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Attachment 4

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| **Report to:** | NEL CCG Joint Co-Commissioning Committee  |
| **Presented by:** | Julie Wilson, Assistant Director Co-Commissioning |
| **Date of Meeting:** | 18th October 2016 |
| **Subject:** | **Update: Move to Fully Delegated Commissioning by April 2017** |
| **Status:** | [x]  OPEN [ ]  CLOSED |
|  | [x]  Complies with latest CCG Strategy for Primary Medical Services, if not, please give a brief reason why: |

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| **OBJECT OF REPORT:** |
| This report has been prepared to provide the Joint Co-Commissioning Committee with updated information to support a discussion to reaffirm the CCG’s decision to move to fully delegated commissioning of general practice services from April 2017. |

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| **STRATEGY:** |
| The detail contained within this paper describes how co-commissioning supports the delivery of the primary care strategy. |

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| **IMPLICATIONS:** |
| The process for CCGs to put forward requests to move to fully delegated arrangements for the commissioning of general practice services from 1st April 2017 has recently been published. CCGs have until 5th December 2016 to submit their applications. The proforma is embedded within this document, for information. NHS England’s Board states that it has committed to support the majority of CCGs to assume delegated responsibilities for the commissioning of primary medical services from 1 April 2017. It views delegated commissioning as being critical to local sustainability and transformation planning (STP), supporting the development of more coherent commissioning plans for healthcare systems, including the development of place-based commissioning, and giving CCGs greater ability to transform primary care services. In 2015 the CCG made a decision to move to fully delegated arrangements from April 2017. The paper that was considered at that time is attached as Attachment 1.Since that time, the following learning and/or changes that could impact on the move to fully delegated arrangements have occurred:1. Greater oversight and increased experience and knowledge of core contract issues within CCG: There has been a significant increase in the amount of joint working over the past year; for example, officers from both NHS England and the CCG have visited practices to discuss changes to contract, requests for mergers, requests for temporary list closures, etc. This has led to far greater local oversight of the core contract issues, as well as the development of processes and increased knowledge within the CCG team, some of whom have acted as though already operating within delegated arrangements. As such this has placed the CCG in a stronger position for fully delegated arrangements. However, in terms of capacity to deliver, there has still been a heavy reliance on the NHS England team staff members, particularly in relation to the background paperwork and detailed technical expertise on the contract, and the work has not as yet impacted to the same degree on the CCG’s contracting or finance teams. Continued support, potentially through alignment of current NHS England staff members across groups of CCGs, would therefore support effective fully delegated arrangements; otherwise the CCG will need to make a decision regarding a shift of resource to support the increased responsibilities.
2. ‘Level 2’ arrangements have provided the flexibility to deliver local strategy, but can be cumbersome: within the current arrangements, the CCG has the ability to agree with NHS England ways in which existing commissioning arrangements can be realigned to support the strategic vision. One specific example of this is the work we have done within this year on developing a single service specification, bringing together NHS England and local CCG specifications for supporting the most vulnerable and housebound patients to help avoid unplanned admissions. However, separate decision making processes meant that the pace was slower than expected and there is a transactional overhead in arranging for transfer of funding between the organisations. Neither of these issues would exist within fully delegated arrangements, therefore supporting swifter changes and less transactional overheads.
3. Progress towards an Accountable Care Partnership: The local system has made progress within the past year in moving towards an Accountable Care approach, with primary care as a key partner. Having full control over all general practice budgets provides greater local oversight and would fit with the ultimate aim of allocating a capitated budget to an Accountable Care Partnership, although there is no plan for including the core general practice contract within the scope of the ACP at this point. This therefore raises the question as to whether to establish new arrangements next year at CCG level, when this could ultimately change again soon after as new system arrangements develop, with either the ACP or strategic commissioner taking on responsibility. It is acknowledged that any management of core contract at a local level brings a requirement for revised conflict of interest arrangements.
4. General Practice Forward View: This emphasises and encourages new models of care for general practice, supported by new contractual models. Fully delegated arrangements potentially offer greater visibility and flexibility to develop alternative models at CCG level.
5. STP development: The workstreams within the STP have developed at pace over the last few months and the STP has a focus on ensuring new models of care across all CCG areas, with general practice being central to this. NHS England views delegated budgets as an enabler for new models of care and there is likely to be strong encouragement nationally, via STPs, for all CCGs to take on fully delegated arrangements as soon as possible. Two of the six CCGs within our STP are already operating fully delegated arrangements and the current understanding is that others have plans to take this on from 2017. There is the potential for the CCG to be out of line with the rest of the STP, which could impact on the support available via the STP.
6. Financial and resource position: The CCG’s financial position has worsened since 2015, increasing the potential impact of financial implications associated with fully delegated, such as increases in premises costs, etc, identified last year and set out within the attached paper. Clarification is needed from NHS England to confirm whether all financial and resource risks would transfer in full to the CCG (e.g. protracted legal costs associated with contentious practice closure action, additional capacity and support required to manage significant CQC/Quality investigations and action planning processes). Some risk mitigation may be possible, for example through collective risk management across the STP footprint – although it should be remembered that most parts of our STP health economy are facing significant financial challenges

The updates above have been provided to support the Committee members in reviewing and reaffirming the recommendation to move to fully delegated commissioning arrangements from 1st April 2017. |

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| **RECOMMENDATIONS (R) AND ACTIONS (A) FOR AGREEMENT:****The Joint Co-Commissioning Committee is asked to consider the updates and changes listed within the covering paper and provide a recommendation as to whether the CCG should continue with a move towards fully delegated commissioning arrangements from 1st April 2017.** |

|  |  | **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 | n/a |
| ii) | CCG Equality Impact Assessment | N | n/a |
| iii) | Human Rights Act 1998 | N | n/a |
| iv) | Health and Safety at Work Act 1974 | N | 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 |  |