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GPC update on co-commissioning of primary care: Important Guidance for CCG member practices and LMCs

This paper is to inform GP practices and LMCs about options for your CCG to take greater commissioning control (called "co-commissioning") including the commissioning and performance management of general practice contracts. It is important that all practices understand these changes and their implications. As a practice it is important you are aware of what is happening in your area so you can exercise your rights as a member to democratically influence the decision of your CCG.

December 2014

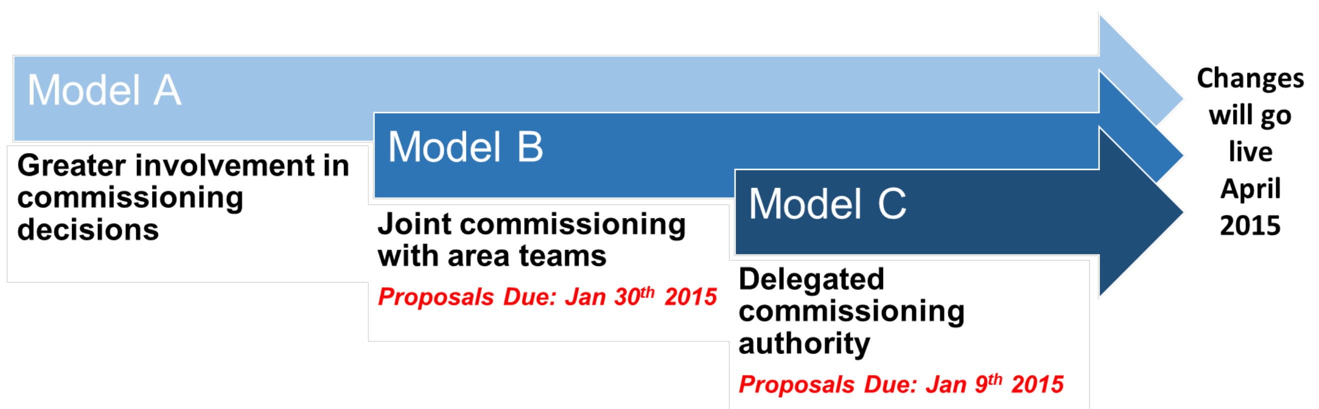
Know your rights: Key points for CCG member practices and LMCs

1) All GP practices in England are members of a CCG (this is a statutory requirement)
2) As membership organisations CCGs are accountable to their members; members can vote to have CCG Board dissolved, or an individual Board member removed
3) CCGs must consult their membership before making any decisions about co-commissioning and/or amending constitutions and before submitting proposals to NHS England; this must be done with the agreement of member practices
4) The **deadline for submissions**, including amending constitutions, is:
   - January 30th (for joint commissioning)
   - January 9th (for delegated commissioning)
5) CCGs need not rush – this is not a "one off" opportunity; CCGs can wait until 2016/17 before they seek to take on board greater co-commissioning responsibility

What is co-commissioning?

Co-commissioning refers to the process whereby CCGs will be granted greater powers to directly commission primary medical services and performance manage practices (but not individuals).

Under plans released in early November 2014 in the document **'Next steps towards primary care co-commissioning'** (here), NHS England is offering each CCGs across England the opportunity to adopt one of three commissioning



models.

What do the different co-commissioning models mean?

1) Model A: Greater Involvement

Greater involvement in primary care co-commissioning is an invitation to CCGs to collaborate more closely with their Area Teams to ensure that decisions taken about healthcare services are strategically aligned across the local health economy. There is no formal approval process for greater involvement; arrangements should be taken forward locally.

2) Model B: Joint Commissioning

A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their Area Team.

The functions joint committees could cover are:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services (LES and DES);
- Design of local incentive schemes as an alternative to QOF;
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

Within this model CCGs also have the option to pool commissioning and GMS/PMS funding for investment in primary care services.

Joint commissioning will require a joint committee or "committees in common" to make commissioning decisions. This could be with one or more CCGs and the Area Team. It is for Area Teams and CCGs to agree the full membership of this Committee. Representatives from the local HealthWatch and Health and Wellbeing Board will also have the right to join this committee as a non-voting member.

3) Model C: Delegated Commissioning

Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. CCGs continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation. Because of limited management resources within Area Teams, as well as proposed mergers, NHS England suggests CCGs wishing to take on delegated commissioning to consider collaborating with other CCGs to receive requisite support.

The functions CCG with delegated authority could cover are:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action, such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services (LES and DES)
- Design of local incentive schemes as an alternative to the QOF;
- The ability to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payments (e.g., returner/retainer schemes).

Within this model CCGs also have the option to pool commissioning and GMS/PMS funding for investment in primary care services.

Delegated commissioning will require CCCs to create a 'primary care commissioning committee' to oversee the exercise of delegated functions. It is for CCGs to agree the full membership of this Committee. However, this Committee will be required to have a lay Chair and lay and executive majority. Representatives from the local HealthWatch and Health and Wellbeing Board will also have the right to join this committee as a non-voting member.

What won't CCGs be able to do?

CCGs – regardless of the commissioning model adopted - will not have any additional powers over the performance management of individual GPs, including the medical performers' list, appraisal or revalidation. Although CCGs will not have direct power to performance manage individual GPs, they will have significant influence.

CCGs will not have any additional powers over the commissioning of dental, community pharmacy and eye health. NHS England will retain this role until at least 2015/16.

How will my practice be affected by these changes?

Co-commissioning has the potential be a mechanism for GPs as members of CCGs to have greater influence over the commissioning of services, including the ability to enhance the funding and provision of general practice, for the benefit of the profession and patients.

However, it is important for practices to be aware that co-commissioning also enables CCGs to hold and manage the core GP contract of their members, with powers to issue breach notices and terminate contracts. This is a major change to the way general practice is commissioned and performance managed and could have serious and far reaching consequences.

GPC has consistently and vigorously opposed granting CCGs greater control over the GP contract and performance management functions, because we believe it carries an inherent conflict of interest between Board GPs and member practices. Further information is detailed in the conflicts of interest (COI) section below, as well as measures of how this can be mitigated.

Whether or not your CCG decides to submit a proposal, changes to the way primary care is commissioned are inevitable, as described in NHS England's Five Year Forward View. Regardless of co-commissioning decisions, proposed mergers of Area Teams will impact on management and administrative support to CCGs.

A list of potential benefits and risks of each model is tabled below, which practices should carefully consider.

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Weighing up the pros and cons:
The co-commissioning models and their implications for GP practices

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	Opportunities for practices	Threats to practices
Greater Involvement	CCGs have more influence in the development of general practice without any of the risks of having any direct responsibility or accountability Opportunity to build on gains made since the introduction of CCGs *without* the need for restructuring May allow CCGs to take a significant advisory and consultative role to NHS England without the risk associated of responsibility	Commissioning decisions remains slow and fragmented CCGs (and practices) are less able to make changes to general practice services than those who have decided to take on greater responsibility (widening gap between practices and for patients) CCGs have minimal influence over national strategy – will not be able to design local incentive schemes to replace QOF and DES Risk of further deterioration of the quality of GP commissioning with remote, recently merged sub-regional NHS England teams
Joint Commissioning	Opportunity for significant new and increased influence over GP commissioning agenda Ability to design local schemes to replace QOF and DESs Could create better collaboration with neighbouring CCGs as they work together in one joint commissioning group with the AT CCGs (and member practices) relatively less exposed to COI issues compared to full GP commissioning responsibility	Risk that joint structures will have no real accountability to individual CCGs (and member practices) Local schemes to replace QOF and DESs may result in increased workload as practices likely to still be expected to adhere to QOF indicators (which will be monitored); local negotiations could undermine the national contract Increased exposure to COI (whether real or perceived) related to CCGs role in procuring services from members (and their own practices) Tensions between CCGs Board and member practices related to COI arising from CCGs jointly commissioning, holding, and managing GP contracts Could worsen tensions where historic relationship between member practices and CCG is poor or dysfunctional
Delegated Responsibility	Opportunity for GPs in CCGs to have direct leadership to influence the development and investment in general practice CCGs will be best placed to commission primary/community/ secondary care in holistic and integrated manner Ability to design local schemes to replace QOF and DESs CCGs will have more power to drive forward the development of new GP provider models and the 5yr forward view agenda	Unclear whether CCGs will have sufficient capacity, expertise (or will be large enough) required to deliver since CCGs will not be provided any additional resources (and AT becoming more distant) – likely to weaken influence of GP member practices CCGs commissioning, holding and managing GP contracts could worsen tensions where historic relationship between member practices and CCG is poor or dysfunctional Local schemes to replace QOF and DESs may result in increased workload as practices likely to still be expected to adhere to QOF indicators (which will be monitored); local negotiations could undermine the national contract Increased exposure to COI (whether real or perceived) related to CCGs role in procuring services from members (and their own practices) Paradoxically the COI issue could therefore lead to less true influence by GPs, practices and CCGs in commissioning of general practice

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Managing increased Conflicts of Interest in Joint and Delegated Commissioning

There are ways of mitigating conflicts of interest by putting in place specific measures in the CCG constitution. CCGs must consult with their member practices about the necessary changes to their constitutions. NHS England proposes a "joint committee" in joint commissioning, and a "primary care commissioning committee" in delegated commissioning to make decisions affecting member practices.

These will have a lay chair and executive majority. GPC believes that such measures should be robust, transparent and vitally command confidence amongst member practices. As a minimum we believe that GP members of CCG boards must not be involved in any investment or performance management decisions affecting member practices.

Rather the Committee should bring in external non-conflicted GP(s) such as from neighbouring CCGs or LMCs.

GPC will soon be issuing further specific guidance covering conflicts of interest.

As GP provider and CCG member, what should I do?

CCGs must submit deadlines by Jan 30 (joint commissioning) and Jan 9 (delegated)

- ☑ Understand the different co-commissioning models and their implications for your practice as in this guidance, as well as NHS England Next Steps
  - Consider the potential benefits and risks of each option/model
- ☑ Consult your LMC on your CCGs plans **NOW**
  - What commissioning arrangements are surrounding CCGs seeking?
  - How will these changes affect the local health economy?
- ☑ Know your rights, and your CCG's responsibilities:
  - Be aware that CCGs are membership organisations who must consult with their members and secure their support before submitting co-commissioning proposals. GPC believes this should take the form of a formal democratic vote of member GPs/practices
  - Any CCGs granted Model B or C commissioning arrangements must update their constitutions – this MUST be done in collaboration with member practices
- ☑ Engage your CCG Board. Discuss with them:
  - What do they see as specific proposed benefits of co-commissioning?
  - What are their views on holding and performance managing member GP contracts?
  - What will membership of 'joint committees' and 'primary care commissioning committees' be?
  - How will CCGs manage and mitigate the risks of Conflicts of Interest (COI)
  - Under joint and delegated commissioning arrangements, where do practices go for arbitration (what frameworks is your CCG putting in place)?
- ☑ Know your constitution: this applies to partners and sessional GPs
- ☑ Any CCGs granted Model B or C commissioning arrangements must update their constitutions – this must be done in collaboration with member practices (see submission deadline above)
- ☑ Remember this is not a one off "all or nothing" decision. CCGs can opt for co-commissioning models later in 2016/17 and beyond and therefore they must not feel pressurised to pursue any particular option now.

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FAQs about the commissioning landscape: important information for practices and LMCs

NHS England Area Team boundaries are changing? Could this have an impact on practices?	Yes. Area Teams boundaries are being redrawn and the number of Area Teams across England is being reduced from 27 to 15. These changes are likely to make Area Teams more remote and with less capacity than they have now.
Once co-commissioning comes into effect, are any other changes to commissioning likely?	Yes. NHS England has noted that co-commissioning reforms are the first step towards turning CCGs into organisations which may use a capitated budget to deliver care to defined populations.
Is it true that CCGs are also soon to be commissioning specialised services?	Yes. CCGS will also be taking responsibility for more of the specialized commissioning decisions, much of which has a deficit. In effect we are moving back to the level of responsibility of former PCTs but with the requirement to balance the books across a much wider range of services. The risk is general practice funding could be used to plug other budget deficits.
The Next Steps report mentions personal commissioning – what is this?	NHS England (from April 2015) will be extending personal commissioning through its Integrated Personal Commissioning (IPC) programme. The details of this programme, and the extent to which IPC will impact on CCGs or GPs remains unclear.
The General Election is rapidly approaching; might this further change the commissioning landscape	It is also unclear what impact the General Election will have on primary care co-commissioning (or clinical commissioning more generally), however, there has been some discussion of transferring commissioning responsibilities to Health and Wellbeing Boards.

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FAQs specific to CCGs seeking Joint or Delegated commissioning arrangements

How will local incentive schemes/contracts align with national arrangements?	Any migration from a national standard contract could only be affected through voluntary action. CCG Boards can not compel practices to change from a national contract to a local contract. National monitoring for all QOF indicators via CQRS will continue (practices should be mindful that this may put them at risk of doing new work without stopping any QOF obligations).
Will there be a formal process for CCGs developing local incentive schemes or enhanced services?	No. There will be no formal approvals process for any CCG wishing to develop a local QOF scheme or local alternative to a DESs. Any proposed new incentive scheme should be subject to consultation with the LMC, and must be able to demonstrate improved outcomes, reduced inequalities and value for money which must be within national standards (yet to be defined by NHS England).
As it relates to the GMS/PMS contract, will CCGs by bound by national regulations and/or directions?	Yes. 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. This is likely to be the same for GP premises.
Will CCGs be bound by national plans for MPIG and PMS reviews?	Yes. CCGs will be required to adopt the findings of the PMS and Minimum Practice Income Guarantee (MPIG) reviews. As such any locally agreed schemes will need to reflect the changes agreed as part of the review.
Will CCGs who take on additional responsibility have access to additional resources?	No. NHS England is clear that there is no possibility of additional administrative resources being deployed to CCGs constraints. It will not be possible to transfer running cost allowances associated with primary care commissioning to CCGs in 2015/16 or to transfer the employment of the associated staff from Area Teams to CCGs. Pragmatic local solutions will need to be agreed by CCGs and Area Teams

Further information

NHS Clinical Commissioners and the RCGP have produced joint guidance on co-commissioning, in which GPC was consulted, and which you may also find of use (here).