Primary Care Commissioning in North West London

NHS Harrow CCG

Exploring delegated commissioning

November 2016

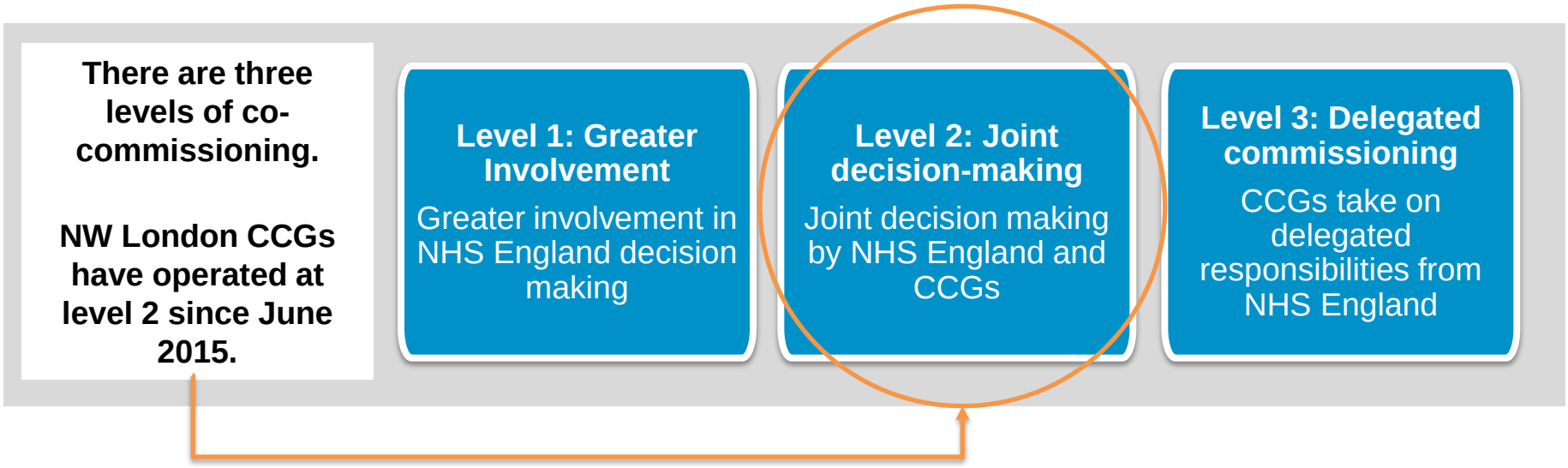
Where are we now?

NHS Harrow Clinical Commissioning Group

Currently NHS England (NHSE) has responsibility for commissioning and management of core primary medical services. They also commission enhanced services, manage the primary care budget, manage patient communications and complaints, estate and revalidation, appraisal and performance. They retain 51% decision making under level 2.

CCG members across North West London (Brent, Harrow, Hillingdon, Ealing, Hounslow, Hammersmith & Fulham, Central London and West London) need to determine whether to move to delegated commissioning – the greatest level of responsibility for primary care commissioning

Initial applications are due on 05 December 2016 for interested CCGs. Any applications submitted are subject to a vote of Member Practices



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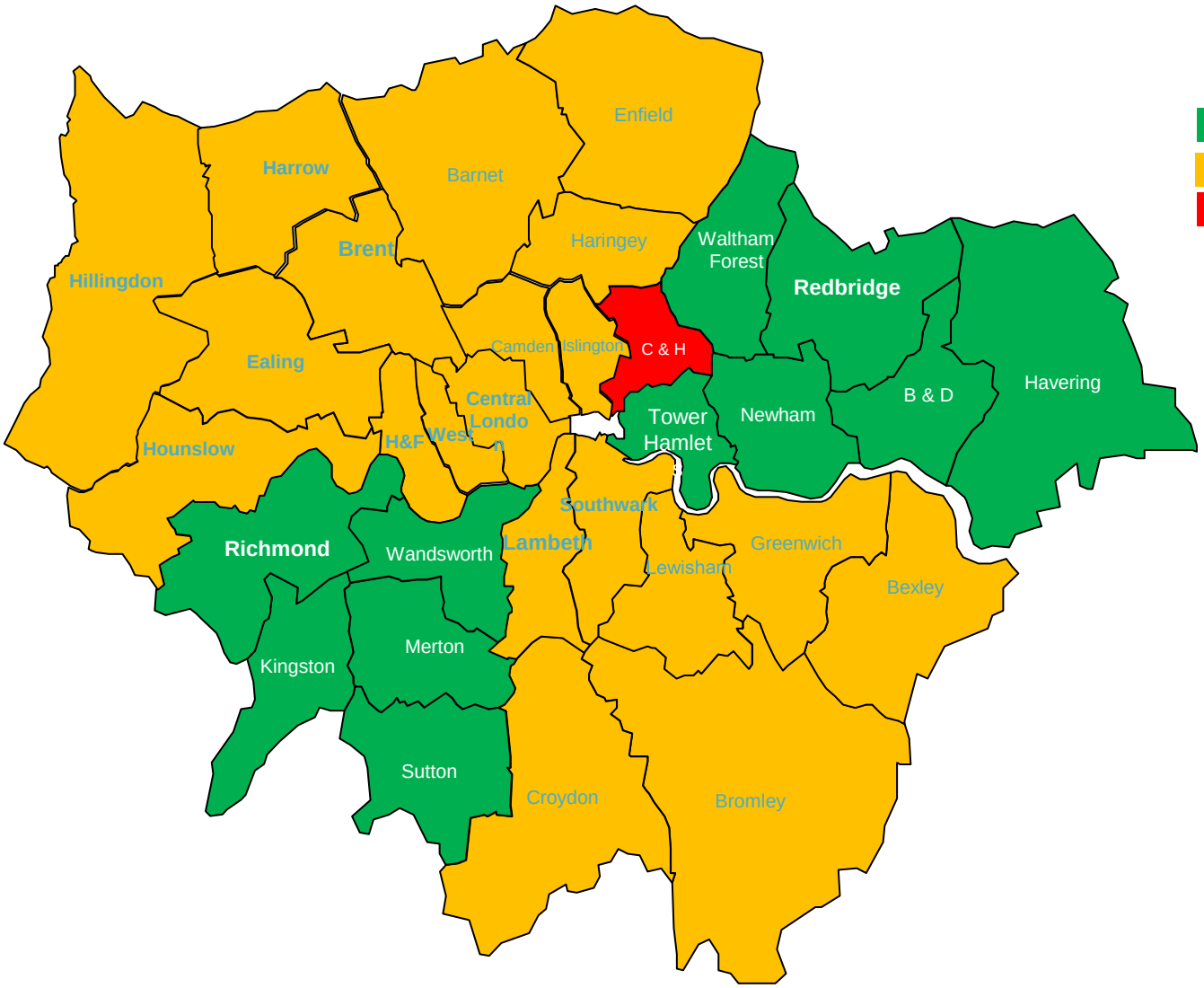

- Delegated (level 3)
- Joint (level 2)
- Greater Involvement (level 1)

- **11 CCGs** are fully delegated (level 3)
- **20 CCGs** are joint commissioners (level 2)
- **NWL, NCL & SEL CCGs considering** going for full delegation from April 2017
- **Nationally 114/209 CCGs are currently Level 3.**

What functions would be delegated?

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CCGs that move to fully delegated arrangements will be responsible for the management of the duties previously carried out by NHS England & their own statutory duties.

Newly Delegated Functions	Reserved NHS England Functions
GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing breach/remedial notices, and removing a contract)	Management of the **national performers list**
Newly designed **enhanced services and local incentive schemes** ("Local Enhanced Services (LES)" and "Directed Enhanced Services (DES)")	Management of the **revalidation** and **appraisal** process
Financial management of primary care budget	**Administration of payments** in circumstances where a performer is suspended and related performers list management activities
Ability to establish **new GP practices** in an area	**Capital expenditure** functions
Approving **practice mergers & closures**	**Section 7A** functions (e.g., screening and immunisation)
Making decisions on **'discretionary' payments** (e.g., returner/retainer schemes)	Functions in relation to **complaints management**

NWL Consideration of Level 3 – Delegated Commissioning

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- Expectation of CCGs, outlined in the FYFV and seen as key to delivery. NHSE keen all London CCGs move to Level 3 from April 2017.
- NWL Collaboration Board 29th September – agreed to engage member practices on the option.
- Engaging across all 8 CCGs with oversight across NWL – Locality meetings and GP Forums underway
- Any NWL application is subject to a formal vote – confirmed by NHSE
- Primary Care leads meeting weekly
- NHS NWL Local Services team supporting planning & comms
- NWL Finance and Governance leads involved in planning and due diligence
- Londonwide & local LMCs invited to contribute views
- Patient information & engagement plans also being developed with NWL Lay Partners Advisory Group (LPAG)

What are the pros and cons?

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Opportunities/Benefits	Risks /Issues
• GPs in CCGs will have more direct influence over investment in general practice. • Ability to redesign local schemes to replace QOF and LES contracts based on local knowledge. • Ability to use innovative commissioning approaches to implement local priorities - set commissioning intentions that cover key primary care issues such as workforce resilience. • Tailored services to meet the local needs of the population. • Opportunity to develop and commission end to end care and integrated out-of-hospital services & drive the Five Year Forward View agenda. • Could drive outcomes based commissioning in primary care by aligning outcome measures and incentives used in PC.	• Resources to deliver/resource intensive e.g contract management & complaint handling and increased expectations from NHSE. • Performance management could cause tension between the CCG and its Members - anxiety about the CCG performance managing practices. • Failure to deliver will undermine the primary care transformation plan. • Reliant on IT and practice data sources being shared outside of Primary Care. • There are governance rules in terms of GPs not being able to make certain decisions: strengthened and transparent processes for decision-making will be needed that avoids this but retains the advantages of the clinically led model. • Perceived conflicts of interest.

Harrow process & key milestones (Sep-Nov 16)

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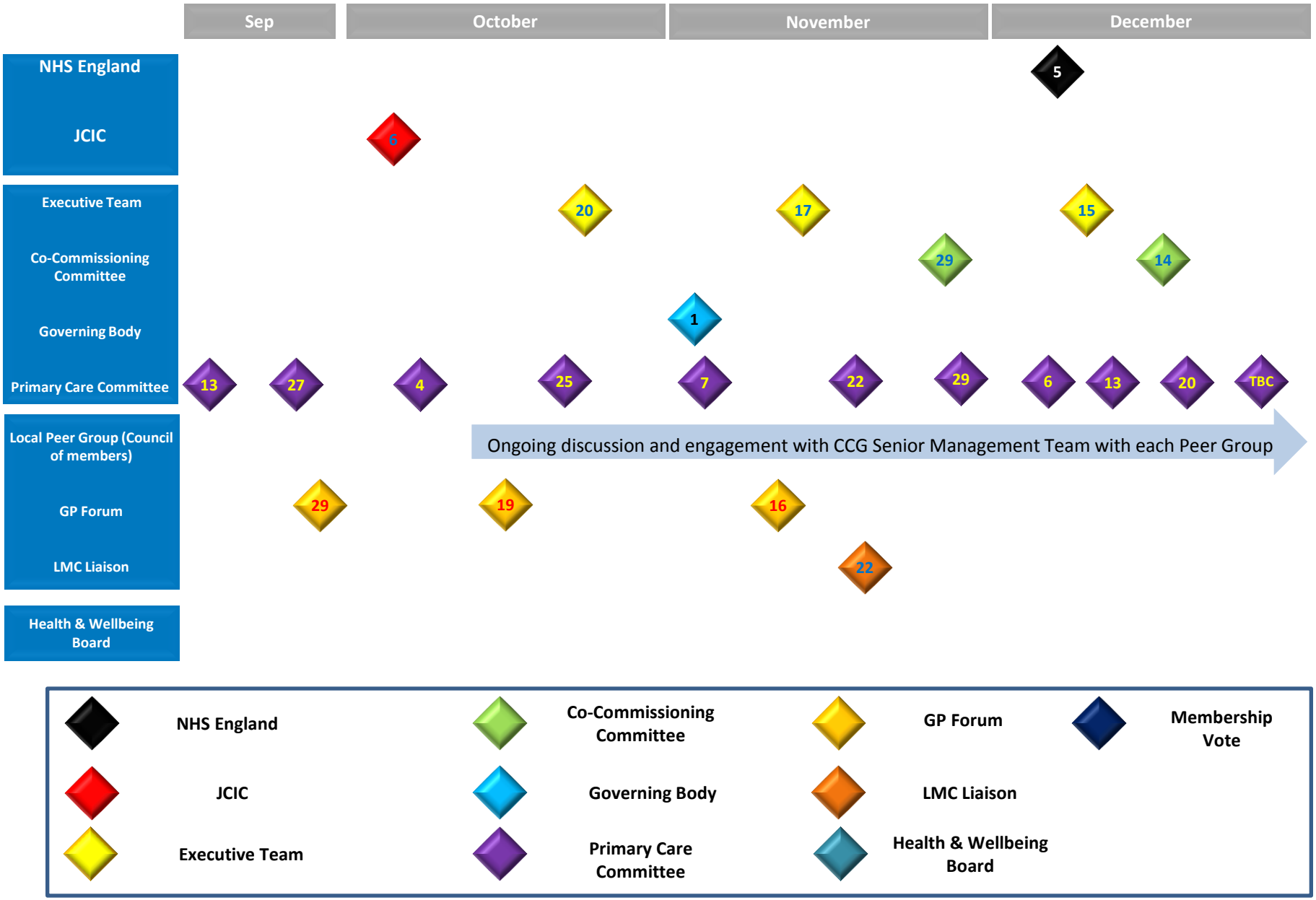

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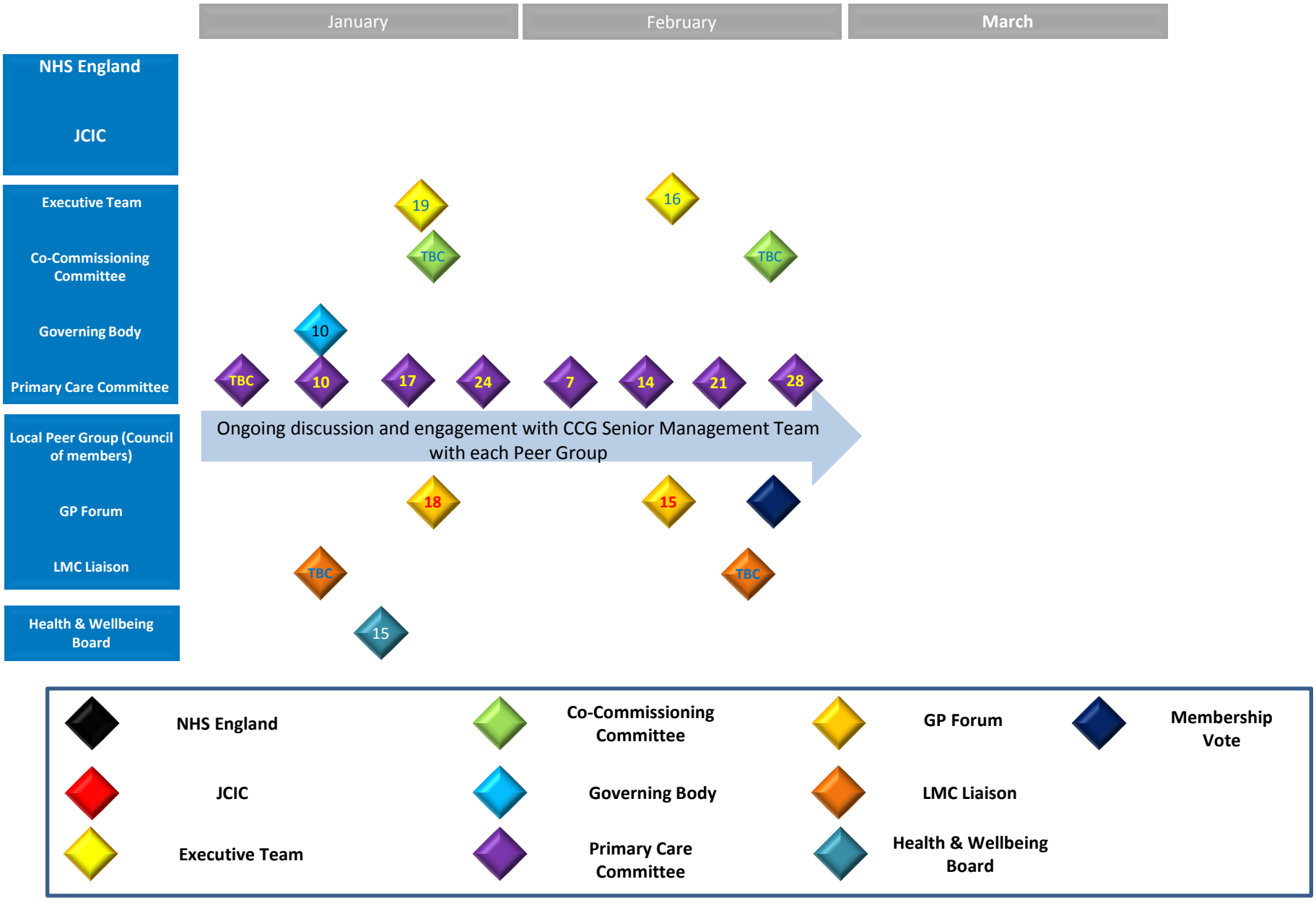

Qu's from member practices – *will the CCG have sufficient capacity*?

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- Capacity is a challenge we would need to address
- NHSE has commissioned an external organisation to develop options for a NWL Operating Model; this wont be final until we know how many CCGs decide to go to level 3 in 2017
- Considering - functions, processes, teams, roles, skills and the structures in which these would be organised
- Likely elements of Primary Care commissioning will be organised at NWL level (contract mngmt), others may stay centrally (eg Medical Directorate, BI/analytics)
- Would be challenges in the first 12 months as any new model embeds
- Due diligence will include consideration of which teams would play a part eg Primary Care team, Finance, Procurement, Comms & Engagement

Qu's from member practices – *what are the plans for governance?*

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- CCGs are acutely aware of the need to manage real or perceived conflicts of interest.
- Governance leads are working on the implications and looking at models in place elsewhere.
- In areas with delegation out of area GPs and Lay members ensure the GP and patient voice remain heard.
- NWL Joint Co-Commissioning Committees in Common (JCiC) would be reviewed but a NWL-wide body would remain to support alignment across 8 CCGs (decision making is CCG level).
- Due diligence by Governance leads will include pathway for different types of decision.

Qu's from member practices – *what are the financial implications?*

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- Under full delegation CCGs would receive the total published allocation and have access to the contingency and 1% non-recurrent reserve (within the business rules).
- CCGs will have more opportunity to commission models of care that span sectors - primary, community, secondary, mental health.
- Locally decisions can be made about use of funding spent by NHSE on enhanced services (DES, QOF alongside LIS).
- We have heard the need for assurances regarding the primary care budget and whether ring-fenced – primary care monies cannot be used to plug gaps in other budgets.
- Due diligence will need to assess current and future liabilities.

Qu's from member practices – *What due diligence will be done..?*

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- BHH CCGs are appointing external capacity & expertise to support.
- With it comes experience of undertaking due diligence to inform the move to L3-Delegation in other CCGs.
- Will help us identify, understand and mitigate risks and develop a robust transition plan and acceptable ongoing risk profile.
- Will include
  - review of historical financial performance (core contracts, QOF, DESs, LES, discretionary payments, premises costs) over the last 3 years.
  - Consideration of implications for current budget setting process and any implications for future years including any risks from budget transfer known (or likely).
  - current contractual arrangements and any risks associated with transfer including contract renewal dates.
  - Identification of any known regulatory, quality or service issues relating to the services being delivered under the transferring contracts.
  - assessment of the level of resource currently engaged in the management of contracts for core and state of readiness of the CCG.

Qu's from member practices – *how will this improve patient care?*

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- Opportunity to set priorities and commissioning intentions locally based on local needs
- Opportunities to look at primary care offer in totality and to design services alongside patients, carers and practices
- Supports development of new and integrated models of care
- Supports consistent and equitable offer for Harrow patients, at-scale working and high quality care across the patch
- More control over local investment in primary care
- Less fragmented system for patients when they need advice or wish to raise issues
- Doesn't detract from patient care in any way, but has potential to improve it