Delegated Commissioning in NW London: Frequently Asked Questions

16 November 2016
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General FAQs

1. **What is delegated commissioning?**

   This is when the CCG assumes full day-to-day responsibility for commissioning general practice services.

   The formal liability for primary care commissioning, for legal reasons, will remain with NHS England although the CCG will remain accountable for meeting their statutory duties, for instance in relation to quality, financial resources and public participation.

   Functions relating to eligibility for and maintenance of medical performers lists for GPs are exempt from the delegated CCG.

   CCGs are required to consult with NHS ENGLAND before making a decision about practice closures.

   NHS England remains the contract holder, and the functions of commissioning and contract management will be delegated to the CCG.

   When CCGs receive delegated functions from NHS England, they are able to collaborate with other CCGs. However, NHS England can only delegate its functions once, and therefore this delegation will be to a single CCG. As a result, any committees functioning on behalf of more than one CCG cannot be a decision making body.

2. **Why introduce delegated commissioning?**

   Delegated primary care commissioning is one of a series of changes set out in the NHS 5 Year Forward View. The aim of delegating the commissioning of primary care services is to help to improve integrated out-of-hospital services based around the needs of local populations. It will also enable the development of new models of care such as voluntary multispecialty community providers and primary acute care systems for local determination.

3. **Can membership votes be held after the application is submitted?**

   NWL CCGs can submit a completed application checklist on the 5th December with the membership vote pending. All voting must be completed and evidence provided by the end of February.
Benefits of delegated commissioning

4. What are the intended benefits?

The CCG will have more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services. By aligning primary and secondary care commissioning, it also offers the opportunity to develop more affordable services through efficiencies gained across the system.

The potential benefits for patients are that more services can be available closer to home, providing high quality out-of-hospital care which supports health outcomes, providing a better patient experience.

Furthermore, it will enable the development of a more collaborative approach to designing local solutions for workforce, premises and IM&T challenges.

The local GPs are best placed to understand local issues and the needs of local patients and practices. Fully delegated primary care commissioning affords local GP’s the greatest level of control in setting the Primary Care Strategy.

It will enable the CCG to better align locally identified needs and priorities. This offers the opportunity to commission on the basis of achieving locally defined outcomes rather than nationally prescribed processes.

5. What gains are to be seen from less NHSE and more expansion of the CCG? Key Benefits? (H&F GP Workshop)

There are 3 principal advantages: access to primary care budgets in aggregate, without sums being held back by NHSE – as in Q4; greater freedom in allocating primary care budgets to the benefit of primary care as a whole (e.g., releasing revenue funding to invest in capital development) or to local priorities that might not meet NHSE’s national requirements; and, finally, as commissioners, joining up the clinical knowledge, influence and spending-power of the CCG across the spectrum of local healthcare to strengthen local health outcomes.

6. How will investment be improved in primary care by fully delegated commissioning?

It will enable the CCG to look at the whole health system rather than individual parts, and will provide the levers to support the flow of investment from secondary to primary care.
7. How will support for GP practices improve by moving to fully delegated commissioning?

CCGs are committed to investing in the development of our existing primary care team into a responsive primary care commissioning team. Having a local team will mean they are more aware of local issues and pressures and would be available to come out and meet with practices, and be able to offer a range of support.

8. How is it going to improve patient care?

Patients will have more opportunity to input and influence what and how primary care services are commissioned - in particular enhanced services which can be tailored to meet the needs of the local population.

It will give CCGs the opportunity to meaningfully engage with the local public about the totality of expectations for general practice. The patient voice will therefore, be heard more clearly in the design of services.

All local decisions about primary care will take place in public, allowing patients more insight into decisions being made that may affect their care.

9. What will be different if we chose to move to delegated Primary Care commissioning?

CCGs will be enabled to locally improve the quality of Primary Care and improve access to services where needed. Delegated commissioning will provide more control flexibility and influence over how local Primary Care services are developed and enable the progression of new models of care. It will also give CCGs the opportunity to strengthen relationships and communication with practices. The aim of local decision making is that it will enable the local building of foundations that will provide a more sustainable and stable Primary Care system for their population.

10. Can CCGs with directions/ in special measures apply for delegated commissioning?

This does not automatically prevent CCGs from applying; they will be judged on a case by case basis. Applications must be clear on how delegated commissioning will be of benefit to these CCGs and what will be done to mitigate risk.
11. Will there be a risk to practice partnerships?
There will be no change to present arrangements.

12. Who has the CCG spoken to – which other CCGs – to understand their experiences with delegation?
Learning has been obtained from South West CCGs and NHS England (South West), West Midlands CCGs and NHS England (West Midlands) and neighbouring CCGs from London – with Tower Hamlets presenting to CWHHE SMT in October.

13. Why did Camden say no?
A significant number of Camden practices abstained from voting in the Members’ ballot, although over 60% of practices voted in favour of delegation. Unusually, the constitution required a 75% majority in favour to be approved.

The elected governing body GPs were in favour of delegation and appreciated the benefit of being able to influence decisions being made and shaping the process.

Camden CCG is still in joint co-commissioning with NHS England, which means that North Central London runs two parallel but separate approaches to medical services commissioning. Camden CCG are considering making another application for delegated commissioning this December (2016).

2017 V 2018

14. What is the main advantage of being granted full delegation in 2017 vs. 2018? (H&F GP Workshop)
The CCG will have unrestricted access to contingency, headroom and growth funding for 2017/18. This means that the CCG can determine how they finance primary care locally, i.e. Targeting revenue to fund capital developments or increase Primary Care capacity without the risk of NHS England applying a veto to these schemes.

15. Will the risks change if we go in April 2017 rather than April 2018? (Hounslow)
It is obviously harder to predict the issues facing CCGs in April 2018, however moving to fully delegated in April 2017 will allow the delivery of the GP Forward View, Strategic Commissioning Framework for primary care and the STP, with the full ability to commission primary, community and secondary care, 1 year earlier.
16. What is the impact if we do not go in 2017 but wait until 2018? Will there be a financial penalty? (Ealing GP Drop in session)

There will be no financial penalty for opting for 2018 delegation; however, the opportunity to be able to use Primary Care budgets to target local priorities will be enhanced by the earlier move to delegated commissioning in 2017 (see benefits in GP engagement pack.

NHSE have made it clear that CCGs who take on fully delegated commissioning will have unrestricted access to contingency, headroom and growth in 2017/18. Those that continue at Level 2 will have less input to decisions made around the use of growth without agreement from NHS England.

For example, the CCG can decide to use revenue to fund capital developments or increase Primary Care capacity. Under co-commissioning, NHS England can veto this spend if they identify pressures in Primary Care elsewhere.

17. What impact/repercussions will it have on the CCG if we choose to postpone full delegation to 2018? (Hammersmith & Fulham)

It is the intention of NHS England to encourage all CCGs to move to fully delegated commissioning as soon as possible. This would enable CCGs (and their member practices) to take on the highest level of commissioning responsibility. In the event that NW London CCGs choose not to move to Level 3 Commissioning, we would be in the minority of London CCGs and support for practices would continue to be from the regional NHS England team, who are likely to be focussed on working with fully delegated CCGs.

Members will be asked again in advance of the 2018 financial year. We expect NHS England teams will continue to work with all CCGs, but in not moving to delegated commissioning there is a risk CCGs with joint arrangements may not get a fair share of staff time and resources, as they implement delegated structures and roles. This is more of a risk if the decision not to move to delegation is taken by one CCG or by a minority of NWL CCGs.

18. What is the evidence that Joint Decision Making (Level 2) has been successful and how will full delegation be an improvement?

Joint Decision Making has ‘put primary care on the map’ at executive level and confirmed that primary care is capable of managing the Primary care budgets. CCG’s have been able to influence IT investment decisions, and in practice have taken on more responsibility where possible. However, NHS England have
always had the ultimate authority over decision making. Moving to full delegation will enable CCGs to be fully responsible for primary care spend locally.

19. If there are no financial penalties then what is the case for going in 2017?

The GP Forward View encourages local decision making for Primary Care investment, service redesign, and workforce development and for providing sustainable general practice. Moving to delegated commissioning now, will enable this process to be accelerated and will enable local practices to be in the driving seat of change.

In addition, the benefits of moving to delegated commissioning are highlighted below:

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<td>Quicker access to funding streams due to elimination of existing layer of application/approval processes can be obtained this financial year</td>
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<td>Less delays and time-lags in local decision making can be addressed more quickly</td>
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<td>Increased autonomy at local level to shape future Primary Care services</td>
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<td>A stronger voice for General Practice at the higher level to influence decision making</td>
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<td>More control and local influence over decisions, services and contracts</td>
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<td>Builds on the good work that we are currently delivering against in Primary Care and fits with our overarching Primary Care Strategy, enabling us to fully Implementation of our plans around the Five Year Forward View</td>
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<td>Direct relationships with contractors/practice, and will also give the CCG the ability to design local schemes to replace QOF and DESs based on local knowledge</td>
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<td>Local decision making: Gives us greater opportunity to use innovative commissioning to deliver local improvements, whilst optimising the use of resources to target them more effectively</td>
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<td>Ability to set commissioning intentions that cover key Primary Care issues such as workforce resilience and to work on these at NW London level</td>
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<td>The CCGs will be enabled to be more responsive to members needs</td>
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<td>Will benefit our local population by improving Primary Care access, outcomes, patient experience and supports our work to reduce inequalities</td>
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<td>Central funding streams may be held back if we do not take on delegation (consequence of not applying)</td>
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Conflict of Interest

20. Managing conflicts of interest

All CCGs need to review their conflicts of interest following latest guidance. Applications should refer to this specifically, including what they have done to address this. Where there are recommendations which have not been addressed directly, CCGs will need to be clear why and how this is being mitigated.

CCGs already manage conflicts of interests as part of their day-to-day work and assuming responsibility for commissioning GP services will make this even more important. The guidance on delegated commissioning makes it clear that GPs cannot participate directly in the procurement of their own services.

Should CCGs take on fully delegated commissioning; the CCG will ensure that any future committee formed has independent GP input and is led by lay members. CCGs across NW London currently have a co-commissioning sub-committee which is lay chaired, there is a possibility that this could be reviewed and the membership of this committee be refined in line with the new responsibilities that delegation would bring, should this be the direction member practices choose to take on fully delegated commissioning.

21. What is being done about conflict of interests and conflict management?

Conflict of Interest management is being developed as part of the NW London collaborative support programme – which includes formal legal advice and shared learning from other CCGs, while ensuring it complies with CCG constitutional priorities around conflicts of interest. GP practices will be kept fully up to date on how this is being developed.

22. Where are the conflicts? If conflicts become an issue how does the GP voice get heard? (Brent)

CCGs have a duty to ensure there is robust conflict of interest policy in place. These are currently being rewritten as part of the NW London Conflict of Interest reference group that has been set up. These will be reviewed by various stakeholders including GPs to ensure that the GP voice is central to the policy. When GPs are commissioning primary care services, it is important that the decision-making process is clear and open.
23. Can GPs on the Governing Body be involved in the decision to apply or is it a conflict? (NWL CCGs)

There are procedures in place for all Governing Body members to declare an actual or potential interest when this is relevant to the matter under discussion. The conflict of interest policy is currently being rewritten as part of the NW London Conflict of Interest reference group that has been set up. GP practices will be kept fully up to date on how this is being developed.

Contracting

24. Will the GP core contract still be negotiated locally and therefore include the input of the relevant representative bodies?

Delegated commissioning by CCGs will not change the detail of the GP core contract. This is nationally negotiated.

25. How will this affect the practice GMS contracts? (LMC)

Delegated commissioning by CCGs will not change the detail of the GP core contract. This is nationally negotiated.

26. Will the content of contracts be more broadly explored? Is this an opportunity for the CCG to change these? (K&W Locality)

Please see answer to Q25 (above)

27. Will the CCG put in place overly strong/onerous contract management?

CCGs will continue to work in partnership with their member practices, to commission jointly agreed improvements in patient care and the best ways of providing professional services.

28. Will CCGs be able to change contracts?

The default for practices remains the GMS contract which remains in perpetuity. Delegated commissioning will enable local areas to determine the best contracting method for their practices - whether this is developing a local alternative for QOF, redesign of practice profiling, opportunity for working at scale or adopting the voluntary Multi-speciality Community Provider (MCP) contract.
29. Will there be a strong push towards APMS contracts?

There is no change anticipated to the current balance between GMS, PMS and APMS contracts.

30. Will all CCGs share how core contracts are managed across NW London?

There is an appetite to work at scale and there are the obvious benefits of sharing the small pool of expertise. Collaborative working will continue, should all CCGs continue to value this approach.

31. Will there be any changes to performance monitoring returns and regime under full delegation?

The assurance process for fully delegated may be refined but will largely be in line with current CCG reporting.

32. Can the CCGs make changes to the GMS contract?

The CCG cannot make any changes to the existing nationally agreed GMS contract. Alternative contracting options such as application of a local QOF to meet local priorities, ACP/MCP contracts to deliver new models of care etc., can be explored and proposed but can only be introduced with agreement from the CCG GP membership.

33. How will the CCGs performance manage practices?

CCGs will adopt a locally agreed supportive approach to performance management – ensuring that the focus of ensuring sustainable general practice is at the heart of the new relationship. The responsibility of managing GP individual performance through the management of the national performer list will remain the responsibility of NHS England as well as complaints management. Conflicts of interest will be observed as part of this process.
34. How does delegation impact Out of Hours commissioning?

Delegated commissioning will enable local priorities to be fed into wider system requirements, including urgent care. The local primary care strategy will inform directly what is needed for urgent out of hours primary care provision - for example aligning shared records, determining workforce needs and developing seamless shared care plans that cover a 24 hour period.

35. If the CCG moves to fully delegated commissioning what will happen to the PMS Review if it is not complete by April 2017?

This will be managed locally enabling the local voice to shape the outcome.

Due Diligence

36. What will the process of due diligence entail?

The process of due diligence will happen in parallel to engagement. A checklist has been developed which will be shared with GP practices to ensure that all operational as well as constitutional and strategic priorities have been addressed. The development of the financial, legal, workforce and constitutional due diligence considerations will be developed by the NW London COI group for consideration by CCGs and GP practices. Legally, NHS England retains liability for primary medical services commissioning.

• In addition CCGs must ensure that any governance arrangement they put in place does not compromise their ability to fulfil their duties, and ensures they are able to meaningfully engage patients and the public in decision making.

Engagement

37. Why hasn’t the proposal to move to delegated commissioning been discussed with the LMC? Does it have their support? (Brent)

The Londonwide LMC have been engaged with our proposal to move to fully delegated commissioning from an early stage. Senior managers from both NWL
CCGs and Londonwide LMC have met on a number of occasions to discuss the approach to this debate. Both NWL CCGs and Londonwide LMC are keen to ensure all GP membership practices have a consistent and robust opportunity for discussion and debate and will continue to work towards this together.

38. Patient engagement - how will we demonstrate we are meeting our statutory engagement requirements? How do we manage any risks around patient engagement if not formally engaging at point of application?

A patient information pack co-produced with the Lay partners across NW London is in draft and will be circulated at patient groups and co-commissioning committees for review. These will then be circulated to patients via Patient Participation Groups, Healthwatch and any other appropriate forums.

39. Why have we only now just started engagement for delegation?

Active engagement (beginning with CCGs) began on 28 September 2016 with Harrow, and in Ealing CCG on 12 October. There is a shared programme for full engagement between all key stakeholders between now and mid-February when CCG GP membership voting takes place, which gives four months of engagement with CCG membership: longer than for many CCGs. NW London CCGs can submit a completed application checklist on the 05 December with the membership vote pending. No move to delegation can be made without the support of the GP membership. We attach a letter from NHSE to this effect.

Finance

40. Is the Primary Care budget protected?

No, but the allocation cannot be spent on anything else and CCGs will be held to account for delivering their Primary Care outcomes and, accordingly, for adequately resourcing general practice.

41. What would delegated commissioning mean in terms of budgets?

Under full delegation, CCGs will receive the published primary medical care allocations and take on responsibility for the expenditure budgets relating to GMS, PMS and APMS contracts.

42. How will primary care be protected from deficits in acute care? (Brent LMC)
CCGs will be able to commission across the spectrum of secondary, community and primary care, but primary care budgets cannot be used for acute expenditure.

43. Who will authorise primary care payments and how? (changes to SBS)

The CCGs will authorise primary care payments as they have control of the budgets under full delegation.

44. What will happen to the Enhanced Services (DES) budgets in the event that the CCG membership vote to move to full delegation?

This forms part of the primary medical care allocations and will be included in delegated primary care expenditure budgets.

45. Does counter-fraud responsibility around primary care medical services sit with CCGs under full delegation?

The current NHSE contract with Deloitte will not be delegated at present.

46. Does opting to move towards full delegation early result in an extra uplift for the CCG? If so, how much?

Opting in early will not result in an extra uplift for CCGs, however CCGs will lose the opportunity to have unrestricted access to contingency, headroom and growth if they do not take on full delegation in 2017/18. CCGs will not be able to make decisions on use of growth without requiring agreement from NHS England.

47. What is the amount of funding available that will support the transformation from joint commissioning to full delegation? (H&F)

There is primary care budget headroom available for Primary Care Transformation in NW London. A business case is currently being developed with proposals for utilisation of this headroom. CCGs will need to review their capacity and determine what additional resources will be required.
48. Will going to delegated commissioning risk the way the LMC is paid for?  
- At the moment it comes straight out of salaries at source.  

This is handled by Primary Care Support England, so there will be no change.

49. How will the “5 year forward view” money get to practices?  

Funding will be distributed by CCGs once their Commissioning Intentions have been approved by Governing Bodies.

50. Will we have the resources to go to fully delegated commissioning in 2017? Can we be more specific about the organisational structure required?  

Using examples of best practice, there will be staffing resource options produced which includes: allocation, secondment and working at scale options for current NHS England staff as well ensuring this addresses the capacity needs for each CCG. This will be aligned to current Primary Care expertise within each CCG (including finance). This will be shared with CCG teams and GP practices for consideration with the priority on providing adequate capacity and expertise to address all local needs.

51. As the PMS review has not been completed, will this funding be at risk?  

The PMS funding is already included in the primary medical care expenditure budgets and funded from the allocations, and as such will not change.

52. What is the process of accessing recurrent additional funding from the acute sector once delegated commissioning has been achieved?  

This remains unchanged in that it will be managed via the STP/CCG out-of-hospital strategy.

53. Will resources from primary care be moved to support / subsidise other parts of the system?  

CCG will control the allocation and cannot use the primary care budget to support/subsidise other parts of the system.
54. Do CCGs have to be delegated to change QOF?

Yes. However, it is possible for a CCG with joint arrangements to agree a change with its area team. This is best established at the start of the financial year – not mid-year. It is also worth pointing out that if a CCG plans to make changes to QOF - it needs to show that it has consulted with its patients and identified/mitigated any risks.

55. If an alternative to QOF is used, can the QOF budget be used to support that?

If an alternative to QOF is offered, a practice has the choice to accept it or not.

As for the budget - if the budget is not used for QOF it could finance an alternative but only the funds which have been allocated to the practice for QOF. QOF reporting must continue even if they do create an alternative. The commissioner (CCG responsibility) must identify for CQRS which practices are not to be paid QOF.

If a practice is opted into QOF then the money is to finance QOF not an alternative.

Also to be clear - if a practice were to opt out of QOF part-way through the year, the commissioner has to locally calculate the achievement up to that point and pay it.

56. If practices are not delivering QOF, do they still have to do the monitoring submissions?

Practices must continue to record and allow extraction of data on any continued activity on indicators formerly incentivised through QOF. QOF data is data that would be recorded as part of delivering care, and NHS England still requires assurance on the service patients are receiving. Any information collected from the patient through QOF is part of that patient’s care package.

57. What primary medical care payments are discretionary, i.e., maternity, sickness?

Full list of discretionary payments are published in the GMS Statement of Financial Entitlement.
58. Will premises reimbursements be included under delegated arrangements?

Reimbursable rent and business rates reimbursements will be included under delegated arrangements.

59. What will the CCG do to mitigate the risk of overspend on the primary care budgets?

CCGs will be required to have a primary care financial plan which will be reviewed regularly through the finance and performance committees. The internal and external audit process will also apply, as well as NHS England assurance monitoring.

60. What is the current state of the primary care budget for each CCG in NW London?

The month 5 primary medical care finance position will be sent to each CCG in a separate email. The month 6 position will also be provided once it has been made available by NHS England.

61. Will CCGs be expected to make a prescribed surplus on delegated budgets?

The value of any required surplus the CCG will be expected to make is based on the entire CCG budget, and is not required to be specifically taken against delegated commissioning budgets.

Governance

62. Who will sit on the Co Commissioning board?

This has still to be discussed and decided. The current arrangement of a local CCG commissioning committee, and an overarching oversight Committee, is likely to continue.
63. What will NWL level arrangements mean for local structures and governance?

Please see answer to Question 62 (above)

64. What will the membership have influence over in relation to setting targets and work plans?

Currently the CCG Governing Body brings the strategic and operational plans to the Membership for development and approval, and reports regularly on progress and challenges. This will continue with delegated commissioning. GP Members will be able to draw up plans for improving day-to-day services and longer-term developments, across primary, community and secondary care whilst addressing any conflicts of interest. Due diligence will address any potential risks associated with COI.

65. What changes need to be made to our constitution?

This is currently being reviewed by the CCG governance leads. GP Practices will be updated in due course.

66. Do we have a detailed programme plan for delegated Primary Care commissioning? What does the organisational shape look like?

There is a full delegated commissioning programme plan which has robust timescales and processes attached to support each CCG and its membership through the engagement process. The organisational shape will vary according to each CCG, but we are sharing models from other CCG areas where this has been developed.

An options appraisal for NW London is being developed with a priority to ensure that each of the eight CCGs has access to the expertise it needs to deliver Primary Care commissioning and contracting expertise locally. This forms part of a Primary Care OD review, commissioned by NHSE. The results of this will be shared in due course.
67. Can we continue with our joint committee?

Each CCG has to retain decision making power within its committee; therefore joint committees are not permitted. However governance needs to be set up in a way which:

- Enables collaborative discussion and aligned decision making across the STP
- Shows how any CCGs with special measures/ directions will be supported by other CCGs
- Supports effective decision making and reduces administrative burden which results from complicated/ multi-levelled governance

Committees in common which are structured effectively for example, can provide the above.

**Resource and Workforce**

68. Will there be extra resource and support at CCG level and how will this be financed? Do we have the manpower/resource to deliver delegated commissioning?

NWL CCGs are in conversation with NHSE to understand the details of the commissioning resource that will be made available. CCGs will need to review their capacity and determine what additional resources will be required.

69. How will the CCG manage this additional volume of work - what resources will come to us? What resources will we need locally? Have STP/footprint level contract management resources been agreed?

See answer above

70. What is actually coming across from NHSE to the CCG?

The Primary care budgets which includes budgets for GP core contract payments, enhanced services, QOF, premises, GP seniority payments.

NHSE and CCGs are in the process of finalising proposed structures for Primary Care support (Commissioning, Contracting and Finance). Any resources that transfer from NHSE to CCGs will be made available, however any additional resource required will need to be funded through the primary care medical allocations.
Primary Care Premises

71. What would change – or stay the same – for GP practice premises finance should NW London decide to take on under Level 3 commissioning?

The NHS (General Medical Services - Premises Cost) Directions 2013 set out the arrangements across England for the payments made to primary care contractors for:

1. Premises developments or improvements
2. Professional fees and associated costs related to occupying new or significantly refurbished premises
3. Relocation or re-mortgaging by the contractor
4. Recurring premises costs i.e. rent, rates and running costs

Under the proposed Level 3 devolution of primary care services to CCGs, items 1 and 2 above will remain the responsibility of NHS England. Responsibility for capital funding, including managing bids for renovations or for new premises will also remain with NHSE.

Matters relating to items 3 and 4 will become the responsibility (managerially and financially) of the CCG. Administration of this service is currently outsourced by NHSE to NHS Property Services, who liaise with the District Valuer, so CCGs will be responsible for overseeing this contract to make sure it meets local needs. The governance for this is likely to be retained by the CCG’s local commissioning committee, which currently oversees relocation issues jointly with NHSE.

72. What is the process for managing ongoing reviews of rent, rates, service charges etc.?

It is understood that there will be a number of rent and rates matters unlikely to be resolved by 31 March 2017. NWL CCGs have added the query on details of outstanding rent reviews to the due diligence list and the potential impact is being assessed. It is recommended that the NWL CCGs request from NHSE a side letter to the delegation agreement that provides assurance that NHS England will remain liable for any pre April 2017 liabilities. It is understood that a precedent has been set in SW London in relation to historical matters.

73. Will the process for bidding for Improvement Grant funding, or small items of capital equipment, change?

Funding for these items, and management of the bidding process, will continue to be the responsibility of NHS England.