority-led Health and Well Being Boards need to ensure that the individual agencies are held to account for delivering their part of the local public health strategy. There are several facets of improving the public's heath that the NHS will lead. For instance: vaccination and immunisation; cervical screening and improving the health of those who have a long-term condition. These are services where general practice providers have already achieved much.

CCGs will have to take this further and develop a system-wide role in enabling and ensuring that all their providers deliver appropriate services to the local community. Having responsibility for a given population is often interpreted in a utilitarian collectivist manner, rather than a way of enabling individuals within that population to fulfil their health potential.

Relationships within the wider health system will be key to the success of CCGs. The King's Fund's Nick Goodwin says that they will have to be managed on many levels. From commissioning support organisations to relationships with voluntary and third sector groups, CCGs will have to embrace the wider public health system. He points out that there are a number of innovators who have receptive and productive relationships of this sort: "NHS Cumbria has a long history of partnership working with a broad range of organisations focussed around the provision of home-based services. With these relationships already in place commissioners have a significant head start." NHS Tower Hamlets and NHS Knowsley have also been outstanding in this area.

Julie Wood, Director, NHS Alliance Clinical Commissioning Federation says that having the right relationships will be fundamental to effective service delivery: "CCGs will need to have functional relationships across the public health system so that services are responsive to the needs of the local population."

Given the mixed picture, some CCGs will need to consider the issue of relationship building more than others. Specific skills and experience will be required in this area — individuals who are trusted either locally, or who have a track record in building lasting relationships will be sought after.

Skills and experience needed — developing wider relationships within the public health system

Partnership working will be vital for better relationships between CCGs and the wider public health system. Local Authorities have experience and skills in this area and will be a useful resource for CCGs. CCGs will need to ensure that they are able to access individuals who understand the benefits of partnership working and are able to put this into practice.

- Willingness to listen and learn from other providers
- Good track record in developing relations across the healthcare system
- Understanding of the benefits of partnership working
- Ability to see the bigger picture in public health terms
- Ability and willingness to work alongside other CCGs

THE FOUR AREAS OF FOCUS

Becoming the healthcare system leader

CCGs have to set the bar when it comes to delivery of healthcare services. Becoming the healthcare system leader involves developing a vision but also ensuring that organisations within the healthcare system engage with this vision.

Dr Mark Spencer points out that general practitioners have a significant advantage when it comes to engaging with clinicians throughout the system because they have common ground. "It comes back to the importance of clinical engagement and ensuring that all clinicians are happy with the direction of travel. If we are going to follow the big agendas around care closer to home, better care pathways for people with long-term conditions then primary care has to be at the heart of what we do and this is one of the big differences between what PCTs did and what CCGs will do," he says.

Given that strategic lead requires GPs to think in terms of sustainable, transparent and accountable relationships. Good leaders will support and challenge where necessary in order to meet the objectives that the vision demands. This clarity of purpose across a multiplicity of relationships is paramount. The question for CCGs is what is it about good leadership that makes the change happen.

One test for CCGs is whether they can choose the right leaders — individuals who possess an awareness of the various cultures of community-based services, technical skills and a past history of enabling and changing management skills.

Nowhere is the coming together of individual and population needs more important than for serving those patients and individuals with long-term conditions. And, nowhere is there a more urgent need for system leadership.

The system of care for those with long-term conditions, in particular those who have a co-morbidity of conditions and especially those who are also frail and elderly, should serve as a template for NHS commissioners. Long-term conditions are the healthcare issue of this early century and, as such, are a key priority. Delivery will depend on the NHS providing optimal care but many facets of the strategy are also for the wider public healthcare system and its system-wide accountability. NHS commissioners, as with all statutory bodies, need to exhibit a leadership beyond their own remits and specific responsibilities — a leadership for sustainable development.

Skills and experience needed — becoming the healthcare system leader

CCGs will have to exhibit strong leadership which means engaging other professionals (and not just clinicians) within the healthcare system. This will require change management skills and a clear understanding of what makes good leaders.

- Understanding of good leadership skills
- Ability to develop a vision for particular healthcare needs (e.g. long-term conditions)
- Ability to encourage 'buy-in' to the vision across the healthcare system

THE FOUR AREAS OF FOCUS

Developing new relationships with providers

Good commissioners need good providers, and vice versa. The future of healthcare provision must be about a transparent partnership between commissioner and provider. However, the question is whether CCGs can look beyond a focus on solely contractual relationships and think instead in terms of being system facilitators and leaders?

Current contracts are often too detailed, with inadequate review processes and frequent exclusion of clinical input. We need to move to a situation where we have far more clinically-influenced enabling contracts. Detailed contracts may be reserved only for those providers who lack the necessary vision and leadership to form a new relationship with commissioners.

The focus of a new relationship is how CCGs can ensure a system of provision for their population and not become preoccupied with the needs of an individual provider organisation. There is a danger that CCGs will be wearied by the frequently tendentious claims of 'this will de-stabilise my organisation', when this is used as a pretext for inaction.

There is of course a corollary to commissioning. Where is the provider responsibility and leadership in ensuring good quality care that is cost-effective and achieving maximum efficiency? For provider organisations, the optimal approach to making an impact on commissioners and playing to clinician's strengths is, of course, to provide high quality care, extended in scope but at the same time necessarily accountable.

The King's Fund's Nick Goodwin points out that when you examine previous research into commissioning it shows that effective commissioners are much better at developing relationships with providers. "There is quite a skill in brokering and negotiating relationships with providers and it's not just about procurement," he says. "CCGs cannot divorce themselves from developing good relationships with providers and it can't be done in a purely contractual way."

He acknowledges that the road ahead may be difficult to navigate as

managerially-led commissioners do not traditionally understand the business of provision, especially when it comes to large acute trusts. However, he argues that it is incumbent on CCGs to deliver against the Quality, Innovation, Productivity and Prevention (QIPP) agenda. In most areas, CCGs will have to build capacity in home-based services and prevention so the starting point is going to be developing relationships with acute trusts. "If these relationships are mature, acute trusts will recognise that it is about developing services that meet community need."

Dr Mark Spencer looks back to the days before primary care trusts and says that relationships between GPs and their colleagues in mental health and acute trusts were good: "Somehow it has all got lost in the bureaucracy of contracting. Engagement has all been around numbers and bed utilisation, whereas we need to refocus on clinical care and outcomes by working together with providers — the words need to be clinical again."

Skills and experience needed – developing new relationships with providers

Good provision drives good commissioning and CCGs must be able to re-align the relationship with providers. This means having the skills in developing relationships and negotiation but also understanding what the benefits of closer working can be.

- Good understanding of the business of acute trusts
- Experience in developing relationships and in negotiation
- Insight into the mindset of acute providers
- Willingness to overcome historic mistrust
- Track record in developing relationships between primary care and secondary care

Commissioning for community-based services

In the short-term, CCGs will have to focus on many aspects of service provision. The longer-term priority if the NHS is to achieve significant whole-system service re-design is to major on a step change in community-based services.

Many current commissioners complain that as the contracts of independent contractors (including GPs) are held nationally, it makes it impossible to manage those services: reflecting the all too common view that it is only through a contractual relationship that you can manage clinicians. In fact, forty per cent of current GP contracts are local, without much evidence that those contracts are outcome-oriented.

Clinician-led commissioning gives us an opportunity for a new approach to the management of primary care to achieve the step change required — even if the contracts are held nationally. The providers of most first contact primary clinical care are GPs, who nationally provide some 80 per cent of all the NHS clinical contacts with patients. NHS care is also provided by community health services, social services, voluntary organisations and on occasions privately-funded services, but rarely have these community services enjoyed a centrality their importance deserves.

This deficit was rectified to some extent by the potential of the 'Transforming Community Services' initiative of the NHS Next Stage Review Primary and Community Services Strategy. However, the quality improving potential has become

lessened by the current structural and contractual focus on community services. The title 'Transforming Community Services' is often misapplied to describe this linear and reductionist approach to community health services.

All community-based services need to contribute to and deliver against the whole clinical or long-term conditions 'year of care'[4] pathway from prevention, screening, early diagnosis through to co-ordination and review of care. Community dentists and optometrists are a helpful source of health promotion by identifying systemic disease. Community pharmacists are among the most popular of local professionals and their services can be wide-ranging and serve a large footfall.

By adopting the community-oriented primary care approach, CCGs can significantly contribute to and, locally, potentially lead the necessary multi-agency approach to prevention and community awareness of early disease.

One model CCGs might adopt is the 'Primary Care Home' (see full paper on www.dctconsultingltd.co.uk). This integrated community-based care model is funded by a holistic approach that is based on a 'make or buy' philosophy to care delivery. It is a home not only for GPs and their teams, but for all primary care independent contractors and their staff (pharmacists, dentists, optometrists), together with community health service and social care professionals. It is also potentially a home for clinical professionals currently working in hospitals, in particular those who have a responsibility for long-term conditions, rehabilitation and re-ablement.

Conclusion

In this report we have sought to outline the attributes of an effective CCG and four areas of focus: becoming a people's organisation; developing new relationships within the wider public healthcare system; becoming healthcare system leaders and developing new relationships with providers. GPs will have a lot to offer in terms of the skills and experience required to deliver in these four areas. The majority run their practices effectively, but they will undoubtedly need support to replicate this at macro level across the healthcare system. CCGs do not have to do everything themselves and talent is available.

However, to get the right mix of in-house expertise and external support, CCGs should start asking fundamental questions such as what does good commissioning look like, what does accountability mean, and what are the skills and experience we are lacking? In short, they have to challenge what has gone before.

We believe that it is only through a management culture far removed from linearity, but strongly accountable to local populations, that the NHS will be more effective, efficient and sustainable. Top down gives a short-term sense of certainty and safety but spawns dependency, an aversion to innovation, and even disappointingly among many clinicians, a passivity and indeed a victim culture.

It is a lot to ask, but necessary for CCGs to exhibit leadership of this complex and adaptive, fiercely local system. In doing so, and by embracing the opportunity of assuming clinician leadership, they can challenge the aphorism of Dr Julian Tudor Hart that 'clinicians often lay claim to ground they do not wish to occupy'[4].It is a test and opportunity for a new commissioning.

Appendix

CLINICAL COMMISSIONING GROUPS — THEIR DUTIES

Although the prime role for GPs and other clinicians is to be system leaders not administrators or managers, we have reproduced a list of duties from the Department of Health.

1. Planning services:

- To commission health care to the extent the consortium considers necessary to meet the reasonable requirements of patients registered with the GP practices who are members of the consortium.
- To commission health care for other groups of patients, as defined in regulations, which it is intended will include:
  - people who live within the consortium's defined geographic area who are not registered with any GP practice;
  - people present in the consortium's geographic area who need access to emergency care.
- To exercise their functions with a view to securing continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical-effectiveness, safety and patient experience.
- To co-operate with local authorities and participate in their Health & Wellbeing Boards.
- To co-operate with other NHS bodies.
- To have regard to the NHS Constitution.
- To have regard to commissioning guidance published by the NHS CB.
- To ensure that the consortium obtains advice from people with professional expertise in relation to people's physical and mental health.
- To involve patients and the public in developing, considering and making decisions on any proposals that would have a significant impact on service delivery or the range of health services available.
- To have regard to the need to reduce inequalities in access to health care and healthcare outcomes, promote patient and carer involvement in decisions about them ("no decision about me, without me") and enable patients to make choices with respect to aspects of their health care.
- To pay providers (in specified circumstances) for the costs of health care commissioned by another consortium but provided to a patient for whom the consortium is responsible (e.g. for urgent care).

- To provide the NHS CB with specific information, if considered necessary by the Secretary of State for the purposes of carrying out his functions in relation to the health services (this is likely to be primarily financial information).

2. Agreeing services:

- To adopt any 'standing rules' that may be required under the Bill in relation to the contracts to be used by consortia, e.g. specific terms and conditions that should be included in those contracts.
- To comply with any regulations that may be made governing procurement activities.

3. Monitoring services:

- To exercise functions with a view to securing continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical-effectiveness, safety and patient experience.
- To provide information, where required, to the Information Centre which is necessary or expedient for the Centre to have for the purposes of its function, e.g. to support publication of national data on healthcare services.

4. Improving the quality of primary care

- To assist and support the NHS CB as regards its duty to exercise its functions with a view to securing continuous improvement in the quality of primary care.

5. Improving the quality of primary care finance:

- To break even on the consortium's commissioning budget (i.e. ensure expenditure in any financial year does not exceed the allocated budget and any other funding or other sums received).
- To ensure that revenue expenditure and capital expenditure do not exceed the separate limits set for each.
- To ensure that expenditure on administrative costs (i.e. costs relating to anything other than the healthcare services commissioned) does not exceed a specified proportion of the overall commissioning budget (the 'running costs allowance').
- To ensure that the use of resources in a given year (i.e. the expenditure incurred,

which may not be the same as the cash payments made in that year, and changes in the value of assets) does not exceed a specified amount.

- To provide financial and other data to the NHS CB as required to allow in-year monitoring against budgetary and Parliamentary controls.
- To keep proper accounts and have these audited annually.
- To use a prescribed banking system (i.e. the Government Banking Service) to manage the consortium's funds.

6. Governance:

- To have a constitution that sets out:
  - the name of the consortium and the GP practices that are members;
  - the area for which the consortium is responsible that is relevant to their commissioning responsibilities and to define which Health and Wellbeing Board(s) it is a member of;
  - how it carries out its functions (i.e. who will be responsible for day-to-day executive decisions about commissioning);
  - how the consortium makes decisions, how it deals with conflicts of interest, and how it ensures effective participation of all its members.
- To have an Accountable Officer, responsible for ensuring that the consortium carries out its functions in a way which ensures continuous improvements in quality and proper stewardship of public money.
- To publish an annual report on how the consortium discharged its functions in the previous financial year, with particular reference to how it has discharged its function in relation to quality improvement and patient and public involvement. To hold a meeting to present the annual report to the public.
- To have regard to the proper stewardship of patient and other personal information and manage information risk in line with guidance published by the NHS Information Governance Toolkit by assigning Caldicott Guardian and Senior Information Risk Ownership responsibilities.
- To provide information or explanation where the NHS CB has reason to believe that the consortium might have failed or might fail to discharge its functions.
- To offer NHS pension arrangements to staff employed by the consortium.

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