

Attachment 06

**North East Lincolnshire CCG**

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| **Report to:** | NEL CCG Partnership Board |
| **Presented by:** | Cathy Kennedy |
| **Date of Meeting:** | 15 January 2015 |
| **Subject:** | Primary Medical Services Co-commissioning |
| **Status:** | OPEN  CLOSED |
| **Agenda Section:** | STRATEGY  COMMISSIONING OPERATIONAL ISSUES |

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| **OBJECT OF REPORT** |  |
| This report is brought to the board in order to:   * Notify the board of the decision taken under Chairman’s action taken on 23rd December 2014 * Ask the board to consider and comment on the emerging proposals for local arrangements * Agree delegation of authority for finalising and submitting the application | |

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| **STRATEGY** |  |
| The effective commissioning of primary medical services is critical to the delivery of the local service strategy, and in particular the Healthy Lives Healthy Futures programme. | |

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| **IMPLICATIONS** |  |
| The enclosed papers provide an overview of key risks. | |

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| **RECOMMENDATIONS (R) AND ACTIONS (A) FOR AGREEMENT**  **The board is asked to** | | |
|  | 1. Note and ratify the decision taken by the Chairman on 23rd December 2014 to proceed with Joint (Level 2) co-commissioning arrangements for Primary Medical Services from 1 April 2015 2. Consider and comment on the emerging proposals for local arrangements 3. Authorise the Clinical Chief Officer to approve the content of the CCG application on 30th January 2015 |  |

|  |  | **Yes/No** | **Comments** |
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|  | Does the document take account of and meet the requirements of the following: |  |  |
| i) | Mental Capacity Act | n/a |  |
| ii) | CCG Equality Impact Assessment | n/a |  |
| iii) | Human Rights Act 1998 | n/a |  |
| iv) | Health and Safety at Work Act 1974 | n/a |  |
| v) | Freedom of Information Act 2000 / Data Protection Act 1998 | Y |  |
| iv) | Does the report have regard of the principles and values of the NHS Constitution?  [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\_113613](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613) | Y |  |

**PRIMARY CARE CO-COMMISSIONING DECISION AND SUBMISSION**

1. **Chairman’s Action**

In recent weeks a number of briefings and discussions have been undertaken with the limited information available at the time at Council of Members, with clinical leads, and with board lay members. However, the timescales recently set by NHS England for expressing interest in co-commissioning required the board decision to be made in advance of the 15th January 2015 board meeting. It was therefore determined that the decision should be taken through Chairman’s action. The embedded document was circulated to all board members on 19th December 2014 explaining the need for this approach, and requesting members to comment to inform the chairman’s decision.



On 23rd December 2014 the Chairman notified board members by email (below) of his decision that the CCG should progress an application for Joint co-commissioning arrangements with NHS England from 1st April 2015.

*Hi all, many thanks to those of you who sent your views on this important matter. I have also had further discussions with Peter Melton and Helen Kenyon.*

*There was a lot of mixed views on going for co commissioning at level 3 (full delegation) or level two (Joint with the Area team). There are clearly advantages and risks with both. One offers the chance of getting full control of the budget but comes with the requirement to manage the core contracts and some of the existing challenges faced by the Area team on our own with no extra resource. The other represents a more staged approach, working with the Area team, but creates a risk of not being in control of our budgets as we face an uncertain election year.*

*A number of soundings have been taken from NHS England, and various reassurances offered with regard to current funding being protected. On balance I have decided  we would be better off going for managing  the “PMS” / discretionary elements of the budget (level 2) and take the opportunity that will be provided to us after the election has taken place to reassess our position and if needed move on to full delegation (level 3) in 2016/17.*

*This is clearly the safer option and although we have never been an organisation to flinch from innovation, during these uncertain times proceeding caution is perhaps the best advice.*

*Regards Mark*

1. **Emerging Local Proposals**

The wide range of risks and benefits in Joint Co-commissioning are summarised in the annex to the embedded document above. The local arrangements will seek to mitigate the risks wherever possible (without reducing the potential benefits)

* 1. **National Requirements**

There are a number of NHS England requirements that have been set for the co-commissioning arrangements, but those enable a reasonably high degree of local flexibility for Joint arrangements. More details and background regarding general co-commissioning arrangements are available at <https://www.england.nhs.uk/commissioning/pc-co-comms/>

Recent national guidelines (including Conflicts of Interest and templates for Joint Committee Terms of Reference) that set out some key principles as follows:

* the membership of the committee should be constituted so as to ensure that the majority is held by lay and executive members
* the specific composition is a matter of determination for individual CCGs, subject to the provisions of their constitution. However, the chair and vice-chair must always be lay members of the committee
* a standing invitation must be made to the CCG’s local Healthwatch and Health and Wellbeing Board to appoint representatives to attend commissioning committee meetings, including, where appropriate, for items where the public is excluded from a particular item or meeting for reasons of confidentiality. These representatives would not form part of the membership of the committee
* as a general rule, meetings of these committees, including the decision-making and the deliberations leading up to the decision, should be held in public (unless the CCG has concluded it is appropriate to exclude the public)
* the arrangements for primary medical care decision making do not preclude GP participation in strategic discussions on primary care issues, subject to appropriate management of conflicts of interest
  1. **Local Governance draft proposal – Joint Committee**

The joint committee would be established across three organisations – CCG, NHS England and NEL council. Membership proposal is currently:

* Lay chair – one of CCG Governing Body lay members
* 2 NELC members
  + elected member nomination (potentially chair of H&WB board)
  + NELC officer (probably DPH/deputy DPH)
* NHS England representative
* 2 GPs
  + CoM chair/governing body vice chair
  + CCG clinical lead for primary care/CoM vice chair
* CCG Chief Financial Officer
* Community representative - nominated by CCG (Accord member)

Attendees:  Healthwatch representative, H&WB board representative (if not included above). There is also a suggestion that we may wish to have a local provider organisation representative either as a full member, or in attendance.

Quoracy : 4 (of 8), with at least two of the three member organisations represented and non-GP attendees being in the majority.

Frequency of meetings: minimum bi-annual (probably quarterly initially)

Advisory sub group: based on the existing CCG primary care (GP) development group, which has wide General Practice attendance as well as LMC, NELC and NHS England representatives.

* 1. **Local Governance draft proposal – Pooled funds**

A section 75 pooled fund is proposed, hosted by the CCG, which all three organisations may contribute to.

At 1st April 2015 NHS England contribution will not include core contract funding or primary care estate, but will include all other (discretionary) NHSE primary care budgets for NEL practices. CCG will contribute all its primary care budgets. NELC will not contribute at this stage.

A risk management protocol will be drawn up – content proposals are not yet agreed but they will include contributions, and management of overspends and underspends. For example:

* No organisation to take money out of pool in-year unless agreed by the joint committee
* The value of the contributions will be determined annually by the contributing organisation, but must reflect (at a minimum) the level of unavoidable cost commitment for services that the organisation is accountable for.
* Any in-year underspends will be ring fenced for investment in primary medical services, and their use determined by the joint committee
* Any in-year overspends that cannot be recovered in year or through use of prior year underspends will be shared between contributing partners (pro rata to the level of contribution to the pool)

1. **Submission Timetable**

By 30th January the CCG must agree with its partners the following documents for submission

* Submission summary
* Terms of Reference and Scheme of delegation for the Joint Committee
* Draft Section 75 agreement
* Governance arrangements including conflict of interest management and CCG constitution changes

A working group of the three partners has been established to develop these documents during January, and procedures for them to be agreed are in hand within NEL council and with relevant NHS England officers. It is proposed that the CCG Chief Clinical Officer is authorised to agree them on behalf of the CCG.