AGENDA ITEM

REPORT TO HEALTH AND WELLBEING BOARD

24 FEBRUARY 2015

CHIEF OFFICER NHS HARTLEPOOL AND STOCKTON ON TEES CLINICAL COMMISSIONING GROUP

PRIMARY CARE CO-COMMISSIONING

SUMMARY

1.1 This paper is to:-

1.1.1 provide the Health and Wellbeing Board an overview of current primary care co-commissioning guidance since the publication of the 'Next steps towards primary care co-commissioning' document (Appendix A);

1.1.2 outline the CCG Council of Members decision in progressing this;

1.1.3 share the CCGs application to NHS England for Joint Commissioning arrangements from 1 April 2015, together with the draft Terms of Reference for the Joint Committee.

RECOMMENDATIONS

2.1 The Health and Wellbeing Board is requested to receive the update and consider, should it be approved, whether they wish a local authority representative to attend the Joint Committee.

BACKGROUND

3.1 In May 2014 Clinical Commissioning Groups (CCGs) were invited to submit expressions of interest (EOI) for the co-commissioning of primary care. Following consultation with member practices at the Council of Members meeting on 3 June 2014, the CCG submitted an EOI for delegated arrangements.

Although all of the following criteria were identified as being appropriate for delegated arrangements; the CCG expressed an interest in the four areas highlighted, pending further guidance from NHS England:

Scope,	
Working with patients and the public and with Health and Wellbeing Boards to assess needs and decide strategic priorities;	✓
Designing and negotiating local contracts (e.g. PMS, APMS, any enhanced services commissioned by NHS England);	✓
Approving 'discretionary' payments, e.g. for premises reimbursement;	x
Managing financial resources and ensuring that expenditure does not exceed the resources available;	✓
Monitoring contractual performance;	x
Applying any contractual sanctions;	x

Deciding in what circumstances to bring in new providers and managing associated procurements and making decisions on practice mergers.	✓

In November 2014 NHS England published the document 'Next steps towards primary care co-commissioning'.

The overall aim of primary care co-commissioning described in the document was to harness the energy of CCGs to create a joined up, clinically-led commissioning system which delivers seamless, integrated out-of-hospital services based around the needs of local populations. Co-commissioning is seen as an enabler to deliver the vision described in 'The NHS Five Year Forward View' document (Appendix B) where the new models of care outlined firmly include GP services working in new ways to meet local needs.

3.2 The aims of co-commissioning were to secure:-

- Improved provision of out-of hospital services for the benefit of patients and local populations;
- A more integrated healthcare system that is affordable, of high quality and which better meets local needs;
- More optimal decisions to be made about how primary care resources are deployed;
- Greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services; and
- A more collaborative approach to designing local solutions for workforce, premises and IM&T challenges.

Co-commissioning is the beginning of a longer journey towards place-based commissioning and clearly intrinsic to the delivery of the Five Year Forward View.

3.3 *Scope of co-commissioning*

In 2015/16, primary care co-commissioning arrangements will only include general practice services. CCGs will be able to discuss dental, eye health and community pharmacy commissioning with NHS England and local professional networks, but will have no formal decision making role for these areas during this period.

It would not be appropriate for CCGs to take on certain specific pseudo-employer responsibilities around co-commissioning of primary medical care. NHS England has therefore agreed that functions relating to individual GP performance management (medical performers' list for GPs, appraisal and revalidation) will be retained by NHS England, who will also be responsible for the administration of payments and list management.

The terms of GMS contracts – and any nationally determined elements of PMS and APMS contracts – will continue to be set out in the respective regulations and directions and cannot be varied by CCGs or Joint Committees.

NHS England's analysis of expressions of interest identified three main forms of co-commissioning CCGs wanted to take forward:

3.4 *Models*

The three models of co-commissioning are:-

3.4.1 Model 1 – Greater Involvement

- The CCG would collaborate closely with NHS England around primary care commissioning decisions, particularly with regard to its duty to improve the quality of primary care;
- No new governance arrangements would be required for this model and the approach to closer working could be agreed between the CCG and NHS England;
- In recognition that many CCGs are already working closely with NHS England to influence and shape primary care decision making, there is no formal approvals process for CCGs wishing to progress this model;
- CCGs have the opportunity - already available to them - to invest in primary care services.

Opportunities

- This arrangement does not provide additional opportunities for the CCG – it is effectively the status quo. It may, however, provide the CCG with more time to pace changes and develop robust plans that can be undertaken under different co-commissioning arrangements at a later date;
- Performance management of member practices remains with NHS England, so there is no potential for conflicts of interest over contracts;
- No CCG resource would be required to deal with public complaints relating to GP services.

Risks

- Although some of the risks associated with the other models could be avoided, the CCG may not be able to realise the potential benefits offered by the other models, which could mean the CCGs vision for integrated care and a reduction in health inequalities across the area might be harder to deliver;
- If most other CCGs in the north east opt for model 2 or 3 NHS England's resources could be significantly reduced resulting in a reduction in staff for the CCG to work with. This may also impact on the contact GP Practices have with NHS England primary care team;
- If this model was chosen as an interim measure with a view to move to model 2 or 3 later in the year, the CCG may find its choices more limited [eg if other CCGs join together and make good working partnerships it would be unlikely that they would wish to destabilise arrangements that are working well];
- The CCG would be unable to progress a model to deliver the expectations set out in the five year forward view at any pace.

3.4.2 Model 2 – Joint Commissioning

- The CCG would work jointly with NHS England to develop localised incentive schemes; to manage general practice budgets; manage primary care complaints and manage contractual GP practice performance;

- This model requires a Joint Committee to be established and a Legislative Reform Order (LRO) was passed through parliament to enable this from 1 October 2014;
- The formation of a Joint Committee would require the CCG to amend its constitution;
- The CCG and NHS England would agree the full membership of their Joint Committee. However, in the interest of transparency and the mitigation of conflicts of interest, a representative from the local Health and Wellbeing Board and a local Healthwatch representative will have the right to join the Joint Committee as non-voting attendees;
- The CCG and NHS England could create a pooled fund arrangement under this model; which would require close working between the two to ensure that the arrangement establishes clear financial controls and risk management systems and has clear accountability arrangements in place.;
- The CCG and NHS England would remain accountable for meeting their own statutory duties.

Opportunities

- This model provides the CCG the opportunity to be involved in a wide range of primary care commissioning without taking on full responsibility;
- Governance arrangements provide opportunities to work with other CCGs to commission services at a larger scale;
- The CCG will be able to deliver a model of care as described in the five year forward view;
- It will support the integration of health and social care services locally;
- The CCG can offer support to member practices to drive quality improvement within primary care, and reduce health inequalities;
- It will support the development of sustainable local services;
- It will ensure as a membership organisation, the CCG has a greater positive influence on decisions affecting primary care locally.

Risks

- Resource pressures at NHS England may lead to the CCG having to undertake the majority of co-commissioning related tasks making the option more akin to delegated arrangements;
- The CCG would be involved in all of the same areas available through delegated co-commissioning arrangements, including contract management and primary care complaints. There would be shared responsibility with NHS England for these areas, but the CCG would still be involved in decision making and would not be able to distance themselves from areas that may be highly scrutinised;
- The CCG will have less autonomy to make decisions under this model than under delegated arrangements and so may be constrained in their ability to fully shape GP services to reflect their strategic vision;
- Joint decision making can be time consuming if concerns are raised or the balance of decision making is uneven;
- Some decisions driven by NHS England may affect members but the CCG would still be required to stand by decisions made by the joint committee;
- It is unclear whether NHS England would have the resources to be part of several Joint Committees, so joint arrangements with other CCGs may be the only way that they could practically support joint commissioning arrangements;
- Involvement in primary care complaints may take CCG resource away from commissioning work.

3.4.3 Model 3 – Delegated Arrangements

- This model offers an opportunity for the CCG to assume full responsibility for the commissioning of primary care services;

- For legal reasons, the liability for primary care commissioning remains with NHS England. They will therefore require assurance that its statutory duties are being discharged effectively;
- Includes responsibility for contractual GP performance management, budget management and complaints management;
- There will be no formal approvals process for a CCG which wishes to develop a local QOF scheme or DES. However, any proposed new incentive scheme should be subject to consultation with the Local Medical Committee (LMC), and be able to demonstrate improved outcomes, reduced inequalities and value for money;
- The approvals process will be a straightforward one in which regional offices will review how the CCG proposes to handle and mitigate conflicts of interest;
- The CCG already handles conflicts of interests as part of their day to day work. However, it is likely that co-commissioning will lead to an increased number of conflicts of interest for CCG governing bodies and GPs in commissioning roles. CCG must be able to give sufficient confidence to the public, patients, providers, Parliament and NHS England that conflicts of interest, real and perceived, are being managed effectively through the appropriate safeguards;
- Recommended governance arrangements for this model include that the CCG establishes a Primary Care Commissioning Committee to oversee the exercise of the delegated functions. This Committee should have a lay chair and a majority of lay/executive members. As with Joint Committees for joint co-commissioning arrangements, a local authority representative from the local Health and Wellbeing Board and a local Healthwatch representative will have the right to join this Committee as non-voting attendees;
- The CCG will be required to maintain and publish a register of interests and a register of key decisions in relation to the primary care commissioning committee.
- Will require an amendment to the CCG constitution;
- The CCG will be expected to sign a legal agreement for delegation of the functions from NHS England;
- Where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act.

<u>Opportunities</u>

- Those as described in model 2, plus:-
- The CCG will have the ability to fully commission primary care and include GP services as part of the wider plans for an integrated health and social care vision;
- Full control over provision of GP services would allow the CCG to direct resources to areas of most need and also put together bespoke quality improvement schemes that are linked to priority areas for the CCG;
- Avoids uncertainty over NHS England resource that would be required for models 1 or 2;
- One commissioning organisation for the majority of health services would be a simpler and more understandable structure to patients who are often unclear about the differences between the different commissioning organisations currently responsible for the provision of their healthcare.

<u>Risks</u>

- Managing conflicts of interest would be more challenging as the CCG will be required to take over management of all GP contracts;
- Taking over the budget for GP services adds substantial requirements for financial management and potential for financial risk;
- No ‘bail-out’ for the CCG with regard to overspend in GP services budget;
- Added resource pressure with taking on more contracting, governance and payment responsibilities with no additional financial support available;

- Inability to change GMS terms and conditions – the CCG will be required to offer out nationally driven services including QOF/DES, although can agree local schemes - there may be an expectation from primary care for enhanced resource to deliver local requirements;
- Involvement in primary care complaints may take CCG resource away from commissioning work.

3.5 *CCG Submission*

The guidance and standardised models [including opportunities and risks] were discussed in detail with the Council of Members at their meeting on 6 January 2015. An impact and risk assessment was fully considered and it was agreed that Model 2 - Joint Commissioning was the preferred option for 2015/16, as it would enable the CCG to further consider their plan and implementation strategy, and better understand the potential finance and resource risks of moving to the fully delegated model.

The CCG submitted an application to NHS on 30 January 2015 [Appendix C] together with draft Terms of Reference for the Joint Committee [Appendix D]. The CCGs in the north east are currently discussing roles and responsibilities for the Joint Committees with NHS England, with a view to the Terms of Reference being agreed by the end of March 2015, in preparation for implementation on 1 April 2015.

FINANCIAL IMPLICATIONS

N/A

LEGAL IMPLICATIONS

N/A

RISK ASSESSMENT

N/A

BACKGROUND PAPERS

Appendix A - Next Steps Towards Prima | Appendix B - Five Year Forward View.p | Appendix C - Completed and signe | Appendix D - Draft ToR for joint commiss

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