PRIMARY CARE CO-COMMISSIONING

A Briefing for Practices

October 2015

Background

CCGs have had the ability to take part in co-commissioning with NHS England since April 2015. There are three models of co-commissioning proposed in the Guidance provided by NHS England entitled *"Next Steps Towards Primary Care Co-Commissioning"*:-

A. Greater involvement in primary care decision making

B. Joint commissioning arrangements

C. Delegated commissioning arrangements

The basic roles and responsibilities envisaged as part of these models are detailed in the table below.

Primary Care function	A Greater involvement	B Joint commissioning	C Delegated Commissioning
General practice commissioning	Potential for involvement in discussions but no decision making role	Jointly with area teams	Yes
Pharmacy, eye health and dental commissioning	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role
Design and implementation of local incentives schemes	No	Subject to joint agreement with the area team	Yes
General practice budget management	No	Jointly with area teams	Yes
Complaints management	No	Jointly with area teams	Yes
Contractual GP practice performance management	Opportunity for involvement in performance management discussions	Jointly with area teams	Yes
Medical performers' list, appraisal, Revalidation	No	No	No
Administration of payments, list management	No	No	No

Aims of Co-Commissioning

Co-commissioning is intended to give CCGs the option of having more control of the wider NHS budget, enabling a shift in investment from acute to primary and community services. It could potentially lead to a range of benefits for patients including:-

- Improved access to primary care and wider out-of-hospital services with more services available closer to home.
- High quality out-of-hospital care.
- Improved health outcomes, equity of access and reduced health inequalities.
- A better patient experience as a consequence of more freed up resources.

Resources for Co-Commissioning

Ensuring that CCGs can access the necessary resources as they assume new co-commissioning responsibilities will be a major challenge. Flexible solutions will need to be agreed by CCGs and the Area Team that work locally from 2015/16 onwards. Arrangements will need to ensure that:-

- CCGs taking on delegated commissioning responsibilities have access to a fair share of the Area Team's primary care commissioning staff resources to deliver their responsibilities.
- Area Teams retain a fair share of existing resources to deliver all their ongoing primary care commissioning responsibilities.

Conflicts of Interest

There is a legal requirement for CCGs to have arrangements in place for managing conflicts of interest. Statutory Guidance has been produced for CCGs with the aims of:-

- Enabling CCGs and clinicians in commissioning roles to demonstrate that they are acting fairly and transparently and in the best interest of their patients and local populations;
- Ensuring that CCGs operate within the legal framework, but without being bound by over-prescriptive rules that risk stifling innovation;
- Safeguarding clinically led commissioning, whilst ensuring objective investment decisions;
- Providing the public, providers, Parliament and regulators with confidence in the probity, integrity and fairness of commissioners' decisions; and
- Upholding the confidence and trust between patients and GP, in the recognition that individual commissioners want to behave ethically but may need support and training to understand when conflicts (whether actual or potential) may arise and how to manage them if they do.

a) Legislative Framework

The starting point for CCGs is Section 140 of the National Health Service Act 2006. This sets out the minimum requirements in terms of what both NHS England and CCGs must do to safely manage conflicts of interest. For CCGs this means that they must:-

- Maintain appropriate registers of interests;
- Publish or make arrangements for the public to access those registers;
- Make arrangements requiring the prompt declaration of interests by the persons specified (members and employees) and ensure that these interests are entered into the relevant register;
- Make arrangements for managing conflicts and potential conflicts of interest (e.g. developing appropriate policies and procedures); and
- Have regard to guidance published by NHS England and Monitor in relation to conflicts of interest.

b) Views of the GPC

GPC has consistently argued that clinicians – especially GPs – should have an integral role in commissioning decisions. However, GPC is clear that the proposals set out in NHS England's Next Steps document, coupled with the statutory requirement for GP practices to be members of a CCG, significantly increases the frequency and range of potential conflicts of interest, both real and perceived. This will be especially the case for CCGs taking on delegated co-commissioning arrangements.

It is important for practices to be aware that co-commissioning, especially delegated responsibility - enables CCGs to hold and manage the core GP contract of their members, with powers to issue breach notices and terminate contracts. GPC has consistently and vigorously opposed granting CCGs greater control over these functions. As CCGs are membership organisations and must be accountable to their member practices, GPC's position is that this is therefore fundamentally incompatible with CCGs holding and managing core practice contracts.

c) Changes to CCG Constitutions

NHS England has stipulated that CCGs looking to adopt joint and delegated commissioning arrangements will require an amendment to their constitution.

Any CCG that is contemplating entering into new commissioning arrangements must check its constitution to ensure it contains no unsuitable or inadequate provisions. This process should be undertaken in collaboration with member practices and the LMC.

Having taken legal advice on this matter, GPC suggests that CCGs taking on board joint or delegated commissioning arrangements should introduce an additional paragraph in their constitutions. This paragraph expressly references the concerns of their member practices and specifically covers contract management.

The principle purpose of GPC's suggested amendment, see below, is not to increase the scope of the CCGs conflicts of interest management responsibilities but to provide a public acknowledgement by the CCG that co-commissioning arrangements are likely to give rise to a greater likelihood that conflicts of interest will arise, and offer reassurances to member practices that these conflicts will be adequately addressed.

"[4] Managing Conflicts of Interest

"[4.1] The CCG recognises that the making of arrangements for co-commissioning (whether with other CCGs or NHS England) and/or the exercise by the CCG of specified NHS England functions (whether jointly or under delegated arrangements) are likely to give rise to conflicts of interest or potential conflicts of interest.

[4.2] The CCG shall keep its policies and procedures for the management of conflicts of interest under review and shall promptly implement any changes necessary to counter any risks or perceived risks) associated with or arising from any arrangements it may make for co-commissioning and/or the exercise of specified NHS England functions.

[4.3] The CCG shall ensure that it complies at all times with its statutory duties in relation to the avoidance and management of conflicts of interest in relation to the exercise of any functions relating to the commissioning and/or management of primary medical services and any activities relating thereto, including (without limitation):-

- designing service requirements;
- investment decisions affecting GP services;
- the establishment of new GP practices;
- approving practice mergers;
- approving contract variations;
- monitoring contracts;
- setting contract performance requirements;
- issuing any notice in relation to a contract, including the application of contract sanctions; and
- terminating any contract.

[4.4] The references at paragraph [4.3] above to the exercise of functions relating to the commissioning and/or management of primary medical services and any activities relating thereto include (without limitation) any exercise of such functions by:-

- the CCG itself or by any committee thereof; or
- any member of the Governing Body of the CCG; or
- any other officer or employee of the CCG; or
- any member of the CCG,

and whether by any such person alone or by way of their participation in any joint committee established with NHS England or with any other CCG.

[4.5] The provisions in paragraphs [4.2] to [4.4] are without prejudice to the CCGs general obligation to comply at all times with all applicable laws. Regulations, codes of conduct and guidance, including (without limitation) the statutory guidance on managing conflicts of interest published from time to time by NHS England and/or by Monitor".

Opportunities and Risks

The LMCs have considered in detail the introduction of primary care co-commissioning and have highlighted the following as being potential opportunities and risks particularly in the case Delegated Commissioning:-

Opportunities Provided by Co-commissioning

- CCGs will have “complete” control of budgets across health.
- They will have more “levers” with which to initiate change.
- They will be closer to practices and more sensitive to their needs.
- They can develop local services through local change.
- New local quality and outcome schemes will better suit their patients.
- Performance management of practices will be through peer review and support.
- They will be free of national control to make more rapid changes to provision.
- They will be able to award contracts where required.
- Practices will be free from interference from distant and resource poor Area Teams.
- CCGs may be able to involve the public more closely in future care arrangements.
- The commissioning of pathways and integration of care may be more readily achieved by Co-commissioning.

Risks of Co-commissioning

- Potential Conflict of Interest issues (COI) within a membership organisation.
- Reduction of clinical input through perceived COI.
- The size of CCGs may work against their success and give rise to mergers.
- Are more “levers” for change merely potential threats to practices?
- Will this lead to regional contracts, and will this be a bad thing?
- CCGs may not have the capacity or resources to properly commission primary care.
- There may be the possibility of local bullying within small organisations.
- Will those who do not go to full delegation be left behind?
- The need to satisfy governance and to remain a credible member organisation could lead to greater bureaucracy.
- CCG commissioning may lead to quality variations in care across England.
- CCGs may not be adequately funded to commission successfully.

Key Points for Practices

- The delegated commissioning model creates a more unified commissioning structure similar to that previously adopted by PCTs. Practices will have their own views on how successful this structure was in terms of supporting and developing general practice.
- CCGs were originally set up without the responsibility for primary care, largely in order to protect them from the complexities of conflict of interest inevitable in a primary care membership organisation. There are risks to the membership ethos of the organisation and to its reputation unless particular attention is given as to how this will be properly managed.
- Co-commissioning is being presented as both a re-unification of commissioning and an opportunity to improve investment in primary care even though it brings no new obvious avenues by which this might be achieved.
- The ability of CCGs to invest more in general practice and primary care already exists under the current arrangements. NHS England's Primary Care Strategy for Essex makes reference to a "shift of up to 5% in resources from hospital providers into primary care, equating to a transfer of £90 million within the system".
- CCGs are required to formally engage with their members when actively considering co-commissioning options. The one CCG that has consulted the LMC on its proposals this year has made it clear that it would not apply for co-commissioning arrangements unless at least 50% of practices exercised their right to vote and at least 75% of these respondents supported the proposal.
- The LMC is of the view that any move to co-commissioning must be supported by two thirds of member practices that exercise their right to vote. **All Practices are strongly encouraged to vote on this important issue whatever their views.**
- There is no requirement on CCGs to move to the delegated commissioning model straight away, neither does this need to take place by 1st April 2016. The Guidance makes it clear that NHS England intends to "make it as simple as possible for CCGs to change their co-commissioning model".
- The CCG's Constitution will need to be changed to legitimise any move to either joint or delegated co-commissioning. Any application to vary its Constitution will need to include "an assurance of the agreement of member practices".
- Under either the joint or delegated model, the CCG would have the ability to offer member practices the opportunity to participate in a locally designed contract, eg. as an alternative to QOF and DESs. . Practices need to be aware that:-
    - Participation in local arrangements is without prejudice to the rights of practices to their GMS entitlements which are negotiated and agreed nationally.
    - The terms of GMS Contracts, and any nationally determined element 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.
    - CCGs will be required to adopt the findings of the national PMS and MPIG Reviews and any locally agreed schemes will need to reflect the changes agreed as part of the Reviews.
    - Individual GP performance, appraisal and revalidation will remain the responsibility of the Area Team.
    - Any move away from national arrangements to a local incentive scheme is voluntary and requires the formal agreement of each individual practice.

Local Incentive Schemes

Any proposed incentive scheme will need to be the subject of consultation with the LMC and be able to demonstrate improved outcomes, reduce health inequalities and value for money. The LMC has agreed the following principles governing the introduction of Local Incentive Schemes:-

General Principles

- It must be ethical.
- It must not threaten the GP/patient relationship.
- It must not merely involve a target financial figure.
- It must be voluntary.
- It should be based on patient outcomes.
- It must be driven by improved quality.
- It should include an educational element.
- Ideally, it should originate at practice or locality level.
- Rewards from the scheme should be restricted to improving patient care.
- It should be subject to external scrutiny or review.
- No scheme should attempt to delay or withhold necessary care to an individual patient.

Operational Issues

- The scheme should aim to increase the availability and range of adequately funded primary care.
- It must utilise reliable data at practice level.
- It must make efficient use of public funds.
- It must fund all additional work in primary care.
- It must be practical and sustainable and therefore have a realistic chance of success.
- It should take account of and address health inequalities.
- It must be subject to regular review and audit, and be capable of adaptation to changing circumstances.

Practice Considerations

- Does the scheme answer, where relevant, the points above?
- Will our patients benefit?
- Can the practice contribute to the success of the scheme?
- How much work is involved for the practice?
- Is the extra work adequately funded?
- Do we have the capacity to do this effectively?
- Does this make financial sense for the practice?

The Approvals Process 2015/16 and Beyond

There will be a number of opportunities for CCGs to implement new joint commissioning arrangements with NHS England.

Delegated Commissioning

CCGs who don't currently have delegated arrangements in place can apply to assume delegated responsibility from 1st April 2016. CCGs need to submit their proposal both to NHS England centrally and to their local NHS England team by midday on Friday 6th November 2015.

Regional panels will review the proposals and make recommendations to the national panel on which proposals to take forward. This is expected to be completed by the end of 2015.

Joint Commissioning

There will be two further opportunities this year for CCGs to implement new joint commissioning arrangements with NHS England:-

1st October 2015	Open to CCGs not currently with joint/delegated arrangements
1st January 2016	Open to all CCGs not currently with joint/delegated arrangements

Next Steps for Practices

- The LMC has a role in informing and supporting constituents but the final decision about whether or not to support the introduction of primary care co-commissioning, and in what form, rests with individual practices as members of the CCG.
- Practices are advised to familiarise themselves with the issues raised in this briefing together with the Guidance produced by NHS England: *"Next Steps Towards Primary Care Co-Commissioning"*, and that produced by the GPC: *Important Guidance for CCG Member Practices and LMCs* and *Guidance for GPs and LMCs regarding Conflicts of Interest.,* which can be accessed via the LMC's website, www.essexlmc.org.uk
- Practices requiring any further information are advised to contact the LMC office or their local LMC representative.