Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Meeting of BNSSG Primary Care Commissioning Committee

Date: 28th September
Time: 9:30-11:45
Location: MS Teams

Agenda Number :	7
Title:	**Delegation of Primary Care Services to the Integrated Care System in BNSSG**
Confidential Papers Does this paper contain information that should not be in the public domain? (This box will be removed from Governing Body Open papers by the Corporate Team when the paper is received)	

Commercially Sensitive	No
Legally Sensitive	No
Contains Patient Identifiable data	No
Financially Sensitive	No
Time Sensitive – not for public release at this time	No
Other (Please state)	No

For Discussion

Key Points for Discussion:

To brief the Committee on the proposals for delegation of commissioning primary care services to the ICS and to update the Committee on ICS support for delegation. To invite the Committee to discuss next steps.

Recommendations:	The Committee is asked to note the recommendation endorsed by the ICS Executive Group to submit an expression of interest to NHSE to assume delegation of pharmaceutical and optical services in April 2022, pending a full due diligence process, and to confirm to NHSE that we will be able to assume delegation of dentistry services by April 203.
Previously Considered By and feedback :	ICS System Leads and Commissioning Steering Group, ICS SW Primary Care Delegation meeting, BNSSG CCG Executive Team, BNSSG ICS Executive Group. Recommendations supported by the ICS Executive Group.

Management of Declared Interest:	Not applicable
Risk and Assurance:	There are a number of risks that need to be taken into account as part of system decision making in relation to form and pace of delegation. These are set out in section 8 and a full risk log will need to be developed as part of delegation planning.
Financial / Resource Implications:	The CCG has received expenditure for the 3 contractor groups from NHSE for 19/20. These total £72.5 million. A full financial due diligence appraisal will need to be undertaken to understand the allocation to the ICS in addition to predicted outturn against budgets. This is expected to take place in quarter 4 when the allocations will be announced.
Legal, Policy and Regulatory Requirements:	The Health and Care Bill published in July confers the duty on Integrated Care Boards to secure the provision of primary care services for its populations.
How does this reduce Health Inequalities:	Delegation of these services will enable the ICS to be locally responsive and respond to population health needs. With delegation we will be able to respond to local health inequalities and ensure a focus on preventative care across our primary care services, working with system partners.
How does this impact on Equality & diversity	Delegation of these services will enable the ICS to better develop primary care services to meet the needs of our local population.
Patient and Public Involvement:	No patient and public involvement has been undertaken in the development of this paper. The changes are governed by national strategy and legislation, however as we assume delegation we will want to ensure that we involve patients and the public in how we develop our primary care services.
Communications and Engagement:	Initial meetings have been held with the Local Pharmaceutical Committee, Local Optical Committee and Local Dental Committee to explore developing closer working relationships and integration with the ICS. Further engagement with these representative bodies and the providers will be critical as we prepare for and assume delegation, subject to the satisfactory conclusion of the due diligence phase..
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Sponsoring Director / Clinical Lead / Lay Member:	Lisa Manson, Director of Commissioning

Agenda item: 7

Report title: Delegation of Primary Care Services to the Integrated Care System in BNSSG

1. Background

The February 2021 White Paper "Integration and innovation: working together to improve health and social care for all" set the direction for Integrated Care Systems to become responsible for a greater range of primary care services – namely to take on the responsibility for dental, pharmaceutical and ophthalmic services in addition to primary medical services which is currently delegated to the CCG. This was confirmed by the Health and Care Bill published in July which confers the duty on Integrated Care Boards to secure the provision of these services for its populations.

The NHSE letter dated 22nd July "NHS England and NHS Improvement's direct commissioning functions" sets out the expectation that all ICBs will assume responsibility for primary medical services and **be able** to take on delegated responsibility for dental (primary, secondary and community), general ophthalmic services and pharmaceutical services by April 2022 and that these latter **will be** taken on by April 2023. These may in addition be accompanied by some public health services. The letter recognised the work needed to set out the full scope of delegation, the enablers and financial framework and proposed that by 14th October it will be determined which ICBs will take on the additional primary care services in April 2022. The actual scheme of delegation for these services has yet to be defined as it was nationally for primary medical services but it is expected that this will largely mirror this approach and that NHSE will retain an assurance function and responsibility for professional standards – management of complaints is not yet known.

2. Benefits of delegation

The overall goal of the ICS will be to improve health and care outcomes for the population of BNSSG. The new legislative framework seeks to enable decisions to be taken as close as possible to their populations to secure maximum benefit. The key benefits of delegation of primary care services are therefore the ability to commission services across the whole pathway for our population and secure the breadth of preventative, personalised and responsive primary care services to improve population health.

Some of the key opportunities with delegation include:

- Ability to be locally responsive and respond to population health needs and commission services accordingly
- Tailored approach working with partners to respond to health inequalities and ensure a focus on preventative care

- Transformation and pathway integration – greater ability to integrate these services into local transformation and system working both within the place and system agendas and to incorporate these services more fully into a local primary care strategy
- Ability to develop and create closer relationships which can then support increased partnership working
- Opportunity to build a more integrated clinical leadership model which reflects the wider primary care system in BNSSG
- Ability to involve the wider primary care services in developing approaches to quality improvement and supporting wider primary care resilience

These benefits clearly respond to the triple duty conferred on ICSs as part of the reforms:

- Achieving better health for the whole population
- Achieving better quality of care for the whole population
- Achieving provision which is financially sustainable for the taxpayer

This triple duty provides a useful framework for the BNSSG ICS to consider and confirm the approach for delegation in BNSSG as we work through the due diligence process.

3. Local Context

As part of the regional approach to supporting the development of ICSs a primary care ICS development group has been meeting since May of this year chaired by Ian Biggs, Director of Primary Care and Public Health Commissioning. This group has been seeking to develop regional principles and approaches to delegation to recommend to the regional ICS Steering Group. As part of this process systems have requested information from NHSE to inform local decision making in relation to timing and models of delegation. These could include:

- Delegation as per anticipated national scheme of delegation to each ICS
- Partial delegation of functions – e.g. could delegate strategic transformation or contracting
- Hosted commissioning function provided on regional or sub regional level by NHSE or an ICS or CSU
- Hybrid of above

As part of this process information on the 3 contractor groups has been shared at the last 3 meetings including contract numbers, strategic priorities and commissioning functions. In addition NHSE have shared their structure and WTE for their dedicated primary care commissioning teams and expenditure for these contract types in 19/20. A summary of the headline service information is provided in the next section and as more information is shared by NHSE it is proposed that a more full service profile is developed and shared within the system.

It should be noted that there are currently some key information gaps. Nationally it has been confirmed that allocations for next year will not be available until the new calendar year. This is a clear and significant risk for systems wishing to progress with delegation for April 2022 and this stage of delegation assurance would be undertaken in quarter 4. The feedback from all systems to

the regional group has been that any system expressions by the end of the month would need to be seen as an Expression of Interest with the ability to withdraw subsequently contingent on the financial envelope.

In addition NHSE has been requested to provide a greater level of breakdown of information at ICS level to include:

- Contract expiries and procurements
- Risks and issues by system
- A greater breakdown of the proportion of time spent on particular functions within the teams to enable systems to effectively work plan and assess the requirements locally or within a shared model
- An assessment of the workload impact on associated support services to the primary care functions – i.e. on quality, communications and finance with a particular focus on finance given the contract types and payment verification processes

This information will not be available to systems by 30th September and will need to form part of the subsequent due diligence process and delegation assurance work up.

The NHSE regional team are proposing the establishment of a South West Primary Care Commissioning Group to plan and oversee the development and mobilisation of the model of delegated commissioning of Community Pharmacy, Primary Care Optometry and Dentistry (Primary, Community and Secondary).

4. Service Overview

Contract Type	Number in BNSSG
Optical contracts	
Mandatory (Held in a physical location) – Sight Tests and Dispensing	63
Additional Contracts (Domiciliary Providers to attend patients at home setting) – Sight Test and Dispensing	16
Dental contracts	
Primary care incl orthodontics	113
Secondary care	1
Community	1
Community Pharmacy	
Total pharmacies (incl 3 distance selling pharmacies and 1 dispensing appliance contractor)	173
Dispensing GP practices	4

Total	**371**

Strategic and operational priorities:

Optical
National Eyecare Recovery and Transformation Programme with a focus on prevention, access and patient centred transformation. Operational guidance has following priorities for eyecare:

- Focus on equity of access: elective patient tracking list, surgical pathways/hubs
- Integrated Care Pathways: cataracts, urgent eye care, medical retina and glaucoma – primary care managing low risk patients in the community.
- Risk stratification of new and follow-up patients
- Digital transformation: implementation of Electronic Eyecare Referral Systems (EeRS)
- Enabled via a Strategic Eye Care Board and ICS Eye Care Delivery Groups

Dental
Dental – access and restoration (minimum contract of 60% set currently) maintaining and improving urgent care access and unmet need. South West Dental Reform programme developing work streams on workforce, access and oral health improvement. 4 Managed Clinical Networks and setting up 2 more on children and urgent care. Short term priorities –digital improvements, review seven dental helplines, develop standard specification for high street dental.

Community Pharmacy
5 year deal for Community Pharmacy up until 2024 which focuses on access, quality and delivery of a greater range of services (e.g. smoking cessation, new medicines service expansion, hypertension case finding, Community Pharmacy Consultation Service, palliative and End of Life Care, contraception, menopause and HRT, cholesterol and statins). Year 3 of the contract negotiations has just been concluded and there are some adjustments to start dates for these services which are staggered between September this year and 2024. Applications for market entry assessed against Pharmacy Needs Assessment.

5. Process and timeline

NHSEI has published a Direct Commissioning Functions: Pre-Delegation Assessment Framework. The assessment process will be for existing ICS leaders, and designate ICB leaders as they are appointed, to complete with their regional teams. The key domains of the assessment are set out in the table below and this is attached in full as an appendix to this paper.

Key Principles of Pre-Delegation Assessment

Domain	Principle
Transformation	There is a clear understanding of how receiving each new responsibility will benefit population health outcomes.
	There is a shared understanding across all ICS partners on the benefits of delegation.
Governance and Leadership	Governance enables safe, high quality delivery.
	Clinical leadership combines the specialist expertise to lead and scrutinise individual functions, and the collaborative working necessary to identify, enable, and oversee clinical improvements.
Finance	Major financial risk factors are clearly understood and mitigated.
Workforce and Capability	There is an understanding of the workforce and capability and capacity requirements, with any major risks understood and processed for mitigation.

The national guidance states that an ICS system would need to have undertaken the pre-delegation assessment by 30th September in order for a national decision to be made on 14th October to approve delegation for 1st April 2022. We are proceeding to complete the checklist for the 30th September deadline noting that full assurance in relation to finance will not be possible until quarter 4.

6. Financial resource implications

Expenditure in 19/20 has been shared with the CCG. This totals £72.5 million across the 3 contractor groups - £19 million pharmacy, £7.9 million ophthalmic services, £42.5 million dental services). A full financial due diligence appraisal will need to be undertaken to understand the allocation to the ICS in addition to predicted outturn against budgets. This is expected to take place in quarter 4 when the allocations will be announced.

7. Legal implications

The Health and Care Bill published in July confers the duty on Integrated Care Boards to secure the provision of primary care services for its populations. The delegation of services and

governance of these will need to be developed in accordance with national guidance supporting the constitution and development of the ICS.

8. Risk implications

There are a number of risks that need to be taken into account as part of system decision making in relation to form and pace of delegation. These are set out in the following table.

Risk	Mitigation
Outstanding information to assure local systems about the budget and risks and to inform workforce planning	Complete a full due diligence process to include developing full assurance of these areas and in particular the financial position.
Capacity within NHSE teams to support this process across the region	Full due diligence process between now and March 2022 will support NHSE teams to progress this work. A staggered timeline of systems assuming delegation is also likely to be more manageable for NHSE teams to support.
Capacity within local CCG teams to progress and implement delegation within current primary care resources	Review capacity plan and team structures to support delegation. This will need to form part of ICS structure planning and will require additional resource to be ready to support transition in Q4. Work with NHSE to identify resources able to support transition.
Pace required to develop relationships with Local Dentistry Committee and Local Optical Committee in particular	Julia Ross has met with the LDC, LPC and LOC. Primary care team has held initial meeting with the LOC and LDC to explore opportunities for closer working and all have agreed that we wish to continue to develop local relationships. Relationships are well established with the LPC. Further engagement with these representative bodies and the providers will be critical as we prepare for and assume delegation
Challenging timescale to	Primary care teams will work on

undertake pre-delegation assessment by 1st October	developing and completing the assurance framework bringing in previous expertise of delegation and work with finance and HR teams to support this. This will require Executive sign off.
Ability to influence significant change in these new services which are subject to national contract negotiations	The services do have national contracts, however as with general medical services it is still possible to develop services to meet local needs and in particular the use of enhanced services support greater flexibility.

A full risk log will need to be developed to support the delegation process.

9. Implications for health inequalities

Delegation of these services will enable the ICS to be locally responsive and respond to population health needs. With delegation we will be able to respond to local health inequalities and ensure a focus on preventative care across our primary care services, working with system partners.

10. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

Delegation of these services will enable the ICS to better develop primary care services to meet the needs of our local population.

11. Consultation and Communication including Public Involvement

No patient and public involvement has been undertaken in the development of this paper. The changes are governed by national strategy and legislation, however as we assume delegation we will want to ensure that we involve patients and the public in how we develop our primary care services.

12. Recommendations

There are significant benefits of delegation of these primary care services with the opportunity to address population health holistically and bring together primary care services and integrate these within the wider system.

It is proposed that a full due diligence process is undertaken over the coming months to mitigate the risks and to enable the ICS Board when constituted to make a go/no go decision in quarter 4 of this financial year.

It is also proposed that a phased approach to delegation of these services is taken in order to spread the workload and allow for greater development of relationships. Delegation of services is most effectively achieved at the start of each financial year (this was the approach taken for medical services) so it is therefore proposed that delegation of pharmacy and optical services is assumed from April 2022 and dentistry from April 2023.

A paper was presented to the ICS Executive Group on 16th September to seek ICS approval for the following:

- That we confirm to NHSE our intent to assume delegation of pharmaceutical and optical services in April 2022
- That we confirm to NHSE that we will be able to assume delegation of dentistry services by April 2023
- That we complete the delegation assurance framework by the 30th September to support delegation of pharmaceutical and optical services by April 2022
- That we undertake a full due diligence process working with NHSE to support a final BNSSG go/no go decision in quarter 4

The ICS Executive Group supported these proposals.

The Primary Care Commissioning Committee is asked to note these proposals and the support for the approach from the ICS Executive Group. The Primary Care Commissioning Committee is invited to discuss these recommendations and the next steps.

Report Author: Jenny Bowker, Head of Primary Care Development, BNSSG CCG
Report Sponsor: Lisa Manson, Director of Commissioning, BNSSG CCG

Appendices – Appendix 1 NHSEI Direct Commissioning Functions: Pre-Delegation Assessment Framework

ICS	**Integrated care systems (ICSs)** are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

ICB	Integrated Care Board – the governing body of the formally constituted ICS from April 2022, subject to the successful passing of the Health and Care Bill
CSU	Commissioning Support Unit – organisations which provide Clinical Commissioning Groups with external support, specialist skills and knowledge to support them in their role as commissioners

NHSEI Direct Commissioning Functions: Pre-Delegation Assessment Framework

Introduction and Context

ICSs have an explicit purpose to improve health outcomes for their whole populations, and the proposed new legislative framework is designed to enable decisions to be taken as close as possible to their populations for maximum benefit.

To enable this, NHS England and NHS Improvement expects to delegate certain direct commissioning functions to ICBs as soon as operationally feasible from April 2022. Details of this have been set out here.

This pre-delegation assessment framework is designed to help ascertain each system's capability to assume responsibility for services within their geographies in advance of an anticipated April 2022 delegation. Informed by the assumption that ICSs should own all functions by default, the framework focusses on the minimum standards which should be met prior to delegation. The assessment process will be for existing ICS leaders, and designate ICB leaders as they are appointed, to complete with their regional teams. This document therefore refers to the readiness of 'ICSs'. The formal delegation of functions from April 2022 will be to the statutory ICBs within each system (subject to the passage of legislation and their establishment).

Please note that this framework applies only to Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services.

Principles of Pre-Delegation Assessment

Domain	Principle
Transformation	There is a clear understanding of how receiving each new responsibility will benefit population health outcomes.
	There is a shared understanding across all ICS partners on the benefits of delegation.
Governance and Leadership	Governance enables safe, high quality delivery.
	Clinical leadership combines the specialist expertise to lead and scrutinise individual functions, and the collaborative working necessary to identify, enable, and oversee clinical improvements.
Finance	Major financial risk factors are clearly understood and mitigated.
Workforce and Capability	There is an understanding of the workforce and capability and capacity requirements, with any major risks understood and processed for mitigation.

Pre-Delegation Assessment Domains

The principles detailed above have informed a pre-delegation assessment framework. Strong performance across these domains will be considered an indicator of readiness to assume responsibility for the functions receive the functions in April 2022.

#1 Transformation

Description	Indicators
ICSs will have clear, feasible plans to improve population health outcomes which are compatible with the use of the delegated functions. These plans will be underpinned by realistic and sustainable financial assumptions, integrated with existing plans at different ICS tiers, and reflect patient priorities and engagement.	The ICS has plans which demonstrate how it could use the functions to improve population health, deliver improved care quality, reduce health inequalities, improve preventative capability, co-produce services with patients, and increase efficient use of resources.
	The ICS has demonstrated an understanding of how the functions could be integrated into wider pathways, including interfaces with provider collaboratives, for patient benefit. It will also demonstrate how this transformation aligns with national policy where appropriate.

#2 Governance and Leadership

Description	Indicators
ICSs will have a clear governance structure in place. This must involve the expertise necessary to scrutinise individual functions, and to oversee integrated planning and service development encompassing multiple functions. ICSs will determine whether the decisions made on particular functions should be at system or place level, and develop governance accordingly. Clinical leadership should be robust and embedded throughout. Engagement mechanisms should enable people who use services to influence commissioning decisions.	The ICS will have clear governance and accountability structures covering every stage of the planning cycle.
	The ICS will have developed governance and accountability structures to make decisions at the appropriate level for each function.
	The ICS will have sufficient expertise (clinical, operational, and financial and strategic) embedded in its governance and accountability structures to ensure that each function can be adequately overseen, including effectively managing risks and having robust impact assessment processes.
	The ICS will have cross-functional governance and accountability structures which can oversee integrated pathways, and which align with other stakeholders to support integration and co-commissioning.

#3 Finance

Description	Indicators
The ICS will have developed a distinct plan identifying critical financial risk factors. The ICSs financial plans enable the wider improvement objectives.	The ICS will have developed a financial risk management strategy which identifies and mitigates all critical risks associated with the function.
	The ICS will have scrutinised key delegation-related decisions for their degree of financial risk throughout its governance and accountability structures.
	The ICS will have earmarked an appropriate level of funding to enable the transformation and improvement benefits identified in the relevant planning processes.

#4 Workforce and Capability

Description	Indicators
ICSs will assess the capability development and capacity needed to deliver the function, and to ensure a smooth transition for staff (in alignment with the applicable regional workforce model). The workforce model enables population health benefits. Evidence of consideration of the wider needs of staff – for example, OD and cultural integration – will be necessary.	The ICS has assessed its workforce capabilities and needs, demonstrating that it has, will possess, or will have access to sufficient resource, capability, and capacity to commission the delegated functions. This may incorporate assumptions on the number of staff required, and the mechanism for deploying them to align with the benefits identified.
	The ICS will map where external support will be needed, and how this is expected to evolve over time. This may imply CSU support, shared services between ICSs, or interfacing with NHSEI regions.
	The ICS will have developed an understanding of how transitioned staff will integrate into existing teams.
	The ICS will have aligned the development of new staffing capabilities and the integration of staff with broader OD and change management processes, connecting with any initiatives which enable integration.
	The ICS will have demonstrated that its senior leadership has appropriate capability, capacity, and information. Robust clinical leadership should be demonstrably established.

Assessment Framework: Checklist

Assessment Checklist [1] ***To be pre-populated by the ICS management team and corroborated by the relevant Regional Director of Commissioning*** [2]	**Status (ICS)**	**Status (RDC)**
Domain 1A: Will the ICS have a (shared) understanding of how the functions could be used to deliver additional benefit for people who use services, and could be integrated with current processes and pathways to do so?		
Domain 1B: Are there current or expected mechanisms through which people who use services and the public could be actively engaged and involved in shaping the functions to be delegated?		
Domain 2A: Will the ICS have sufficient general governance capability (mature structures, appropriate expertise) to oversee the functions at every tier of their commissioning and delivery?		
Domain 2B: Will the ICS have sufficient clinical governance capability and leadership to oversee the functions?		
Domain 2C: Will the ICS have mechanisms in place which allow for monitoring of emerging risks, impacts, and unanticipated dependencies in the immediate post-delegation period?		
Domain 2D: Will the ICS have broad agreement amongst the parties relevant to delivering the functions on the approach to monitoring and governance?		
Domain 3A: Will the ICS have severe financial management issues or risks?		
Domain 3B: Will there be sufficient safeguards built into ICS governance processes which militate against financial risks specifically in relation to the POD functions?		
Domain 4A: Will the ICS understand the resources, capabilities and skills it needs to deploy to exercise the function upon assuming responsibility?		
Domain 4B: Could the ICS confirm that the resources, capabilities and skills needed to exercise the function upon assuming responsibility can be made available in due course?		
Any additional comments		

[1] Please answer 'yes' or 'no'. Supporting evidence should be provided where appropriate, and NHSEI regions are expected to verify the accuracy of this evidence.
[2] Please note that non-compliance against any of these domains will be considered by regional and national teams. At each key step, a decision will be made on whether to allow the application to progress, based on mutually (ICS and NHSEI) agreed prospects for resolution ahead of April 2022.
