Attachment 4

****

|  |  |
| --- | --- |
|  |  |
| **Report to:** | NEL CCG Joint Co-Commissioning Committee |
| **Presented by:** | Julie Wilson, Assistant Director Co-Commissioning |
| **Date of Meeting:** | 1st September 2015 |
| **Subject:** | Consideration of Fully Delegated Commissioning |
| **Status:** | OPEN  CLOSED |
|  | Complies with latest CCG Strategy for Primary Medical Services, if not, please give a brief reason why: |

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

|  |
| --- |
| **STRATEGY:** |
| The detail contained within the attached paper describes how co-commissioning supports the delivery of the primary care strategy presented to the Committee at the meeting on 23rd April 2015. |

|  |
| --- |
| **IMPLICATIONS:** |
| NHS England has recently issued guidance to CCGs who are currently operating level 2 co-commissioning arrangements regarding the process for submitting requests to move to level 3, fully delegated arrangements. CCGs must submit their documentation to request fully delegated arrangements by 6th November 2015.    The attached paper sets out how the two co-commissioning levels support the CCG in delivering the strategic vision, and provides information regarding the potential benefits, and risks, of both options. |

|  |
| --- |
| **RECOMMENDATIONS (R) AND ACTIONS (A) FOR AGREEMENT:**  **The Joint Co-Commissioning Committee is asked to discuss the detail contained within the attached report and provide comments and a recommendation to support the Partnership Board decision on 10th September 2015.** |

|  |  | **Yes/**  **No** | **Comments** |
| --- | --- | --- | --- |
|  | 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 |  |

**Fully Delegated Commissioning of General Practice Services**

**Background information**

Co-commissioning is a term that means NHS England and the CCG (and, in our case, the local authority) formally coming together to take decisions about the commissioning of general practice services.

The introduction of co-commissioning is a national initiative that is seen as an essential step towards expanding and strengthening primary medical care. It is one of a series of changes set out in the NHS Five Year Forward View, as a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It is also expected to drive the development of new models of service delivery and could potentially fit well within a locality that is operating an integrated health and social care commissioning model, such as ours.

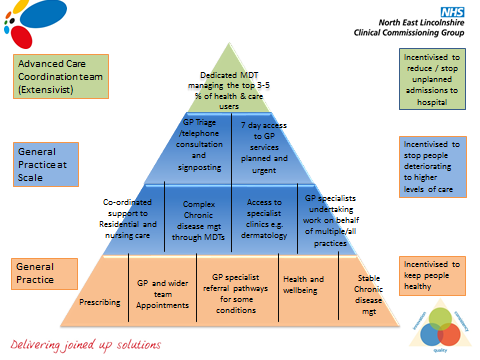
There is an expectation nationally that all CCGs will eventually assume fully delegated arrangements for the commissioning of general practice services. NHS England has recently published guidance to support CCGs in reaching a decision regarding their next steps for Co-Commissioning, and the CCG has to respond by 6th November 2015 if it wishes to move to the next level. The guidance is attached for information.

This paper has been prepared to provide information to support the CCG in reaching a decision regarding the application to implement fully delegated arrangements for the commissioning of general practice services effective from 1st April 2016. It will be shared and discussed with the Joint Co-Commissioning Committee and the Council of Members, prior to being taken to the Partnership Board Meeting on 10th September 2015 for a decision.

**Strategic Direction**

The NHS Five Year Forward View (FYFV) sets out how the NHS needs to change in order to respond to the current challenges – rising demand, changes in patients’ health needs and preferences, changes in treatments and technologies and changes in health services funding growth – and sets a clear direction of travel for the introduction of alternative care models. It is also very clear that list-based primary care will remain the foundation of the NHS, giving general practice an important and prominent role. For example, one of the proposed alternative models within the FYFV is a ‘Multispecialty Community Provider’ (MCP), combining GPs, nurses, other community health services, hospital specialists, mental health and social care.

The CCG’s local strategic direction aligns with the vision set out in FYFV and the local service strategy will see more care delivered within community settings and better integration of care between the various sectors and organisations. In terms of the implications for primary care, the strategy translates as follows:



This paper therefore focuses on how the current co-commissioning arrangements, and the potential fully delegated arrangements, enable the CCG to move towards this vision.

**Current arrangements**

At this moment the CCG is operating with ‘Level 2’ Joint Commissioning. This approach means that strategy, investment and dis-investment decisions are reached jointly between NHSE and the CCG and we have established a Joint Co-Commissioning Committee with membership from the CCG, NHS England and NEL council to oversee these arrangements.

The CCG already has direct involvement with general practice commissioning, in that it commissions a range of enhanced services and local services (formerly called Service improvement plans) and has responsibility for developing plans for the reinvestment of PMS premium funding. As part of the CCG’s statutory duty to support practice development and quality improvement the CCG has a GP Development Group and provides link individuals to groups of practices (‘Practice Advisors’). This is not overly burdensome, as the NHS England team deal with all of the transactional issues relating to the core contract, e.g. contract performance, issuing of breach notices, etc.

Through the current ‘Level 2’ arrangements the CCG has the ability to agree with NHS England ways in which existing funding commitments could be realigned to support the strategic vision, for example we are able to jointly review the enhanced services that are commissioned by both the CCG and NHS England and combine these with PMS premium funding to resource new specifications that better align with the vision above. Although the formal Committee arrangements have to allow NHS England the right of veto for decisions in areas for which they are accountable, that is only expected to be used if the decision would breach the regulatory or statutory requirements of NHS England. It is therefore highly unlikely that this would be used for decisions and plans that do not breach those requirements and demonstrate their alignment with the local CCG strategic direction.

Our ability to move forward with any changes to the services commissioned relies on timely exchange of information between the organisations, as we do not currently have access to the information regarding the services commissioned by NHS England, and the associated funding. Baseline information to support work in the current year is expected by the end of August 2015; inability to exchange information in a timely manner could impede our ability to agree any changes to realign funding to the strategic direction. While we continue to operate joint arrangements, with separate organisations using different systems, this could remain an issue.

In summary, while ‘Level 2’ does offer the flexibility to jointly agree the realignment of resources in line with the strategic direction, our ability to enact these changes could be hampered by our separate organisational arrangements.

**‘Level 3’ Fully Delegated Arrangements**

Under the ‘Level 3’ delegated arrangements NHS England still retains ultimate accountability and control of the decision about how much national resource is allocated to primary care, and of the core GMS/PMS contract terms and conditions. However, the responsibility for all the decisions – and risks – is fully delegated to the CCG.  The CCG would take on the responsibility for the commissioning of the core contract and the enhanced services that NHS England commissions. The associated funding would flow through the CCG ledgers, i.e. as part of our accounts, once NHS England has set the annual budget.

This arrangement would therefore involve the CCG taking on responsibility for the additional transactional work associated with the core contract management and monitoring (including payment), as well as quality assurance, such as the oversight and performance management of serious incidents, as we do for other contractors. The following functions would still remain with NHS England:

* Individual performer issues (responding to concerns)
* Performers List
* Complaints management

However, in terms of making changes in line with the strategic direction, this arrangement would mean that the CCG would be fully sighted on the totality of the services commissioned from general practice from NHS England and CCG resources, as well as having the funding flows directly to the CCG accounts. This would give the CCG greater control over making changes to the way in which services are commissioned to ensure that they better align with the strategic direction, potentially resulting in more swift action. It would also simplify the arrangements for the local practices.

The CCG also needs to be mindful of the potential impact of any additional financial risks that come as part of the fully delegated arrangements, for example increases in premises costs and any legal advice, which would need to be funded from the delegated resource and could potentially negate the flexibility in funding to support transformation.

Irrespective of the delegated arrangements, NHS England still has **accountability** for the core contract and unless this changes any significant decisions, such as termination of contract, would require some degree of joint discussion and agreement.

In summary, the full delegated arrangements would give the CCG greater ownership and control over the totality of resource and potentially enable more swift action to be taken to support transformational change. However, it would also bring additional risks that would need to be managed within the overall budget.

Appendix 1 sets out the benefits and risks of each of the two options open to the CCG, i.e. remaining ‘Level 2’ or assuming ‘Level 3’.

**Resources to support new arrangements**

Staffing

NHS England (North) provides support to 23 CCGs across Yorkshire & Humber with the North Yorkshire and Humber locality primary care commissioning team providing services to 8 CCG areas. As such, it benefits from economies of scale that are not possible at individual CCG level.

At the time of writing this report, it is unclear what support might be made available from within the existing NHS England resource, as this is still to be worked through based upon how other CCGs respond. However, NHS England has set out three employment levels for CCGs to consider as part of fully delegated arrangements, which are as follows:

1. Assignment – NHS England staff remain in current roles but are assigned to provide support to CCGs
2. Secondment – NHS England staff are seconded to CCGs that have been granted full delegation
3. Direct employment – NHS England staff have prior access to apply for posts created within CCGs

Options 2 and 3 rely on the CCG having the flexibility to create additional posts and this is unlikely for North East Lincolnshire as an individual organisation within the current running costs envelope. In addition, there is a body of specialist knowledge currently sitting within NHS England that the CCG would not wish to lose. The CCG would therefore consider option 1 and/or a shared arrangement with neighbouring CCGs. It is too early in those discussions to be definitive at this stage about what the arrangements for resourcing the work would be.

Whichever approach is adopted, there would inevitably be a significant shift of work from NHS England to CCG staff from a move to Level 3. This will impact on both senior and less senior staff as it will include matters such as being the first point of contact for all practice contract and payment queries, taking the lead on contract issues and management, and being responsible for handling all serious contractual or relationship concerns. Because the running costs of the CCG are fixed and fully committed, the CCG will need to determine what existing work is to cease to enable these commitments to be picked up.

Appendix 2 uses a generic example (investigating quality issues) to illustrate the differences between Level 2 and Level 3 on a practical level*.*

Finance

In Level 3 arrangements the budget delegated by NHS England will be determined by that organisation on an annual basis, reflecting national allocations and (if flexibility is possible within their overall resource) local plans and priorities.

Within that delegated resource there are opportunities to use the total resource more flexibly on a recurrent basis as outlined above, and some smaller delegated budget areas may offer in year opportunities for non-recurrent use if costs do not arise (such as seniority payments). The CCG will have delegated authority to make these decisions without NHS England involvement, which would offer opportunity to simplify the process and increase the pace of decision making – subject to having robust arrangements for managing potential conflicts of interest.

However, in year pressures on that delegated budget shall be the responsibility of the CCG to manage within its total financial plan. There are a number of known financial risks that might create such pressures including the regular programme of premises rent reviews, and legal costs associated with contract management disputes and breaches (which in significant cases may amount to ‘six figure’ bills continuing over more than one year).

**‘Checklist’ for submission of request to move to fully delegated**

NHS England has issued a checklist for CCGs to complete as part of their request to move to fully delegated arrangements, which is part of the submission for 6th November 2015. Once a decision has been reached, the CCG will therefore need to ensure the following:

* There are clearly defined objectives and benefits of the arrangement (agreed through the process of sharing this paper)
* Amendment to the CCG Constitution in line with NHS England guidance
* Governance documentation updated in line with NHS England guidance
* Conflict of Interest Policy reviewed in line with statutory requirements
* CCG Information Governance Toolkit must meet level 2 as a minimum
* The latest CCG assurance rating is included within the submission template
* A completed finance template is included, which sets out the full delegated budget

The final decision will also be dependent upon support from NHS England’s North (Yorkshire and Humber) Director of Commissioning Operations, who is required to confirm that:

* the CCG demonstrates appropriate levels of sound financial control and meets all statutory and business planning requirements.
* the CCG is capable of taking on delegated functions

**What is the Council of Members view?**

[to be completed following discussion on 3 September].

**What is the Joint Co-Commissioning Committee’s view?**

[to be completed following the Joint Co-commissioning Committee discussion at its extraordinary meeting on 1st September 2015].

**Appendix 1: Benefits and Risks**

|  |  |
| --- | --- |
| Remain as Level 2 – Joint Commissioning | Assume Level 3 – Fully Delegated |
| Benefits:   * Shared reputational risk within the health system (public/media will – as now – view it as the CCG) * Clearer management of Conflicts of Interest due to 3 organisations (CCG, NHS England and NELC) having membership of a Joint decision-making committee * Opportunity for partnership working and better communications/understanding between the 3 organisations * Agreement of aligned single local strategy for primary care – with better potential to feed ‘upwards’ to inform national NHSE view * Practice performance contractual issues dealt with by NHS England (these are very time consuming - with no positive or strategic impact) * Local resource and effort focussed on making positive and strategic change * Risks from financial and allocation ‘business rules’ imposed on NHS primary care funds stays with NHS England. * CCG HQ staff not in the (potentially) confusing position of being ‘performance regulator’ and ‘developer’ for member practices * Opportunity for practice contracts to be simplified into two – ‘core’ (with NHSE) and ‘all other’ (with CCG) | Benefits:   * Full resource is allocated and managed by the CCG, with no opportunity for NHS England intervention in-year (unless there is mis-management or similar crisis intervention) * Raises profile as lead commissioning organisation * All responsibilities are delegated to CCG – simpler to explain to all stakeholders, and for practices to understand and respond to. * Full ownership of the primary care agenda by the CCG * Full control of strategic direction and decisions at local level * Enables a single NHS contract framework with each practice (and opportunity to include NELC contracts) * Supports the opportunity to explore the devolution model if desired * We anticipate increasing funding in future years will lie outside core contracts in the future, so may be easier to manage ‘one pot’ * Some small potential to benefit from PCO budget underspends (unpredictable budget which can overspend too) * Easier for staff and stakeholders to understand the commissioning arrangements |
| Downside/risks   * Reputational risk to CCG of not taking on fully delegated, when this is expectation of direction of travel * CCG not in full control of decisions – the Joint Committee will decide * CCG not fully sighted on all aspects of general practice commissioning, and less direct influence to enact commissioning changes in line with strategic direction * No potential to benefit from PCO budget underspends (unpredictable – can overspend too) * No workforce or relaxation of running cost constraints to take on additional responsibilities in 2016/17 * NHS England may have the ability to change funding in year e.g. to withdraw funds to cover pressures elsewhere   Mitigation of last risk:   * NHS England has given explicit guarantee that CCG primary care funds (as determined by allocation formula) will be spent within that CCG and not moved elsewhere * NEL PMS premium funds are formally ring-fenced to NEL * The section 75 agreement terms can reduce this risk e.g. by requiring Joint Committee agreement to changes to pool funding | Downside/risks   * Full reputational risk lies with CCG * More problematic management of conflicts of interest * Practice performance contractual issues can incur significant legal costs – up to and including Barrister fees – that have to be funded for CCG *and* Practice * CCG HQ staff are in the (potentially) confusing position of being ‘performance manager’ and ‘developer/supporter’ for member practices * Time spent on managing practice performance contractual issues (although these could be addressed through a shared resource with other CCGs) * Risks from financial business rules and allocation changes due to being ‘above target funding’ rests with CCG * Risks from financial pressures pertaining to increases in rents and rates on primary care premises (this is a risk that NHS England carries now, but across a greater footprint and therefore with more flexibility) * No workforce or relaxation of running cost constraints to take on additional responsibilities in 2016/17 – and workload under delegated option will be much higher than under Joint. This could be mitigated through ‘assignment’ of existing NHS England staff to groups of CCGs. |

**Appendix 2**

**Investigating safety concerns – Level 2 requirement:**

* NHS England senior nursing, commissioning and medical team members responsible for investigating concerns (could range from half day to multiple days, depending on issues)
* NHS England responsible for leading and co-ordinating input of other stakeholders, including external bodies such as CQC, into formal quality review meetings – **CCG involvement**
* NHS England responsible for leading and convening multi-disciplinary and multi-organisational meetings to ensure appropriate involvement in discussions and agreement of next steps – **CCG involvement**
* NHS England responsible for drawing up and issuing appropriate contract notices, such as breach notices, and ensuring legal input where necessary

*If the end result is termination of contract:*

* NHS England responsible for ensuring adequate arrangements in place with alternative provider, and for providing support to transition arrangements, including on site presence of senior staff – **CCG input**
* NHS England lead evidence gathering , documentation and legal processes including preparation and attendance at court proceedings where necessary
* Multiple NHS England senior staff meetings to manage the process, risks and legalities involving medical, nursing/quality and commissioning directors and senior officers
* NHS England responsible for leading arrangements to secure longer term arrangements for the patient list, including procurement exercise where this is the desired approach
* NHS England responsible for all associated costs (interim practice cover, legal advice, procurement process…)

**Level 3 requirement:**

Essentially, the fully delegated arrangements would require the CCG to take the lead on all of those areas outlined above where NHS England is currently the lead. Input from NHS England would still be expected in terms of professional advice and support from a medical and nursing perspective. There could also be an assigned/shared commissioning resource, with the knowledge and expertise of handling such issues, but these arrangements are still to be worked through (as identified earlier).

Because the running costs of the CCG are fixed and fully committed, the CCG will need to determine what existing work is to cease to enable the additional commitments of Level 3 to be picked up.