SUBJECT: Primary Care Commissioning

1. Synopsis

1.1 This report provides an update on the consultation being undertaken by North Central London (NCL) CCG’s with members and stakeholders in order to submit an expression of interest to take on full delegation of primary care commissioning from April 2017.

1.2 A recommendation will be taken to Governing Bodies in November 2016 following the outcome of the consultation process.

2. Recommendations

2.1 To note the contents of this report and the consultation undertaken to date.

3. Background

3.1 The North Central London CCGs began primary care co-commissioning with NHS England in October 2015, and formed a Primary Care Joint Committee (PCJC) to oversee this new area. In April 2016 the PCJC held a workshop to discuss how the Committee was progressing and to explore the possibility of moving to ‘delegated’ commissioning arrangements for primary care from April 2017. This would mean CCGs are formally delegated primary care commissioning responsibilities from NHS England, rather than taking joint responsibility with NHS England.

3.2 The PCJC agreed that further consideration be given to requesting delegated commissioning in North Central London. They felt there were potential benefits that needed further exploration, as well as recognition that this is a national direction of travel. The Chairs and Chief Officers of North Central London CCGs agreed to support further work on this.
3.3 A programme of work commenced to consider an application to move to delegated commissioning (application to be submitted in December 2016) which included a programme of engagement with a variety of key stakeholders, including GP practice members and other partners. There was also an assessment of the risks, as well as an option appraisal of the various governance models.

3.4 Since moving to primary care joint commissioning arrangements with NHS England, NCL CCGs have experienced greater involvement and transparency around primary care contracting decisions. For example, CCGs have been involved in contracting discussions at an earlier stage and this has enabled local knowledge to be used to inform the decision making process and to provide support to practices more quickly.

3.5 Building on existing joint commissioning arrangements by moving to fully delegated primary care commissioning is seen as the direction of travel for all CCGs across London and nationally. The NHS Five Year Forward View signals a clear and continued shift towards commissioning based on the specific needs of a local area and its patients. For NCL, for example, developing population-based contracts to deliver health outcomes for the local population is a key priority for ensuring that patients are provided with accessible care, proactive care and that they are supported to care for themselves.

It is anticipated that moving to delegated primary care commissioning would open up a range of opportunities for NCL CCGs:

- We would be better positioned to exercise our duty to ensure continuous improvement in the quality of services provided to our local population e.g. by local decision making on investment priorities and by being able to provide support more quickly;
- We would be uniquely placed to take a whole-system approach to commissioning, bringing about the necessary shifts in secondary care utilisation described in the NCL STP;
- We would be able to have increased clinical leadership and public involvement in primary care commissioning, enabling more local decision making;
- We would be able to use our local knowledge and relationships with patients and local communities to commission in a way that reflects the needs of local people;
- We would be able to maximise our relationships with health and wellbeing board members, our Healthwatch representatives and with local communities to ensure local people are engaged in transforming services in their local area.
- We would be able to forge a collaborative approach to working with CCG constituents to deliver the best possible approach to improving access to GP services locally;
- We would be able to design local incentive schemes which align to our NCL STP. This will minimise duplication or waste of funds on overlaps;
- We would be able to commission primary care services in a way that supports our integrated care programme as we would have an overview of the health system locally;
- We would be able to work together more effectively across NCL to support practices to achieve the specifications within the Strategic Commissioning Framework for Primary Care Transformation in London, which will improve access, proactive care and co-ordination of care for our patients as well as ensuring we develop our workforce, premises and technology and information systems;
- We would be able to progress new commissioning models such as value based commissioning that cannot be achieved without integration of services across care providers;
- We would be able to have greater freedom in planning and investing in our primary care workforce, ensuring that we retain our best staff, develop the staff we have and ensure a
greater clinician to patient ratio and thus lead to greater continuity of care and satisfaction for patients;

- We would be able to more effectively share best practice across NCL;
- We would be able to offer greater transparency around decision making.

3.7 However, alongside the opportunities for transformation and improving the quality of primary care through greater local control of primary care, there are some key risks and issues to consider:

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<tr>
<th>Area</th>
<th>Identified Risk</th>
<th>Mitigation / Comment</th>
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<tr>
<td>Resourcing</td>
<td>The existing primary care contracting service provided by NHS England (London region) is already stretched.</td>
<td>There may be opportunities to realise greater efficiency in the way in which the current contracting team operate. NHS England are currently carrying out an organisational review of the primary care contracting function. It is anticipated that CCGs will be allocated a share of existing NHS England staff at NCL level.</td>
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<td>If NCL CCGs were to deliver a primary care contracting service over and above what is currently provided it will require investment in to the staffing of the team.</td>
<td>It is acknowledged that to realise the ambition of the STP the CCGs will likely need to invest resource to ensure we are better able to proactively support improvements in primary care services in NCL. There may be external funding streams to support this such as NHS England’s practice resilience fund and wider STP funding.</td>
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<td>Primary Care Budget</td>
<td>No additional funding (over the core primary care budget) will be available to implement improvements in primary care and CCGs would assume responsibility for budgetary pressures, deriving from commissioning primary care, including Quality, Innovation, Productivity and Prevention (QIPP) efficiency savings. CCGs may inherit existing liabilities (such as contract disputes) or material financial commitments (e.g. in relation to premises agreements).</td>
<td>These issues will need to be addressed through the CCG’s due diligence process (expected to be completed in mid-October 2016). Where financial risks are identified, CCGs will need to consider how these can be mitigated (or not). NHS England have indicated that money has already been accrued against existing financial risks such as QIPP and contract disputes.</td>
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<td>Conflicts of Interest</td>
<td>Taking on the commissioning of primary care, could create perceived or actual conflicts of interest for GP commissioners.</td>
<td>The proposed governance structure includes a number of mitigates such as ensuring a pool of out of area clinicians are available in circumstances where NCL CCG clinicians are conflicted. In addition, the operation of a Committee in Common across NCL further enhances the management of conflicts by supporting transparency and benchmarking in decision making as CCGs will make decisions in front of each other. NHS England published new conflicts of interest guidance for CCGs in June 2016 including specific recommendations for primary care committees. These are being incorporated into the NCL Conflicts of Interest Policy.</td>
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There may be a perceived tension between CCGs operating as member organisations and performance managing members. CCGs already have a statutory duty to support NHS England in managing the quality of GP practices. Individual GP performance will remain a responsibility of NHS England’s Medical Directorate. Under delegated primary care commissioning, day to day contracting activities will be managed against national contracts supported by national and regional standard operating procedures and by a team employed by NHS England working across North Central London, as is currently the case.

Engagement activities have been carried out throughout May-August 2016. The engagement period provided an opportunity for stakeholders to share their views and identify those areas where further information will be required through the due diligence process. In general stakeholders have been supportive of a move to delegated commissioning and have acknowledged this as the direction of travel for all London CCGs.

Table 3 below summarises the feedback received by each CCG area.

Table 3. Summary CCG feedback for delegated commissioning

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<th>CCG</th>
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<td>Islington</td>
<td>Islington clinicians were positive towards a move to delegated commissioning. Clinicians noted the benefit of having greater control of primary care contracting and the ability to bring about shifts from secondary to primary care. Healthwatch were also supportive, albeit asked that great care and thought be given to the relationship between the CCG and practices and the need for transparency and management of conflicts of interest. The LMC felt that they needed more information to inform their feedback, however their initial feedback suggested concerns regarding the resource/capacity to deliver the function. The chair of the Health and Wellbeing Board acknowledged risks relating to the resource required to undertake delegated commissioning but supported the direction of travel to have more local influence in primary care commissioning.</td>
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<td>Camden</td>
<td>The LMC felt that they needed more information to inform their feedback, however their initial feedback suggested concerns regarding the resource/capacity to deliver the function. Similarly, practice and public forums have focused on the resource/capacity issue picked up by the LMC. Practices also were concerned about how the CCG would deal with performance management of practices.</td>
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<td>Barnet</td>
<td>Information shared with stakeholders, no specific concerns or feedback raised by GP practices, Healthwatch or the Scrutiny Committee. The LMC and practice managers’ forum expressed the need to ensure there is enough resource/capacity to deliver the function. The last meeting of the GB members were interested to better understand the rationale for choosing the Committee in Common governance structure.</td>
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<td>Enfield</td>
<td>Enfield’s LMC and Locality events both felt strongly that the Committee needed not to lose the Enfield voice in discussions about improving primary care. The practice managers and nurses forums welcomed the changes, however flagged the need to ensure there is enough resource/capacity to deliver the function.</td>
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<td>Haringey</td>
<td>Similar to other areas, concerns focused on the resource/capacity to deliver the function. Haringey practices and practice staff welcomed the opportunity to gain greater control, particularly over the primary care budget. As with Enfield, there was a concern that Haringey needed not to lose its voice in discussions about primary care across NCL. The LMC discussion noted the benefit of greater local autonomy, however flagged a concern with any pooling or spreading of funds originally allocated for Haringey CCG.</td>
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As part of the engagement work to understand local views Camden Member practices have now voted on whether to become fully delegated primary care co-commissioners. The ballot closed on 5th
September 2016. Unfortunately out of the 35 practices in Camden, 24 voted yes which was three short of what was required (75% of practices). The CCG continues to work with its member practices on a proposed way forward but at the moment has no mandate to propose delegated commissioning.

3.11 We are now taking stock of our options e.g. to remain at level two, to submit a proposal for four of the CCGs in NCL. NHS England have indicated that the deadline for expressions of interest is early December. Therefore we want to take the next few weeks to explore options with the intention of submitting a proposal to CCG governing bodies in November.

4. Implications

Financial Implications:

4.1 NHS England worked with external consultants appointed by South West London CCGs to complete their financial due diligence prior to taking full delegation in April 2016. The final report was helpful in high-lighting contractual risks that the CCGs may face, but these were identified by NHS England. Learning from this exercise, advice from NHS England has been that commissioning an external financial due diligence exercise to support the CCGs decision is not the most effective use of resources or a necessary step to identify risks and mitigations.

The Healthy London Partnership are therefore proposing to support NHS England and the NCL CCGs to carry out a review and ensure any known cost pressures, such as outstanding District Valuer (DV) claims or historical contract issues are identified and the ownership clear.

Where appropriate, NHSE will ensure sufficient provisions are made in 2016/17 to cover the financial risks of liabilities that the CCGs may incur, which relate to the period prior to NCL taking full delegated responsibility. In addition, NCL have the opportunity through the current organisational development review to establish a Primary Care commissioning structure that supports their future management of Medical Services commissioning and budget management within the published allocations.

Legal Implications:

4.2 NHSE remain holders of the national contract with primary care contractors but with decision making at an NCL level. Further due diligence will be undertaken to ensure conflicts of interest are managed.

Environmental Implications:

4.3 There are no environmental implications directly arising from this report.

Resident Impact Assessment:

4.4 The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

There are no resident impact implications arising as a result of delegated commissioning.

5. Reasons for the recommendations / decision:

5.1 CCG’s have been asked by NHSE to consider moving to delegated commissioning where they have not yet done so. The NCL Primary Care Joint Committee agreed to support consultation with member practices and stakeholders.
5.2 A programme of work has overseen the delivery of consultation as well as a number of work streams, including one to consider governance arrangements and the management of conflicts of interest.

5.3 Recommendations were due to go to Governing bodies in September 2016. However, as Camden continue to work with their GP members the will be taken to the November Governing Body meetings.

5.4 This report has provided an update on the process and consultation undertaken.

Final Report Clearance:

Signed by:

Alison Blair  
Chief Officer  
Islington Clinical Commissioning Group  
Date: 20.09.16

Appendices: None

Background Papers: None

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