REPORT TO: Health and Wellbeing Board

Date of Meeting: 27th January 2015
Report of: Jerry Hawker, Chief Officer, NHS Eastern Cheshire CCG
Subject/Title: Co-commissioning of Primary Care Services

1 Report Summary

1.1 All Clinical Commissioning Groups (CCGs) in England have been asked to indicate to NHS England by January 2015 which option they wish to proceed with in regards to the model of co-commissioning of primary medical care services in 2015/16. The three models which CCG's have a choice to take forward are:

- Model A: greater involvement in primary care decision making
- Model B: joint commissioning arrangements
- Model C: delegated commissioning arrangements

1.2 **Appendix A** provides a summary of the three model options and what adopting a model would mean for a CCG.

1.3 For 2015/16 NHS Eastern Cheshire CCG and NHS South Cheshire CCG have chosen to proceed with joint commissioning arrangements.

1.4 This paper provides additional detail around these models of co-commissioning and the intended benefits and opportunities

1.5 This paper also provides a brief overview of the actions that need to be completed and points to consider ahead of 1 April 2015.

2 Recommendations

2.1 Members of the Cheshire East Health and Wellbeing Board are asked to note the following:

- the model option chosen by both CCGs
- the governance arrangement requirements for joint commissioning and implications of membership of joint committees

3 Reasons for Recommendations

3.1 Guidance for the development of joint committees to oversee joint commissioning decisions indicates that its membership should include other statutory members of the Health and Wellbeing Board.

3.2 Co-commissioning local primary medical care services provides further opportunity to improve quality of services delivered, experience and outcomes for Cheshire East residents and its communities through improving the quality of general practice for patients.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 Co-commissioning could potentially lead to a range of benefits for the public and patients, including:

- improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- high quality out-of-hospitals care;
- improved health outcomes, equity of access, reduced inequalities; and
- a better patient experience through more joined up services.

4.2 Co-commissioning is seen as a way to:

- promoting greater Integration of health and care services
- shaping investment to increase primary care capacity
- designing and negotiating contracts to better meet local care system, patient needs as well as enhancing clinical engagement in primary care contracting
- enable better management contractual delivery, improving performance
- strengthen the quality improvement agenda, ensuring needs are locally defined rather than nationally, galvanising membership engagement
- enable greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services
- improve the quality markers around patient experience, satisfaction and access through enhanced local provision and reduced unwarranted variation in care
- enable a more collaborative approach to designing local solutions for workforce, premises and IM&T challenges.

5 Background and Options

5.1 On 1st May 2014 Simon Stevens at the Annual NHS Clinical Commissioners Conference in London announced that CCGs would have the opportunity to co-commission primary care. CCGs received on the 9th May 2014 correspondence from NHS England outlining the detail behind this opportunity.

5.2 CCGs were asked to submit expressions of interest to develop new arrangements for co-commissioning of primary care services to NHS England by the 20th June 2014.

5.3 Further correspondence was received by NHS England on the 27th June 2014 and on 1st September 2014 providing an update on co-commissioning. 196 CCGs expressed an interest in co-commissioning. Notification was also given about the establishment of a national primary care co-commissioning oversight group to take the co-commissioning agenda foreword and which was to be co-chaired by Ian Dodge – national Director for Commissioning Strategy, and Dr Amanda Doyle – Chief Clinical Officer for NHS Blackpool CCG. This group has been tasked to oversee co-commissioning policy development and the publication of guidance setting out the steps that CCGs need to undertake towards taking on co-commissioning responsibilities.

5.4 On the 29th September 2014 CCGs received further correspondence from NHS England which presented for comment and review the slide deck, 'Proposed next steps towards primary care co-commissioning: an overview', which provided for discussion further detail around the proposed models for co-commissioning and key questions related to the implementation of these models. The three models which CCG's had a choice to take forward are:

- Model A: greater involvement in primary care decision making
- Model B: joint commissioning arrangements
- Model C: delegated commissioning arrangements

Appendix A provides further detail on what adopting a particular model of co-commissioning would mean for a CCG.

5.5 On the 10th November 2014 CCGs received final guidance around co-commissioning. The document entitled *'Next Steps towards primary care co-commissioning'* provided additional detail to CCGs with regards the models of co-commissioning, the steps required to submit the preferred approach and detail around conflicts of interest.

5.6 This document confirmed that for the 2015/16 period the commissioning of primary care services that include dentistry, optometry and community pharmacy services would remain the responsibility of NHS England, however CCGs would still have the opportunity to discuss these areas with their NHS England area team but have no formal decision making role.

5.7 *'Next Steps towards primary care co-commissioning'* was accompanied by a suite of supporting documents providing tools and resources to support CCGs in the process of submitting their proposals, namely:

- submission proforma for joint commissioning or delegated commissioning
- model wording for amendments to CCG Constitutions. This is required due to the passing of the Legislative Reform Order (LRO) in Parliament allowing CCGs to form joint committees with one or more CCG and to form joint committees with NHS England. Further detail has been provided in a briefing letter to CCG's. It is important to note that the LRO does not allow CCGs to form joint committees with Local Authorities. It is not the intention that joint committees will replace other important strategic decision making fora such as Health and Wellbeing Boards. Amendments to the individual constitutions of both NHS Eastern Cheshire CCG and NHS South Cheshire CCG have been made to reflect the model wording within the guidance and approved / ratified by the membership of each CCG and Governing Body.
- model Terms of Reference for joint commissioning arrangements and delegated commissioning arrangements.

5.8 On the 19th December 2014 NHS England released an updated version of 'Managing Conflicts of Interest: Statutory Guidance for CCG's – which incorporated additional guidance on how to manage conflicts with the advent of co-commissioning.

5.9 **Models of Co-commissioning.** For all forms of primary care co-commissioning, there has been clear feedback from CCGs that it would not

be appropriate for CCGs to take on certain specific pseudo-employer responsibilities around co-commissioning of primary medical care. Whilst CCGs must assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services, it has been agreed that NHS England will retain the following responsibilities regardless of what model option is chosen by a CCG:

- functions relating to individual GP performance management (medical performers' list for GPs, appraisal and revalidation)
- the administration of payments and list management
- setting the terms of General Medical Service (GMS) contracts – and any nationally determined elements of Primary Medical Services (PMS) and Additional Primary Medical Services (APMS) contracts. These terms will continue to be set out in the respective regulations and directions and cannot be varied by CCGs or joint committees. For the avoidance of doubt, CCGs will be required to adopt the findings of the national PMS and Minimum Practice Income Guarantee (MPIG) reviews, and any locally agreed schemes will need to reflect the changes agreed as part of the reviews.

5.10 With the freedoms of co-commissioning arises the need for mitigation of the potential risks of inconsistency of approach in areas where national consistency is clearly desirable. There is already an ability to set out core national requirements in GMS, PMS and APMS contracts through regulations. In line with this, NHS England reserves the right to set national standing rules, as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets and IT intra-operability. The standing rules would become part of a binding agreement underpinning the delegation of functions and budgets from NHS England to CCGs.

5.11 Consistent with the NHS Five Year Forward View and working with CCGs, NHS England reserves the right to establish new national approaches and rules on expanding primary care provision – for example to tackle health inequalities. This applies to joint and delegated arrangements.

5.12 Throughout November 2014 both CCGs engaged with their member practices, governing body and clinical leadership seeking their views and agreement as to which model of co-commissioning to indicate to NHS England. Both CCGs agreed that for 2015/16 joint commissioning would be the option of choice.

5.13 In joint commissioning arrangements, individual CCGs and NHS England always remain accountable for meeting their own statutory duties, for instance in relation to quality, financial resources, equality, health inequalities and public participation. This means that in this arrangement, NHS England retains accountability for the discharge of its statutory duties in relation to primary care commissioning. CCGs and NHS England will need to ensure that any governance arrangement they put in place does not compromise their

respective ability to fulfil their duties, and ensure that they are able to meaningfully engage patients and the public in decision making. Arrangements should also comply with the conflicts of interest guidance.

5.14 For joint commissioning arrangements a joint committee structure has been the recommended governance structure as this allows a more efficient and effective way of working together than a committees-in-common approach. A joint committee is a single committee to which multiple bodies delegate decision-making on particular matters. The joint committee then considers the issues in question and makes a single decision. In contrast, under a committees-in-common approach, each committee must still make its own decision on the issues in question.

5.15 A model terms of reference for joint commissioning arrangements, including scheme of delegation, has been provided to CCGs and it being encouraged to be used as the framework for a local terms of reference, adapted to reflect local arrangements and to ensure consistency with the CCGs particular governance structures. Both CCGs are currently adapting the model terms of reference.

5.16 **Membership of joint committees.** It is for the area team and CCGs to agree the full membership, but the membership of the committee should be constituted so as to ensure that the majority is held by lay and executive members. The Chair and Vice Chair of the committee must always be lay members. Guidance indicates that GP representatives from other CCG areas and non-GP clinical representatives (such as CCGs secondary care specialist and/or Governing Body nurse lead can be invited to sit on the committee. Lay members not currently employed/contracted by a CCG can be co-opted onto this committee.

5.17 A standing invite must be made to Healthwatch Cheshire East and the Cheshire East Health and Wellbeing Board to appoint representatives to attend the committee meeting as non-voting attendees.

5.18 It is vital that membership of their committees retains clinical leadership for commissioning.

5.19 Meetings of the Joint Committee are expected to be held in public, unless the CCG has concluded it is appropriate to exclude the public.

5.20 It is not the intention that joint committees will replace other important strategic decision making fora such as Health and Wellbeing Boards.

5.21 **Resources and support.** Under joint commissioning arrangements there will be no direct transfer of dedicated staff resources from the NHS England area teams primary care commissioning staff, and there is no possibility of additional administrative resources being deployed on these services at this time due to running cost restraints. Therefore conversations are ongoing with the area team and neighbouring CCGs with regards identifying a pragmatic and flexible local solution to accessing and pooling support through the

existing area team primary care team and primary care expertise within CCGs.

5.22 It has been recognised by NHS England that it will be challenging for some CCGs to implement co-commissioning arrangements without an increase in running costs. Whilst NHS England has indicated that an increase is not possible in 2015/16, they will keep this situation under review.

5.23 **Approval process.** Both CCGs are required to submit their individual proforma to NHS England by 30th January 2015. The proposal will be agreed by the area team via regional moderation panels that will convene in February 2015, and if they are assured that arrangements comply with the legal governance framework and constitution amendments have been approved. Once approved, the CCG and NHS England will be required to sign a legally binding agreement to confirm how both parties will operate under joint arrangements, with a view to arrangements being implemented by 1 April 2015.

5.24 Unless a CCG:

- Serious governance issues; or
- Is in a state akin to 'special measures'

then NHS England will support a CCG to move towards joint commissioning

5.25 In the event the CCG proposal in not recommended for approval, regional teams will work with the CCG and the area team to support the development of joint arrangements.

5.26 It is anticipated that many CCGs across England intend to enter into joint commissioning arrangements for 2015/16 to see how the agenda develops, before deciding to take on delegated responsibilities from 2016/17.

5.27 **Assurance.** The on-going assurance of primary care co-commissioning arrangements would be managed as part of the wider CCG quarterly assurance process, adapted according to the commissioning function that the CCG is undertaking. NHS England is currently working with CCGs to co-develop a revised approach to the current CCG assurance framework for 2015/16.

5.28 As primary medical care co-commissioning has implications for Local Authorities and Health Wellbeing Boards, NHS England has provided updates to both Local Authority CEOs and HWB Chairs. The last update was sent on 18th December 2014.

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

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Appendix A Model Options for Co-Commissioning

Model A: Greater Involvement in Primary Care decision making Aims to deliver greater CCG involvement in influencing commissioning decisions made by NHS England area teams; this requires no formal governance process and Area Teams will be expected to put the appropriate arrangements in place. This option **does not** change the existing relationship and responsibilities of the CCG. Furthermore, there are no requirements for the CCG to enter into new governance arrangements and it is unlikely that CCGs will encounter increased conflicts of interest.	Advisory role for the planning of wider Primary Care services (not medical): • Assessing needs • Co-designing services/models • Developing strategic direction for services • Liaison with other service partners Advisory role for strategic planning of General Practice • With HEE of workforce • Premises, including Prioritisation of investment via joint SYB wide governance • arrangements • Reducing unacceptable variation in quality of provision • The CCG would have the opportunity

	to invest in Primary Medical Care services in line with current arrangements.
Model B: Joint Commissioning Arrangements Joint commissioning arrangements; requires appropriate governance arrangements and the creation of a Joint Committee across NHS England and the CCG(s). NHS England's scheme of delegation is being reviewed and will be revised as appropriate to enable to formation of joint committees between NHS England and CCGs. Funding under this option will remain on the NHS England financial ledger, and NHS England will remain party to all decision making.	Jointly designing, reviewing and making contract decisions: • GMS/PMS/APMS contracts • Jointly deciding appropriate arrangements for practice splits/mergers/replacements • Joint decisions and setting priorities for discretionary spend on premises and how to increase workforce capacity • Joint approach to decisions on reinvestment of any released primary care medical spend, based on agreed strategic place based strategy • Jointly reviewing practice and deciding strategic direction and scope • Jointly managing enhanced services not delegated to the CCG • Working collectively together on Primary Care Education & Training • Joint decision making in establishment of new GP practices, and approving practice mergers • Joint decision making on "discretionary payments" • Pooling of funding for investment in primary medical care services.

Model C: delegated commissioning arrangements: Requires a comprehensive assurance process to satisfy NHS England that the CCG(s) has the capacity and capability to undertake this additional role, that the evidence of expected benefits to patients is clear, and that CCG governance arrangements, particularly in relation to conflict of interest, are robust. An assurance process, coordinated and managed in line with the broader CCG assurance	Offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. However, legally, NHS England retains the residual liability for the performance of primary medical care commissioning. A standardised model of delegated commissioning responsibilities has been agreed and includes; • GMS, PMS, APMS contracts • Newly designed enhanced services ("Local Enhanced Services" (LES) and "Directed Enhanced Services" (DES)) • Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF) • Ability to establish new GP practices in an area. • Approving practice mergers • Making decisions on discretionary payments (e.g. returner / retainer schemes) • Pooling of funding for investment in primary medical care services