

BOARD PAPER - NHS ENGLAND

Title: Developing commissioning support – the future for commissioning support units

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Purpose of paper:

- To agree the approach and options for the future for commissioning support units, as part of our strategy to ensure all commissioners have access to excellent affordable commissioning support.

Key issues and recommendations:

This paper proposes the adoption of a national framework containing structural options for securing autonomy for commissioning support units (CSUs), and proposes a process whereby CSUs would consult locally on their preferred option, within a framework determined by NHS England.

Actions required by Board Members:

On the recommendation of the members of the CSU committee, the Board are asked to approve:

- a national framework comprising four alternative organisational structures for autonomous CSUs; and
- a locally led approach to developing autonomous CSUs, assured by NHS England.

Developing commissioning support – the future for CSUs

Executive summary

1. Commissioning support units (CSUs), which are not legal or statutory bodies, were created to offer support services to NHS commissioners, freeing them to focus on their core task of achieving the benefits of clinically led commissioning.
2. While commissioning support services (CSS) are support services – they are neither commissioners nor providers of patient care – their quality is vital to raising the capacity and capability of the commissioning system so that it can meet the challenge of continually improving outcomes for the population.
3. CSUs, which were not ready to become autonomous (independent) in April 2013, are being hosted by NHS England until 2016 to give them sufficient time to prepare. They are preparing to become autonomous in an environment where NHS commissioners, and other customers, are free to choose the best support services: CSUs have no guarantee of winning income if they are not the first choice of customers.
4. Being hosted by NHS England will increasingly militate against CSUs remaining their customers' first choice: rules, which are entirely appropriate for statutory public sector hosts, constrain CSUs that need to respond and invest quickly to meet customers' evolving requirements.
5. Therefore, the members of the CSU committee of the NHS England Board recommend that the Board itself approve four options for CSUs to select from: social enterprise, staff mutual, customer controlled social enterprise or joint venture. All offer the prospect of giving the necessary freedoms to remain the first choice of customers. Other options, such as selling CSUs, have been ruled out by the Committee.
6. It is proposed by the Committee members that NHS England prepares during 2014 guidance for CSUs on the process to autonomy, including on public consultation which will be local and led by each CSU when it is ready to submit its application to NHS England. For most CSUs this is expected to be in late 2015 or early 2016.

Background

7. The Health and Social Care Act 2012 established new NHS commissioners – clinical commissioning groups (CCGs) and NHS England – to succeed Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs). It was recognised by the Government that these new NHS commissioners needed to be able to access support services that offered economies of scale and sustainable specialist teams. Therefore, CSUs were set up, staffed largely by NHS employees who had delivered similar functions in PCTs and SHAs. Unlike their customers, CSUs are not statutory bodies or legal entities.
8. CSUs operate at scale to deliver support services such as:
 - analysing data and providing business intelligence;
 - negotiating and managing contracts on behalf of commissioners;
 - service redesign and transformation; and
 - providing business support services – IT, HR and finance services.
9. Whilst the majority of their income comes from NHS commissioners, CSUs do not provide front-line patient care.
10. The Government's original intention, reflected in the 2011/2012 NHS Operating Framework, was that CSUs would become social enterprises or joint ventures by April 2013. However, in light of the complexity of the transition to the new commissioning arrangements, the Government subsequently decided to extend the period to April 2016, and arranged for their hosting through the extended period by NHS England, with the NHS Business Services Authority becoming the employer of CSU staff, reflecting the CSUs' operational independence from NHS England.
11. These arrangements do not affect, reduce or remove the accountability of CCGs and NHS England for commissioning decisions. CSUs support commissioners commissioning front-line services, but are not commissioners themselves.
12. CCGs and NHS England are free to choose where they source their commissioning support, whether from the public, private or voluntary sectors.

Our strategic framework

13. The NHS England strategy for commissioning support services (CSS) published in June 2013¹, adopted the strategic goal of ensuring that “all commissioners can access excellent affordable CSS”. There were three strands to the strategy: developing CCGs as confident customers exercising informed choice; developing a cohort of excellent affordable providers, including CSUs; and establishing simple efficient procurement mechanisms to underpin this.
14. It is recognised that meeting the challenges facing the NHS, now and in the future, will require lean, agile, clinically led commissioning, enabled by expert commissioning support delivered at scale. CCGs were established to be clinically and locally focused, concentrating on their relationship with patients and their communities, rather than building their own internal commissioning support organisations.
15. CCGs, as independent statutory bodies, are already free to choose where they source their commissioning support provider and many already buy services from other providers including the private sector. The 2013/2015 Mandate to NHS England reaffirmed that “CCGs will be in full control over where they source their commissioning support”. It is their responsibility to secure the best support services so as to improve outcomes for patients and secure best value for money for taxpayers.

Benefits of autonomy

16. While CSUs are hosted by NHS England, they are legally obliged to observe rules common to the public sector, such as those relating to procurement, formal financial control, management of risk, and nationally set staffing policies. This regime significantly constrains their ability to respond to customers’ needs in an increasingly competitive environment.
17. Autonomy, appropriately framed, can give CSUs the freedoms to:
 - determine their own business strategy, and pursue individual routes to success;
 - take managed risks;
 - secure flexible investment funding;
 - enter into alliances and sub-contracts simply and quickly;

¹ Available at <http://www.england.nhs.uk/resources/css>

- attract and retain expert staff who are in short supply;
 - change rapidly to match other organisations as they offer CCGs improved services and products; and
 - respond more quickly to changing customer demands.
18. The objective is to provide a framework which will balance giving CSUs the necessary freedom to compete and protecting the public interest while being adaptable to local needs and circumstances.

Key components of a successful approach to autonomy

19. Key to creating successful sustainable autonomous CSUs will be:
- identifying the most appropriate organisational forms;
 - strong effective local leadership;
 - meaningful engagement of staff and customers;
 - robust assurance to ensure that only those organisations which are fit for purpose and viable are approved to become autonomous; and
 - incorporation of essential safeguards to protect patients' and taxpayers' interests and ensure that existing staff are treated fairly.

The proposed organisational models

20. Based on feedback from extensive engagement with stakeholders, the CSU committee identified four potential organisational forms which it thinks would offer CSUs the core freedoms they need to optimise the benefits to patients and taxpayers, accelerate the development of an excellent NHS commissioning system, and be safe and sustainable. These are:
- a. Social enterprise, which will have a public, binding and overriding social purpose (taking the legal form of a community interest company limited by guarantee);
 - b. Staff mutual, which will abide by the seven principles of the co-operative movement, including one member one vote and concern for the community (taking the legal form of an industrial and provident society);

- c. Customer controlled social enterprise, which would be akin to the in-house department of the customers and so its customers would be exempt from going through formal procurement to secure its services (taking the legal form of a community interest company limited by guarantee);
 - d. Joint venture, which would be formed by bringing in other parties in order to raise the value for money and quality of the CSU's services (taking the legal form of a company limited by shares). In the event that a CSU considers a joint venture would offer the best way for delivering excellent affordable CSS, then NHS England would wish to look at this very closely to ensure that extra safeguards are in place to deliver value to the taxpayer, and would wish to engage with national staff side organisations and other stakeholders. This would be in addition to the local consultation.
21. If NHS England assessed that an application from a CSU could not offer sustainability and value for money, then NHS England would work closely with the CSU in trying to improve their plan; if this were not feasible, NHS England would explore other alternatives for securing excellent and affordable CSS for its customers.
22. Under all of these options the autonomous CSU would be subject to a legal agreement with NHS England to ensure that the interests of patients, customers and taxpayers were fully protected; in addition to the rules which would govern all providers of CSS.
23. Under each of these options the terms and conditions of existing staff transferring to the new organisations would be protected. Transferring staff would retain their membership of the NHS Pension Scheme. These protections will be set out in guidance to CSUs, which we would develop and consult on with national staff organisations to ensure a safe and fair transition.
24. Further information about each of these models is provided in the annex on page 10 below.

Options that it is proposed to rule out

25. As part of the process above, the CSU committee considered and then ruled out five other possible models. These were:
- a. selling CSUs – given the early stage in the development of the CSS market and the consequent uncertainty about the value of the CSUs, there would be a significant risk that the NHS would be giving away value to the private sector buyer. In addition engagement with CCGs, as the largest customers, has indicated that this would not win their support, and without the support of customers a CSU would not have a sustainable future;
 - b. centrally outsourcing CSU services as a single entity – although all UK governments over the last 30 years have used this approach for support services, CCGs have made clear that they do not want standard specifications imposed which in practice such central outsourcing would require;
 - c. continuing the existing hosting arrangements – this would deny CSUs the core freedoms of autonomy which will be critical in an increasingly competitive environment. This would increase the likelihood of CSUs failing, particularly as CCGs increasingly exercise their right to choose where they get their commissioning support. This could create significant financial liabilities for the NHS commissioning system and risk a shortfall in the capacity and capability of commissioning support to enable major service change to meet the challenges the NHS faces;
 - d. creation of new NHS bodies – this is contrary to wider Government policy on reducing the number of public bodies, and it is unlikely that such bodies (for example Special Health Authorities) would provide CSUs with the flexibility and access to financing they will need;
 - e. adoption by an existing NHS body (e.g. an NHS Foundation Trust) – this would not provide the core freedoms, may well result in a conflict of interest, and would be a distraction from the body's central purpose; transferring a CSU to an NHS Foundation Trust without holding an open procurement risks challenge in the courts.

Further engagement with stakeholders

26. The CSU committee members considered at length the options for consulting with CSU staff and other stakeholders. It had been originally envisaged that NHS England would consult nationally, followed by individual CSUs consulting locally on their preferred option. The members considered an alternative approach of having one round of consultation: led locally by individual CSUs, working within national guidance.
27. The CSU committee members' recommendation is for this latter approach, as it would avoid: duplication, additional cost and delay, and potential confusion at a time when CSUs and their staff need clarity about their future. Given the extensive stakeholder engagement which has already taken place and that each CSU would need to undertake its own consultation, the committee members have concluded that locally led consultations are the appropriate and preferred option.

The proposed approach

28. The proposed approach is as follows.
 - a. NHS England will continue to work with stakeholders to produce national guidance to inform the development of individual CSU proposals.
 - b. NHS England will publish guidance which will set out the four acceptable forms in which CSUs can elect to become autonomous, any necessary safeguards, and the assurance process. Such guidance would be binding on CSUs, for example, in terms of the forms they could consider and essential safeguards for patients, taxpayers and staff.
 - c. Individual CSUs would consider with their staff, customers and key stakeholders which form is likely to best suit local needs and circumstances, consult on this and make an application to NHS England.
 - d. There would be a phased approach to implementation, rather than a central timetable, with individual CSUs applying when they are ready. We would, however, expect CSUs to become autonomous during 2016.
 - e. NHS England would undertake a robust assurance process, ensuring that only those organisations which are fit for purpose and viable are approved to become autonomous.

- f. Whilst CSUs will be responsible for consulting on their proposals, NHS England will continue to engage national stakeholders, including staff organisations, and provide effective co-ordination to ensure a safe and consistent transition.
29. This approach is very similar to that applied successfully from 2008 to the analogous transfer from PCTs of front line community services to new social enterprises: locally-led and developed plans informed by national guidance, and assured consistently and robustly.

Next steps

30. The Board are asked to approve in principle the development of guidance to CSUs which reflects the above, incorporates essential safeguards and sets out the application and assurance process. This guidance will be subject to approval by the CSU committee prior to publication. NHS England will continue to engage key stakeholders particularly CCGs, CSUs and their staff, and nationally staff organisations, in the development of the guidance and subsequently.
31. CSUs will then be asked to develop, consult on and submit proposals to become autonomous, which will be assured by NHS England. Implementation will be phased, with CSUs submitting their proposals in accordance with their own timetable, so as to ensure that all CSUs have attained autonomy during 2016.

Actions requested

32. On the recommendation of the members of the CSU committee, the Board are asked to approve:
 - a national framework comprising four alternative organisational structures for autonomous CSUs; and
 - a locally led approach to developing autonomous CSUs, assured by NHS England

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Interim National Director: Commissioning Development
January 2014

Annex – Further details of the autonomy options for CSUs

Social enterprise

1. The key feature of a social enterprise CSU would be its public, binding and overriding social purpose.
2. Social enterprises have an established place within the NHS and have been successfully formed by existing NHS staff, most notably under the Transforming Community Services programme.
3. The legal form for CSU social enterprises would be a community interest company limited by guarantee (CIC). This would be the legal entity that would employ the staff of the CSU and would enter into legally binding contracts with customers.
4. As a CIC, the CSU would have its assets locked and would have to adhere to its social purpose under CIC regulation². In all other regards, such as taxation and registration, CICs are limited companies. As a company limited by guarantee it would not have shares on which dividends could be paid: in place of shareholders would be members who would guarantee the company for a nominal amount.
5. Where in the interests of customers, a social enterprise CSU could choose to have a range of relationships with the private sector without compromising its social enterprise status: for example, subcontracting to, forming subsidiary joint-ventures with, or receiving finance from the private sector.

Staff mutual

6. The key feature of a staff mutual would be its adherence to the seven principles of co-operatives:
 - Voluntary and open membership (for staff in this case);
 - Concern for community;
 - Democratic member control (one member one vote);
 - Member economic participation;
 - Autonomy and independence;

² CIC regulation is light touch and would not impose a significant administrative burden. See www.bis.gov.uk/cicregulator/about-us/regulator

- Education, training and information; and
 - Co-operation among co-operatives.
7. A CSU staff mutual would take the legal form of a co-operative society (a form of industrial and provident society). This would be the legal entity that would employ the staff of the CSU and would enter into legally binding contracts with customers.
 8. The Financial Conduct Authority (FCA) approves the establishment of industrial and provident societies, and ensures that any subsequent changes to their constitution allow them to remain bona fide co-operatives. FCA regulation of industrial and provident societies is light touch.
 9. Subject to the Industrial and Provident Societies Act 1965, co-operatives have similarities with companies limited by shares but have important differences. For example, shares would not be equity shares which appreciate or fall in value with the success of the enterprise that issues them; the shares would have just a nominal value which could only be redeemed at face value.

Customer controlled social enterprise

10. The key feature of a customer controlled social enterprise CSU would be that it would be akin to their in-house department: the customers controlling (and owning) the CSU social enterprise would determine its strategy and make the major decisions. This would allow these controlling customers to award work to the CSU without having to undertake an open procurement.
11. Like the social enterprise option above, the legal form would be a CIC limited by guarantee. This would be the legal entity that would employ the staff of the CSU and would enter into legally binding contracts with customers.
12. This option is substantially different to CCG in-house provision: the staff would be employed by the CIC, not by the CCG; there would be a clear operational separation between the CCG and the CSU, supported by a legal contract for the provision of CSS.
13. In order to qualify for the exemption from undertaking open procurement, the controlling customers and the CSU would be heavily constrained: having to comply with legal requirements under procurement law and the legislation governing the freedom of CCGs to trade.

Joint venture

14. A joint venture would be formed by bringing in other parties in order to raise the value for money and quality of the CSU's services. In the event that a CSU considers a joint venture would offer the best way for delivering excellent affordable CSS, then NHS England would wish to look at this very closely to ensure that extra safeguards are in place to deliver value to the taxpayer, and would wish to engage with national staff side organisations and other stakeholders. This would be in addition to the local consultation.
15. Joint venture partners and what they could bring include:
 - Trade investors – capital and operational capability;
 - Financial investors – capital;
 - Specialist firms or charities – niche capabilities or products;
 - Local authorities – expertise in social care commissioning; and
 - CSU staff – retention and recruitment.
16. A joint venture would take the form of a company limited by shares, which would be the employer of the CSU staff and would hold legally binding contracts with customers.
17. NHS England would ensure that the joint venture would be established so as to protect the interests of customers, patients and taxpayers from unacceptable financial outcomes.