Brent

NHS Brent Clinical Commissioning Group

Health and Wellbeing Board
24 January 2017

Report from the Assistant Director - Primary Care, Brent Clinical Commissioning Group

Wards affected:
ALL

Clinical Commissioning Group (CCG) GP Member Practices – Option to Move to Delegated Commissioning Arrangement

1.0 Summary

1.1 North West London (NWL) CCGs are now consulting member practices on the option of a move to 'level 3 - fully delegated' commissioning arrangements from 1st April 2017. CCGs that move to fully delegated arrangements will be responsible for functions previously carried out by NHSE and their own statutory duties.

1.2 Newly delegated functions would include: management of GP core contracts, design of enhanced services and local schemes and financial management of the primary care budget. Functions retained by NHSE would include: management of the national performers list, management of the revalidation and appraisal process, capital expenditure, section 7A functions (e.g. screening and immunisation) and complaints.

1.3 The Health and Wellbeing Board is asked to note that Brent CCG Member Practices will take a vote on the option of moving to level 3 – delegated commissioning arrangements from 1st April 2017.

2.0 Recommendation

2.1 The Health and Wellbeing Board is asked to consider how we ensure we continue to commission effectively, and deliver our shared programme of transformation under the STP, with level 2 – joint commissioning arrangements, or with level 3 – delegated commissioning arrangements.

3.0 Detail

3.1 Currently NHS England (NHSE) has overall responsibility for commissioning and management of core primary medical services. They hold the 'core' GP contracts, commission 'enhanced' services, manage the primary care budget (primary medical allocations), manage patient communications, complaints, primary care estate and GP revalidation, appraisal and performance.

3.2 In 2015 CCG member practices voted in favour of a move to 'level 2 - joint commissioning' arrangements. At level 2, NHSE retain 51% decision making rights but the CCG are part of decision making processes.

3.3. North West London (NWL) CCGs are now consulting member practices on the option of a move to 'level 3 - fully delegated' commissioning arrangements from 1st April 2017. CCGs that move to fully delegated arrangements will be responsible for functions previously carried out by NHSE and their own statutory duties. Newly delegated functions would include: management of GP core contracts, design of enhanced services and local schemes and financial management of the primary care budget. Functions retained by NHSE would include: management of the national performers list, management of the revalidation and appraisal process, capital expenditure, section 7A functions (e.g. screening and immunisation) and complaints.

3.4 Nationally 114 of 209 CCGs are currently Level 3. NHSE are keen for CCG members to choose delegated commissioning. NHS Brent CCG remains impartial. It is possible, and even likely that some CCGs in NWL will choose to move to delegated commissioning and others will choose not to.

3.5 Brent member practices will vote on this option in line with the terms of the CCG Constitution. All member practices are given a vote (one vote per practice). 75% or more of member practices must vote in favour for the proposal to be carried. NWL CCGs submitted an initial application to NHS England on 5th December with the membership vote pending. The Brent vote will run 30th January – 13th February run by the Brent Council Electoral Services team. The result will be announced around 17th February 2017.

3.6 To facilitate an informed vote, the process of stakeholder engagement commenced early October 2016. There has been significant work to date to identify the opportunities and challenges with stakeholders; this has included engagement with GP member practices, CCG and NHSE colleagues, Brent local authority and some elected members: Cllr Butt, Cllr Hirani (Chair of the Health and Wellbeing Board), and Cllr Sheth (Chair of Community and Wellbeing Scrutiny Committee), Londonwide and Local Medical Committees and Healthwatch.

3.7 Some early engagement of lay members and patient representatives has taken place across NWL and more will follow the vote. GP practices have been urged to consult PPGs. This on-going process is helping identify the questions that need to be addressed as part of planning and due diligence.

3.8 NWL CCGs have commenced a process of due diligence. There are three key workstreams being led by leads from across the CCGs in NWL with input from

NHSE, practices and technical experts (lawyers, auditors). The three workstreams underway are as follows:

- **Governance:** governance leads from NWL have been reviewing the constitutional arrangements required for level 3, the revisions required to local committees (including what would be a transition from a local Joint CoCommissioning Committee to a local Primary Care Commissioning Committee), the lines of reporting and accountability and the approach to conflict of interest management. Draft documents have been produced and published for January Governing Body. Principles include ensuring the clinical voice is optimised whilst safeguarding GPs and CCGs from real or perceived conflicts of interest; ensuring local joint working is effective and transparent to all stakeholders and delivers the objectives in our STP and ensuring decision-making remains fully compliant with statutory guidance and reflects good governance.

- **Workforce (CCG and NHSE teams):** functions, processes, roles, skills and the structures in which these would be organised. This workstream is also looking at HR implications and developing an implementation plan taking into account the fact there would be an element of transition in the first year. It is likely elements of commissioning will be organised at NWL level, others locally (Brent or across the Federation of Brent, Harrow, Hillingdon CCGs).

- **Finance and legal:** understanding the financial risks and/or benefits associated with the proposed transfer of responsibilities from NHSE as at April 2017. CCG Finance leads are working with NHSE and RSM Tenon (auditors) to examine financial performance and any inherent risks. Key lines of enquiry include: likely final budget position at the end of 16/17, new budgets for 17/18 and beyond, requirements upon and issues that might impact these budgets and what room (if any) there might be to invest locally. Best efforts will be made to identify risks/disputes/ liabilities as at 31st March 2017 and a Memorandum of Understanding is being drafted between NWL CCGs and NHSE to indemnify CCGs against these legacy issues.

3.9 There are potential benefits in a move to delegated commissioning. Some of the key potential benefits are outlined below:

- Delegation could support delivery of the STP, in particular delivery area 2. It could make it easier to coordinate resources going into GP services so they better achieve local needs, priorities and outcomes.

- With fully delegated responsibility the CCG may have more ability to work with local authority teams (for example Public Health and Social Care) to (re)design and commission local enhanced services.

- Responsibility for all parts of the service provided by GPs could give local commissioners more scope to work with practices to refine contracts and

reporting and in turn to reduce the administrative burden on practices and free up more time for clinical delivery.

- The Primary Care Commissioning Committee would have direct and local control over primary care planning and decisions about how services are shaped. This would include greater ability to shape the future of primary care providers at all levels - practice, Network and Federation (Brent-wide).

- There would be greater emphasis on reducing variation in the services offered to and outcomes achieved for patients locally. The CCG would have better access to data on practice performance and outcomes and increased authority and responsibility to address challenges and seek equitable access for all registered patients, ultimately reducing health inequalities.

3.10 There are also potential risks in a move to delegated commissioning. Some of the key potential risks are outlined below:

- CCG capacity will be a challenge. Staff numbers significantly reduced with the dissolution of Primary Care Trusts (PCTs) and it is likely additional staff would be required to support primary care commissioning and contract management under level 3. The CCG currently has a capped staffing budget and whilst some existing NHSE staff would work at a NWL level, CCGs are unlikely to receive additional staffing resource from NHSE. We think there would be increased expectations around design and management of primary care services and contracts, reporting and governance, relationship management and administration.

- Currently the CCG is involved in shaping the primary care market, investing in primary care through locally enhanced services and out of hospital contracts, and in the development of provider joint working (for example through Whole Systems and delivery of the STP). Expectations would be raised with any move to level 3, and as delegated commissioners the CCG would have more control, but practices would remain independent providers and commissioners will have to work with them and their representatives to effect and deliver change over time.

- There will be an even greater requirement to manage conflict of interest. Whilst this is business as usual for CCGs with robust systems and processes in place, the governance structure and approach will need to be revised to take account of level 3 responsibilities and functions and it will need to be clear to external stakeholders (including practices) that this is being enacted effectively and appropriately. This is also a potential benefit as there will be even greater transparency and accountability for decisions locally.

- The demands on primary care are greater than ever and growing as the population grows and ages. Many practices can’t meet patient demand for access, have staffing shortages, lack suitable premises, are seeing

increased running costs, professional fees (CQC, GMC) and individual and practice indemnity and insurance costs, and have GP Partners considering retirement. This means an increasing number of practices are vulnerable. The CCG will have to work within available resource to support practices. There will likely be a significant number of issues that arise locally over time and all will need to be managed as effectively as possible – recognising these constraints - in partnership with local stakeholders without negatively impacting wider relationships and joint working.

3.11 Once the outcome of the Brent member practice vote is known, it will be announced and the CCG and its partners will consider the implications at local and NWL level.

4.0 Financial and Legal Implications

4.1 The financial implications of this proposal are still work in progress and will be informed by the due diligence exercise being undertaken with a specific workstream on finance and legal implications

4.2 Should the member practices vote yes, any information that arises as part of ongoing due diligence (to end March 2017) that may impact the viability of a move to level 3 will be shared with CCG Governing Body and member practices.

5.0 Equality Implications

5.1 A potential benefit of delegated commissioning is better access to data on practice performance and outcomes with increased authority and responsibility to address challenges for the purpose of securing equitable access for all registered patients. This would result in improved quality, safety and patient experience that would contribute to a reduction in health inequalities.

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