Derby City Council

Council Cabinet
17 April 2012

ITEM 12

Report of the Strategic Director of Adults, Health and Housing

CLINICAL COMMISSIONING GROUP ARRANGEMENTS FOR DERBY

SUMMARY

1.1 This report sets out the new arrangements for the commissioning of health care in Derby as a result of the proposals in the Health and Social Care Bill.

1.2 It explains the role and focus of clinical commissioning groups and the proposed arrangements for Derby.

1.3 It seeks Members' endorsement of the Southern Derbyshire Clinical Commissioning Group.

RECOMMENDATION

2.1 To endorse the configuration of Southern Derbyshire Clinical Commissioning Group as set out in para 4.12 of the report.

REASONS FOR RECOMMENDATION

3.1 The business case for the geographical configuration for Southern Derbyshire Clinical Commissioning Group is well made and represents best value for local people in terms of patient care and business efficiency.

SUPPORTING INFORMATION

4.1 The Government's ambition for the NHS to deliver excellent health outcomes is rooted in the three principles of:

- Giving patients more information and choice
- Focusing on healthcare outcomes and quality standards
- Empowering frontline professionals with a strong leadership role

Key to these principles of the creation of Clinical Commissioning Groups (CCGs).

4.2 CCGs will be statutory NHS bodies based around GP practices that collectively make up the membership of a CCG. The member practices decide, through developing their constitution, and within the framework of the Health and Social Care Bill once law, how the CCG will operate. They must ensure they are led and governed in an open and transparent way which allows them to serve their patients and population effectively.

4.3 An important part of a CCG is that they are clinically led, with the full ownership and engagement of their member practices, bringing together advice from health and care professionals to shape services and consider patients' needs.

4.4 As well as being accountable to local people, CCGs will be accountable to the NHS Commissioning Board. They are expected to play a full role on the Health and Well-being Board including co-operating in the preparation of the Joint Strategic Needs Assessment and agreeing a joint Health and Well-being Strategy

4.5 It is envisaged they will work in partnership with the local authority and, as members of the Health and Well-being Board, have a role in facilitating improved outcomes for people through integrated working (both commissioning and provision). CCGs will also need to be able to give account to local authorities in their overview and scrutiny role for the services they are commissioning.

4.6 They will have a responsibility to ensure that the relevant health and care professionals are involved in the design of services and that patients and the public are actively involved in the commissioning arrangements.

4.7 Clinical commissioning groups have to go through a formal authorisation process. This is undertaken by the NHS Commissioning Board which will assess applications for establishment as a CCG including if the proposed governance arrangements meet the legislative requirements and are otherwise appropriate.

4.8 CCGs are required to have a defined geographical area. This is relevant to a CCG's responsibilities for:

(i) commissioning services (other than those commissioned by the NHS Commissioning Board);
(ii) commissioning services for unregistered patients in the area, i.e. people who are usually resident within the area and are not registered with any GP practice in the CCG.
(iii) commissioning emergency care for anyone present in the area
(iv) co-operating with the local authority (or local authorities) in the area and being a member of the Health and Well-being Board.

Following consultation on the draft Bill, the NHS Futures Forum recommended that the boundaries of local CCGs should not normally cross those of upper tier local authorities, with any departure needing to be clearly justified and in the interests of patients.

4.9 The timeline for authorisation is as follows:

- January – March 2012: conclude any outstanding configuration issues; design proposed organisational form; build partnerships, engagement and collaborative arrangements
- April – August 2012: begin to apply to NHS Commissioning Board for establishment and authorisation (subject to the passage of the Bill)
- October 2012 onwards: first authorisation decisions begin to be taken
- April 2013: all of England covered by established CCGs

Local arrangements for NHS commissioning

4.10 The Derbyshire cluster was formed in April 2011 and comprises Derby City PCT and Derbyshire County PCT. Five Clinical Commissioning Groups emerged in Derbyshire in early 2011 and have developed throughout 2011/12.

4.11 Southern Derbyshire Clinical Commissioning Group (SDCCG) is the relevant CCG for Derby City covering a population of 524,747. It has four localities: Derby Advanced Commissioning, Derby Commissioning Network, Amber Valley and South Dales and South Derbyshire. It is unusual because it spans two upper tiers of local government, i.e. Derby City Council and Derbyshire County Council.

4.12 The two Derby localities are effectively coterminous with the City Council boundary. Each has its own local board and is identifying its own local priorities in additional to working collaboratively with the rest of the CCG.

4.13 The primary rationale for the configuration of SDCCG is based around patient flow. Derby Hospital Foundation Trust (DHFT) is the major provider for services to local communities and, in turn, SDCCG accounts for 90% of the income of DHFT. This means that SDCCG can negotiate a consistent approach to acute care pathways for the majority of patients in the City and County who depend upon Derby Hospital.

4.14 There are a significant number of areas of joint commissioning (dementia, care homes, carers, mental health, learning disability, hospital discharge, continuing care) where benefits could arise from SDCCG and the two Councils working together on service development. The benefits would arise from the sharing of best practice, eliminating duplication and reducing variation in care pathways.

4.15 The smaller the scale of a commissioning group, the larger the proportion of its resources the group will be required to set aside to manage financial risk arising from unforeseen circumstances or overspends in any particular area. There would be concerns about the financial viability of a stand-alone City Commissioning Group.

4.16 The important issues for the City Council to consider is to ensure that the configuration of the CCG can still support a Derby City-specific focus on the needs of its population. This is achieved by having:

- Our own Health and Well-being Board with CCG representatives on it
- A Derby City Joint Strategic Needs Assessment (which the CCG has to pay regard to when drawing up their commissioning priorities)
- The Health and Well-being Board's view on the CCGs commissioning intentions have to be taken into consideration by the CCG
- A Derby City Health and Well-being Strategy
- Our own Joint Director of Public Health
- Derby City representation (in the form of the Strategic Director for Adults, Health and Housing) on the SDCCG governing body.

4.17 With these safeguards in place, it seems sensible to endorse the geographical configuration of SDCCG, because of the benefits to patient care and financial stewardship.

OTHER OPTIONS CONSIDERED

5.1 To not endorse the geographical configuration of Southern Derbyshire Clinical Commissioning Group: although the NHS Commissioning Board will take into account the local authority's views, it is likely to authorise SDCCG on the basis that it is optimal model for patient care and financial efficiency.

This report has been approved by the following officers:

Legal officer	Stuart Leslie
Financial officer	Toni Nash
Human Resources officer	Liz Moore
Service Director(s)	
Other(s)	

For more information contact:	Name 01332 643550 e-mail cath.roff@derby.gov.uk
Background papers:	None
List of appendices:	Appendix 1 – Implications

Appendix 1

IMPLICATIONS

Financial and Value for Money

1.1 There are no specific financial implications for Derby City Council. The proposal does offer the best model for maximising economies of scale and having a coherent approach to the commissioning of secondary care.

Legal

2.1 The establishment and authorisation of Clinical Commissioning Groups are subject to the passing of the Health and Social Care Bill currently going through Parliament.

Personnel

3.1 None specific

Equalities Impact

4.1 None specific

Health and Safety

5.1 None specific

Environmental Sustainability

6.1 None specific

Asset Management

7.1 None specific

Risk Management

8.1 None specific

Corporate objectives and priorities for change

9.1 This development contributes to the Council's ambition to promote good health and well-being.