Brent Health Overview and Scrutiny Committee

Update on GP commissioning in Brent

July 2011

1. Update on Pathfinder activities - Delegated budgets

1.1 In June 2011, the Federation applied for delegated budgets. This is the first step towards achieving authorisation as a Clinical Commissioning Group. The Federation have applied for delegation of the following budgets to be held at consortium level:

- Prescribing
- Direct access
- Outpatients.

Harness consortium has also applied for the budget for elective care and Kilburn for community physiotherapy.

1.2 As a Federation, they have applied for community paediatrics and community budgets. These two budgets will be held at Federation level as there is insufficient information to monitor and control the budget at consortium level. However we have agreed with the PCT to develop shadow budgets for these areas plus mental health so that we can move to consortium level budgets in 2012/13.

1.3 North West London cluster was anticipating being able to delegate all budgets to pathfinder consortia by the end of Quarter 3 but Brent GP Federation is concerned to move at a realistic pace in which they can learn the appropriate skills. The Federation will review their appetite for taking on more delegated budgets in August.

1.4 NHS Brent and NHS Harrow Boards will consider the Federation's application at its meeting on 28 July. If approved, budgets will be devolved from September 2011. While formal delegation of budgets is important, Clinical Directors are already deemed accountable for budget performance and implementation of QIPP as part of our current GP commissioning governance arrangements.

2. Amendments to the Health and Social Care Bill

2.1 Following the Government's listening exercise on the Health and Social Care Bill, the NHS Future Forum published their recommendations on the future for NHS modernisation. The Government published its response on 20 June, setting out the changes it intends to make in response to the recommendations. On 27 June, the Government published a set of briefing notes to accompany Government amendments tabled for consideration by a House of Commons Public Bill Committee. Below we have highlighted those areas that have implications for GP commissioning.

CLINICAL COMMISSIONING GROUPS

2.2 Commissioning consortia will continue to be groups of GP practices, but a number of changes have been made to provide greater assurance that commissioning will involve patients, carers and the public and a wide range of doctors, nurses and other health care professionals. To reflect this stronger emphasis on wider professional

involvement in commissioning decisions, the Government will use the term “Clinical Commissioning Group” to describe these local NHS organisations.

2.3 Clinical Commissioning Groups will have a duty to promote integrated health and social care around the needs of users and their boundaries would not normally cross those of local authorities.

2.4 Clinical Commissioning Groups will be expected to have a name that uses the NHS brand and has a clear link to their locality. Clinical Commissioning Groups must commission all urgent and emergency care within their boundaries, and are also responsible for any unregistered patients who live in their area.

2.5 Clinical Commissioning Groups will have flexibility to work in partnership when commissioning services, for example with other groups, local authorities and the NHS Commissioning Board. But as public bodies, they will be unable to delegate their statutory responsibility for commissioning decisions to private companies or contractors.

GOVERNANCE AND ACCOUNTABILITY FOR CLINICAL COMMISSIONING GROUPS

2.6 Every Clinical Commissioning Group will have a governing body with at least two lay members, one with a lead role in championing patient and public involvement, the other with a lead role in overseeing key elements of governance such as audit, remuneration and managing conflicts of interest. One of the lay members will undertake either the role of Deputy Chair or Chair of the governing body. If Deputy Chair, the lay member would take the Chair's role for discussions and decisions involving a conflict of interest for the Chair.

2.7 Clinical Commissioning Groups will have to include at least one registered nurse and one doctor who is a secondary care specialist but not employed by a local provider. Governing bodies will be required to meet in public and publish their minutes, and Clinical Commissioning Groups will have to publish details of contracts with health service providers.

TIMETABLE FOR ESTABLISHING THE NEW COMMISSIONING SYSTEM

2.8 Primary Care Trusts will cease to exist in April 2013. However, Clinical Commissioning Groups who are not authorised to take on any part of the commissioning budget in their local area will not be required to take this on until they are ready and willing to do so.

2.9 By April 2013, GP practices will be members of either an authorised Clinical Commissioning Group, or a ‘shadow’ commissioning group, i.e. one that is legally established but operating only in shadow form, with the NHS Commissioning Board commissioning on its behalf. No individual GP will need to get involved in the work of a commissioning group if they don’t want to.

2.10 Clinical Commissioning Groups that are ready and willing by April 2013 could be authorised to take on full budgetary responsibility. Some will only be authorised in part. Others will only be established in shadow form. This will be determined through a robust process of authorisation, run by the NHS Commissioning Board, with input from emerging Health and Wellbeing Boards and local clinicians through a senate.

2.11 There a Clinical Commissioning Group is not able to take on some or all aspects of commissioning, the local arms of the NHS Commissioning Board will commission on its behalf

2.12 The Primary Care Trust "cluster" arrangements will be reflected in the local arrangements of the NHS Commissioning Board. Those local arrangements will be established before PCTs are abolished.

WIDER CLINICAL INVOLVEMENT AND ADVICE

2.13 Clinical networks of experts, including patient and carer representatives, that exist in areas like cancer care will be retained and they will be given a stronger role in commissioning, supporting the NHS Commissioning Board and local Clinical Commissioning Groups.

2.14 "Clinical Senates" will be established to give expert advice to Clinical Commissioning Groups on how to make patient care fit together seamlessly in each area of the country. To support the better integration of services, they will include public health specialists as well as adult and child social care experts. Clinical senates will have a formal role in the authorisation of Clinical Commissioning Groups. In addition, the Clinical Senates will have a key role in advising the NHS Commissioning Board on whether commissioning plans are clinically robust and proposed major service changes.

HEALTH AND WELLBEING BOARDS (HWB) / LOCAL AUTHORITIES

2.15 Health and Wellbeing Boards will have a new duty to involve users and the public. HWBs will be involved throughout the process as Clinical Commissioning Groups develop their commissioning plans, and there will be a stronger expectation, set out in statutory guidance, for the plans to be in line with the local Health and Wellbeing Strategy. HWBs will have a clear right to refer plans back to the group or to the NHS Commissioning Board for further consideration.

2.16 HWBs will have a stronger role in promoting joint commissioning and integrated provision between health, public health and social care. They will be given a formal role in authorising Clinical Commissioning Groups. The NHS Commissioning Board will have to take HWBs' views into account in their annual assessment of commissioning groups.

2.17 Health and Wellbeing Boards discharge executive functions of local authorities, and should operate as equivalent executive bodies do in local government. It will be for local authorities to determine the precise number of elected members on a Health and Wellbeing Board, and they will be free to insist upon having a majority of elected councillors.

2.18 HWBs will be subject to oversight and scrutiny by the existing statutory structures for the overview and scrutiny of local authority executive functions. The existing statutory powers of local authority overview and scrutiny functions will continue to apply.

PATIENT AND PUBLIC INVOLVEMENT

2.19 The NHS Commissioning Board and Clinical Commissioning Groups will have a duty to involve patients, carers and the public in commissioning decisions and will require commissioning groups to consult on their annual commissioning plans to ensure

proper opportunities for public input. They will have to involve the public on any changes that affect patient services, not just those with a "significant" impact.

INTEGRATION OF SERVICES

2.20 Clinical Commissioning Groups will have a duty to promote integrated services for patients, both within the NHS and between health, social care and other local services.

3. Next Steps

3.1 Over the coming months, we will consider what changes we may need to make to current governance arrangements supporting GP commissioning prior to establishing shadow Clinical Commissioning Groups.

3.2 The Brent GP Federation will continue to update the Overview and Scrutiny Committee on amendments to existing arrangements.

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