REPORT TO HEALTH AND WELLBEING BOARD

Title: GP/CLINICAL COMMISSIONING - UPDATE ON PROGRESS

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Wards affected: Affects the entire Borough.

1. SUMMARY

In the Health and Social Care Bill that is currently before Parliament, the coalition government proposes that GPs should play a leading role in commissioning health services on behalf of their local populations. This paper describes the work that has taken place to date to introduce GP-led commissioning in Windsor, Ascot and Maidenhead. Note that as a result of the "pause" and "listening exercise", these bodies will be known as clinical commissioning groups once they become statutory bodies.

2. RECOMMENDATION

That the Health and Well-Being Board **(i)** notes the work that has been undertaken to date, **(ii)** recognises the challenges that are faced in managing the changing environment and **(iii)** considers the opportunities presented by new approaches to the commissioning of health care.

What will be different for residents as a result of this decision?
The structural changes remain at a very early stage and the Health and Well-Being Board has an important role to play in supporting integration of services, where appropriate, and in ensuring that care is well-designed to meet the needs of local residents.

3. SUPPORTING INFORMATION

3.1 Background

The Department of Health allowed general practitioners considerable flexibility with respect to the timing and the composition of the introduction of shadow GP commissioning bodies. As a result, they are at very different stages across the

country, often reflecting the level of engagement in the predecessor scheme which was called Practice Based Commissioning.

The twenty Windsor, Ascot and Maidenhead practices (note that three Ascot practices are aligned with Bracknell - see 4.1 below) chose not to be among the forerunners, preferring to take a measured approach. In particular, they recognised the importance of building up grass roots support for this new way of working. They also appreciated that amendments to the proposals were likely as the Bill makes its way through Parliament.

3.2 The Development Panel

The Development Panel was formed in March 2011, bringing together six GPs to lay the foundations for the formation of the shadow commissioning consortium. Its members have met on a weekly basis and have begun the process of engaging with stakeholders, including the local authority, GP surgeries, patient organisations, acute providers, the PCT, the Strategic Health Authority and other locality commissioning groups.

3.3 Forming a shadow organisation

This shadow body will be a sub-committee of the Berkshire East PCT and will have no statutory powers. Over time, it will be delegated an increasingly important proportion of the indicative budget. Shadow consortia can only become statutory bodies after receiving authorisation from the NHS Commissioning Board. This will happen no earlier than April 2013.

3.4 Emerging principles

The Development Panel has articulated a number of key principles which it believes should underpin the work of the shadow commissioning consortium. These are:

- that services should be designed around the needs and real experiences and lives of patients and this will require greater integration than is currently in place

- that clinical leadership of service development can bring important improvements, but this will require clinicians to work collaboratively across organisations and with other disciplines

- that education has a critical role to play both in improving the quality of care and, crucially, in ensuring that changes to pathways etc are successfully implemented

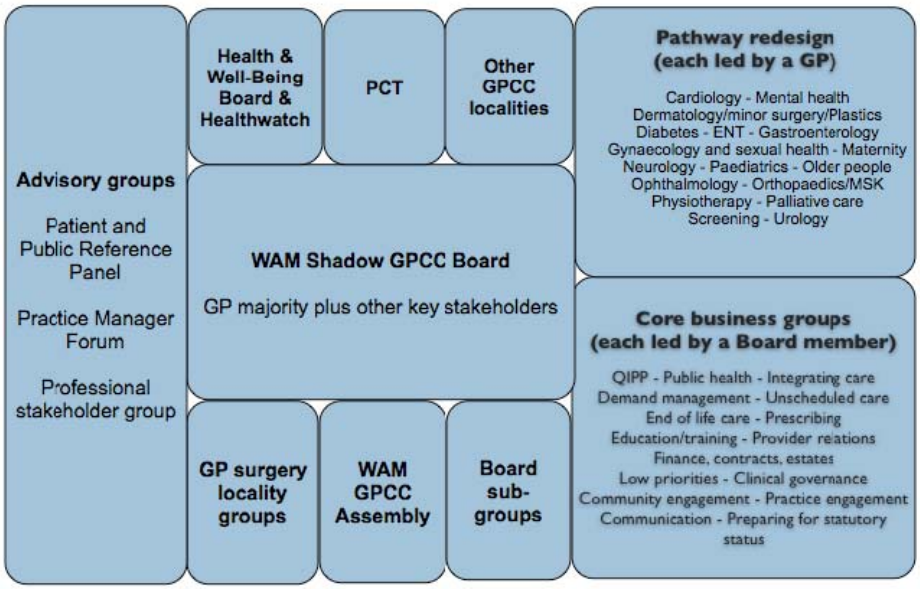
- that the genuine engagement of GP surgeries is critical, drawing on their skills and encouraging them to take an active part in the life of the commissioning consortium

- that the shadow organisation will require highly skilled managers who are able to work effectively within less bureaucratic structures

3.5 Emerging structures

The process to draft a Constitution for the shadow commissioning consortium has been complicated by the uncertainties surrounding national policy. It is also important to note that the shadow organisation should not necessarily mirror that which is expected of the statutory body since their functions are not identical.

Draft Structure for the Windsor, Ascot & Maidenhead Commissioning Consortium



The above diagram represents current thinking and the Development Panel would welcome feedback on this outline from the Health and Well-Being Board.

The shadow commissioning consortium will have an important role to play in supporting the PCT to implement its QIPP plan (Quality, Innovation, Productivity and Prevention) and to work alongside practices to meet the requirements of the Quality Outcomes Framework (which includes new sections relating to referrals, prescribing and emergency admissions). Engagement with practices is critical in both areas and so the WAM GPCC Assembly, bringing together practices from across the patch, will have a crucial role to play in driving the organisation,

As a sub-committee, the organisation will be accountable to the Primary Care Trust. The Development Panel fully recognises the importance of input from other stakeholders and aims to use its time in shadow format to build an array of productive relationships. Although pathway redesign will generally be led by a GP, we envisage that service redesign groups will have appropriate and effective stakeholder involvement in order to deliver the quality of care that patients deserve.

The Shadow Board will be the executive arm of the organisation. The bulk of the current management budget will fund the time that is required of Board members,

together with the educational programme and the clinical and management input that will go into improving pathways of care. Management support will be provided through staff assignments from NHS Berkshire East, and by accessing the expertise of staff employed in that organisation and the Berkshire-wide cluster organisation.

3.6 Timescales

The Development Panel is about to initiate the recruitment process to the Board and timescales are currently being determined with the Local Medical Committee who will be administering the election process. It is expected, however, that the shadow Board will be fully operational by the end of September 2011. It will operate as a sub-committee of NHS Berkshire East until becoming a statutory organisation, some time after 1st April 2013, subject to the approval of the NHS Commissioning Board and to the legislation currently before Parliament.

3.7 Equality Impact Assessment

No equality impact assessment has been carried out on the work to date in developing the structures of the shadow commissioning organisation for Windsor, Ascot and Maidenhead.

4. OPTIONS AVAILABLE AND RISK ASSESSMENT

4.1 Options

	Option	Comments	Financial Implications
1.	Inclusion of all GP surgeries located in RBWM within the consortium	Not the current preference for 3 Ascot practices who have opted to join the Bracknell consortium	Revenue - Higher management and commissioning budget if 3 Ascot practices are included - values not yet quantified Capital - May affect development of secondary care estate
1.	Developing structures for collaboration across localities	Will be essential in some areas, especially once NHS Berkshire East ceases to exist	Revenue - Values not yet quantified Capital - Implications still to be worked through

GP practices have been allowed to determine the shadow commissioning organisation to which they belong and three practices from Ascot opted to join the Bracknell commissioning consortium. The Government's response to the NHS Future Forum report introduced a presumption that clinical commissioning groups (the statutory bodies) will be aligned with local authority boundaries unless they can

demonstrate a clear rationale (accepted by the NHS Commissioning Board) to cross boundaries. So, this test will need to be applied to those Ascot practices.[1]

Noting this presumption of co-terminosity, it is also clear that the commissioning groups in East Berkshire (and beyond) will need to work across boundaries in many areas. Lengthy reflection and discussion will be required to determine how best to deliver and structure that collaboration. The WAM commissioning consortium has begun discussions with other localities to develop the required new ways of working.

4.2 Risk assessment

At present, the budget is held by the Primary Care Trust and so the financial risk attached to the commissioning consortium is limited. As statutory bodies, however, the pooling of risk will be an essential component. This will be part of the discussions referred to in the previous paragraph about working across localities.

Other risks include:

- lack of engagement from practices in the commissioning processes
- lack of interest/time among GPs (and others) to take on leadership roles
- the challenges facing Heatherwood and Wexham Park which may dominate commissioning decision-making and blunt innovation
- failing to build the partnerships that will be necessary to drive improved patient care in the context of severe budgetary pressure

5. CONSULTATIONS CARRIED OUT

Three months into its remit, and with limited time and financial resources, the Development Panel has endeavoured to engage partners in its activities. It recognises, however, that there is more to be done. Engagement activities to date have included:

- Meetings with senior local authority officers and members to understand mutual priorities and to begin exploring joint working opportunities
- Discussing progress with practices, through Masterclass events and workshops for specific staff groupings, such as practice managers and non-principal GPs
- Seeking advice from experienced lay representatives and from Windsor and Maidenhead Voluntary Action, with meetings scheduled together with the Healthwatch project group in July and the third sector partnership organisation in September

[1] Paragraph 3.47 states “if a commissioning group wishes to be established on the basis of boundaries that would cross local authority boundaries, it will expected to demonstrate to the NHS Commissioning Board a clear rationale in terms of benefits for patients: for example, if it would reflect local patient flows or enable the group to take on practices where, overall, this would secure a better service for patients. Further, they would need to provide a clear account of how they would expect to achieve better integration between health and social care services.”

- Ongoing meetings with acute providers, the PCT, the Strategic Health Authority and other locality commissioning groups

6. COMMENTS FROM THE OVERVIEW AND SCRUTINY PANEL

This paper describes the work that has taken place to develop a new shadow organisation and no discussions have yet taken place with the Overview and Scrutiny Panel.

7. CONCLUSIONS

The work to date has been preparatory to the formation of a shadow commissioning organisation in Windsor, Ascot and Maidenhead. The Development Panel's role is to put forward structures and processes that will allow the shadow body to become an effective and engaged statutory organisation some time after April 2013. This paper summarises key elements of the proposals as they currently stand. These should be assessed alongside the core principles that the Development Panel believes should underpin clinical commissioning in Windsor, Ascot and Maidenhead, namely:

- A focus on patients & on the problems that they face in the current system
- Led by people with an expert understanding of primary care
- Built on genuine team-working, focused on patient care, including (i) growing relationships with hospital consultants that change clinical habits and reduce costs, and (ii) integrating health and social care services where this delivers improved care for residents
- Systematic analysis and improvement of clinical pathways
- Minimisation of waste: the organisation needs to develop without complex and expensive management structures
- Deployment of resources where they are most required and cost savings where they will do least damage to patients
- With the skills that are necessary to challenge primary care providers to develop and innovate, and with the energy that encourages talented people to want to contribute
- Prioritising education, training, and development in order to implement new ways of working
- Recognising that primary, community and intermediate services are essential to reduce the pressure on secondary care