The risks and opportunities for CCGs when co-commissioning primary care: Things to consider when making your decision

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Introduction

The ability for CCGs to become involved in commissioning General Practice and primary care services clearly has the potential to bring many benefits. It also brings with it the potential for a number of risks and opportunities.

NHS Clinical Commissioners with the Royal College of General Practitioners (RCGP) have drawn up this paper for CCGs, to support them when making their decision with their membership about taking on an increased role with regard to the commissioning of general practice services.

The three models for primary care commissioning set out within the NHS England document ***'Next steps towards primary care co-commissioning'***, we believe, are most accurately described as:

- Model One : Greater involvement in primary care decision making which is best described as **Co-commissioning** of primary care
- Model Two: **Joint commissioning** of primary care
- Model Three: **Delegated commissioning** of primary care

In this paper we have sought to identify the risks and opportunities for each of the models.

It is critically important that CCGs recognise that they do have a ***legitimate and real choice*** to make in taking on one of these models of commissioning, and we are strongly encouraging CCGs to consider carefully all the factors that might affect their decision, including the detail within this paper. The BMA's General Practitioners Committee has been consulted on the development of this document and has emphasised the need for CCGs to ensure that all GP members are given clear and informed choices to allow democratic influence over decisions relating to the co-commissioning options.

CCGs should be aware that the models outlined by NHS England are optional, which means that CCGs can 'do nothing' and not take up the options proposed. However we would encourage CCGs to think carefully about the consequences for the commissioning of general practice services across their CCG if they do decide to do this.

It should be said at the outset that this document is absolutely <u>not</u> intending to offer a view to lean CCGs towards any of the models and should <u>not</u> be seen as being directive or be interpreted to mean that these organisations co-badging this document prefer one model over another. These decisions need to remain a local, professionally led decision.

This document is however iterative and written at a time when CCGs are working through NHS England options for Commissioning Primary Care differently. CCGs are having live conversations within their Governing Bodies, with their member practices and with wider stakeholders – including the local population, Health and Wellbeing Boards and LMCs. We will aim to update this paper when needed.

The context within which CCGs are being asked to get involved in commissioning primary care (general practice).

NHS England's recent Five Year Forward View document outlines the importance of building strong general practice, and highlights in particular how its ability to provide neighbourhood level access to a family doctor is one of the great strengths of the NHS. Strategically it is also a core element to improving the out of hospital care offer. In light of this, NHS England have committed to stabilise core funding for general practice nationally over the next two years and give CCGs more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.

Yet in spite of this direction of travel, the immediate past for general practice has not helped its positioning for a successful future. Primary care (general practice) has had reduced funding year in and year out for the last 7 years and yet has been required to absorb a substantial increase in workload during that period. Most GPs would describe it as stretched beyond the limit. It is still thought of internationally as one of the most cost effective systems in the world and perceived by all political parties as the solution to the massive quality and financial challenges we all face.

Some of these solutions are around integrated care or shifting care outside of hospital into primary and community care settings. There is no doubt that there needs to be a range of different models of general practice to be delivered in the future. The models need to enable primary care to be delivered at scale, and the Five Year Forward View suggests some of the possible models. However tackling this just through the provider 'lens' will not enable rapid transformational change to take place, and so there is an equally urgent need to address the commissioning of general practice at a local level to enable this change to happen.

CCGs becoming more involved in commissioning general practice provides an opportunity for offering much better care for patients and populations. CCGs have the responsibility for the majority of healthcare commissioned services, yet to date have been unable to fully join up their

commissioning plans and utilise a broader range of commissioning 'levers' to cover general practice. They have instead had to rely on the much more distant Area Teams (ATs) to commission these services, with their lack of local knowledge and underdeveloped relationships with local practices. It has therefore been difficult to get the transactional elements of commissioning to happen effectively, including such things as premises development, and the transformational agenda has hardly been touched. All would now agree that this model of commissioning has not worked and that it is now essential that CCGs are able to become much more engaged in local commissioning of general practice. This involvement could be through one of the three models being offered so that they can either influence others in NHS England making decisions; or can make joint decisions with NHS England; or can make their own decisions and thus effect change locally more rapidly than if they were not involved.

Let us be clear that CCGs are being offered this at a time when there is yet more pressure on resources – both with regard to the running costs and the staff they can access to help them commission services, and the overall resources to spend on commissioned general practice services. Sadly, this is the reality, and CCGs need to take their decision within this context. It is however also worth being clear that if CCGs do not decide to take on any of the commissioning models offered, then NHS England has no choice but to carry on with it, but from an even more remote position if the proposal to reduce the number of Area Teams from 27 to 15 (including the current 3 in London) takes effect, and with access to even less funds.

It is therefore also worth thinking about whether NHS England or CCGs are best placed to shift resources from other areas of spend to be able to invest in additional primary care services. NHS England can invest but only from within the budget it allocates for primary care (which as has been said above, has been declining year on year), or in theory by investing from the other budgets for services it currently directly commissions –i.e. specialised services. That budget has significantly overspent in the last year and is under extreme pressure this year, so any transfer from specialised into primary care is highly unlikely.

CCGs do have the ability to invest from the totality of their budget whilst, of course, needing to balance it and make decisions across its whole portfolio of services about how best to meet the needs of its population and the demands placed upon it both nationally and locally. In addition to this, CCGs will need to think about how they enable longer term sustainability in general practice. While local incentive schemes can improve performance and variation in the quality of practice services, they can all too quickly become 'bolt on' payments, which do not impact on improving the capacity or funding crisis many practices face.

The overarching risk for all CCGs considering the options for primary care commissioning are the timescales involved – in particular that the January deadlines for joint and delegated commissioning will require updated and consulted constitutions, governance processes etc. This rapid pace for submission to NHS England can risk poor local engagement with members and stakeholders, which in turn has the potential to undermine the whole process and purpose of new commissioning arrangements.

This is the national context within which CCGs need to take their decision. More specifically when one looks at the three models of commissioning, there are a number of other risks and opportunities that we feel CCGs should consider (see table below).

The risks and opportunities for CCGs against each commissioning model

Issues to consider	Forms of Commissioning Primary Care		
	Co-commissioning **Greater CCG involvement in NHS England decision making**	***Joint commissioning*** **Joint decision-making by NHS England and CCGs**	***Delegated commissioning*** **CCGs taking on delegated responsibilities from NHS England**
Funding to pay for new/improved/ enhanced general practice services	*Risks* Limited CCG influence over funding - likely to be more like consultation. Area teams are under resourced and facing further reorganisation in smaller number of teams – from 27 to 15 across England. *Opportunities* Under this arrangement, CCGs can continue to use existing levers available to invest in primary care services.	*Risks* Some risk of continued poor resourcing in relation to the management of primary care commissioning. Continue to be rooted in NHS England processes – CCG must ensure it is a significant and equal partner. Additional funding put in to support general practice may place other areas of CCG commissioned care under pressure. *Opportunities* Increased influence for the CCG as a member of a joint committee i.e. Can jointly develop locally designed incentive schemes. Can jointly establish a pooled budget that must comply with SFIs (for both CCG and NHS England)	*Risks* Additional funding put in to support general practice may place other areas of CCG commissioned care under pressure. *Opportunities* Local not central determination of change, some potential for place based budgets. Opportunity for CCGs to stop the instability being caused by various reviews and enable CCGs to invest equitably in primary care. Complete control over how the primary care budget is spent. i.e. CCGs can develop locally designed incentive schemes, which must be consulted with the LMC and ensure an outcome focus.

Relationship to the membership across the CCG – accountability & influence	*Risks* No real change to current arrangements. Could be seen as distant and not interested in core general practice issues. No levers to influence NHS England commissioning. *Opportunities* Unlikely to change your membership model and engagement. Provides continuity in the relationship.	*Risks* CCG may not be in control of decision making as a joint committee and may risk its relationship with practices. There will be a need for some compromises in that respect. CCG may still be making practice performance management decisions although decision making is joint with NHS England. The timescales for this option are tight (5pm 30th Jan 2015) this may risk decisions being made without thorough consultation with members and stakeholders and thorough discussion with the AT. *Opportunities* More influence than model 1 but it is joint with NHS England, and is reliant on good relationships between the CCG and NHS England.	*Risks* Performance management (even through a quality improvement lens) sits with the CCG and this could risk the membership 'ethos' unless particular attention is given to how this will be managed. The delegated model has a very tight timescale for submission to NHSE (12noon 9th Jan 2015) this may risk decisions being made without meaningful consultation with members and stakeholders. *Opportunities* Performance management of general practice individuals and revalidation will be retained by NHS England, but improved ability to influence developmental support to primary care.

Managing potential conflicts of interest (COI)	*Risks* Need to ensure that additional 'burdens' are not placed on the CCG for managing COI as no real change to current arrangements *Opportunities* Chance to review COI processes in light of new guidance, if the CCG wants to.	*Risks* Additional processes to ensure transparency need to be proportionate and, if not, may feel as though it is posing additional 'burdens' on the CCG. *Opportunities* Decision making is through the joint committee – therefore the CCG is not taking the decision alone. Less perceived COI when commissioning from member practices. Need to review CCG COI processes in light of a joint committee arrangement.	*Risks* Will increase perceived COI in relation to the commissioning of services from member practices and federated practices. Potential risk to CCGs in the probity of their decisions if governance arrangements are not robust. Potentially more 'bureaucratic' processes to go through to assure and demonstrate transparency, and need to ensure CCG is still able to take decisions should all member practices be affected. Some added cost implications though tightened governance arrangements, which will require additional lay, secondary care doctor and nurse member input. *Opportunities* Need to review processes and decision making to ensure they are robust and transparent. An opportunity to improve transparency in decision making so defend decisions taken.

Support to undertake the work (people /£)	*Risks* Staff are distant and transactional with reduced numbers of staff supporting the day to day commissioning, particularly if AT staff are seconded to neighbouring CCGs. *Opportunities* CCG can find ways to best influence the AT staff to work in more effective ways/models.	*Risks* AT resource is stretched as it tries to meet the demands of CCGs with joint/delegated model/no delegated models. CCG not fully able to direct shared commissioning 'teams' and may find competing priorities when using the same team with other CCGs under different models. *Opportunities* CCGs will have access to the people across the current AT footprint to support activities as directed by the joint committee.	*Risks* CCG may find that the support that comes from NHS England is not enough to fulfil the full demand of commissioning activity and day to day management. *Opportunities* CCGs will have access to the people across the AT footprint as directed by CCGs. Locally determined approach to staff resourcing, which will involve pan CCG working.
Practice contract management	*Risks* The CCG has no real lever to support a developmental relationship with practices and no levers to address poor performance. *Opportunities* Performance management is not done by CCG so relationship with practices stays consistent.	*Risks* CCG is influential in performance managing practices, and may be accused of making decisions with NHS England. This could strain relationships with member practices if not handled well. *Opportunities* Responsibilities for contract management will sit with joint committee, so CCGs are not alone in taking decisions.	*Risks* CCG can be accused of policing practices (with its contract levers/removal powers), may lead to serious damage to its reputation if this is not executed well. The impact of no NHS England involvement in performance management may lead to a gap in primary care performance information across CCGs. Although NHS England remains the contract holder, CCGs are acting as 'agents of NHS England' and therefore will be taking decisions about levers / sanctions – even

		CCGs could be more influential about seeing 'contract management' through a 'quality improvement' lens than their NHS England colleagues. Quality improvement could be more 'peer led' and driven albeit through the joint committee, and this may mean that member practices are more likely to respond / accept the joint committee's 'action/decision making.	though NHS England would also retain 'residual liability'. *Please note: the precise way this will operate is being discussed with the NHS England Programme Oversight Group and we will update this document as soon as we can. We are encouraging this to include the need for engagement with NHS England over final decision making about levers/sanctions and contract removal.* *Opportunities* CCG can have developmental relationship with member practices. Have a lever in relation to poor performance/practice. CCGs in 'control' of how 'contract management' function is executed and can really push it through the 'quality improvement' lens. Quality improvement will be very much 'peer led' and driven and this may mean that member practices are more likely to respond / accept CCG action/decision making. NHS England ultimately remains the contract holder, and NHS England will need to be assured as to how the CCG is taking decisions in this area. A back stop 'appeals process' – if agreed with NHS England, may help with this in guarding against judicial reviews.

Governance	*Risks & Opportunities* No substantive change to structures, some updating of the CCG constitution.	*Risks* Requires a good mutual working relationship between CCG and NHS England to ensure balance in decision making. CCG will need to update its constitution and consult it with the LMC within tight timescales. Need to ensure the governance and processes needed are proportionate to the joint commissioning responsibilities. *Opportunities* CCGs will need to review their existing governance arrangements to ensure the joint committee arrangements 'fit'. CCGs do not take on things like 'complaints handling' although will influence through the joint committee.	*Risks* CCG is accountable for commissioning to its public and clinical peers. Some risk that the governance processes and procedures are exposed to challenge/appeal. Increased resources will be required around governance, including extensive stakeholder engagement, establishment and running of a primary care commissioning panel and scrutiny processes. CCG will need to update its constitution and consult it with the LMC within very tight timescales. CCGs will be responsible for a broader range of functions including complaints management and therefore needs to ensure processes set up enable this within their broader governance processes *Opportunities* Opportunity for CCG to review and revise their governance arrangements including the constitution and secure improved membership engagement. This is likely to result in strengthened approaches to CCG governance.

Patient engagement	*Risks* CCG has no formal accountability to its population in relation to decisions around the commissioning of general practice – other than its statutory duty to support NHS England in driving up the quality of general practice *Opportunities* NHS England is accountable to the local population for the commissioning of general practice. No CCG time used to deal with challenges/appeals.	*Risks* CCG is jointly responsible with NHS England to its population in relation to decisions around the commissioning of general practice and the involvement of patient/ population groups. Dealing with public appeals and concerns may take CCG resource away from its time on joint commissioning. *Opportunities* Opportunity for CCG to work with NHS England to engage with the local public about the totality of expectations for general practice and the out of hospital care offer.	*Risks* CCG is accountable to its population in relation to decisions around the commissioning of general practice. This is a significant undertaking and any changes to practice contracts/design must engage the public. Dealing with public appeals and concerns may take CCG resource away from commissioning. *Opportunities* Opportunity for CCG to meaningfully engage with the local public about the totality of expectations for general practice the out of hospital care offer, and wider system integration
Ability to re-design service delivery models including integration of care	*Risks* Little leverage on the full out of hospital care offer, due to no formal influence on the AT. *Opportunities* Some informal influence on the redesign elements through conversations with the AT. CCG is free from the performance elements and may have more 'headspace' to redesign.	*Risks* CCG must agree to redesign plans for general practice with NHS England through the joint committee – can be time consuming if concerns are raised or balance of decision making is uneven. Some potential difficulty taking the membership with CCGs on this. *Opportunities* Will have formal influence to make redesign decisions across pathways of care, but through the joint committee arrangements.	*Risks* CCGs are accountable for the decisions they make and require transparency of process as well as the engagement and support of member practices, the public and stakeholders. *Opportunities* Ability to make redesign decisions across a portfolio of providers and so across pathways of care tailored to local need. Opportunity to be more patient focused in commissioning.

Individual performance management & revalidation	*Risks & Opportunities* Not done by CCG	*Risks & Opportunities* Not done by CCG	*Risks & Opportunities* Not done by CCG
Operational arrangements for transacting commissioning arrangements	*Risks & Opportunities* No change	*Risks* CCGs may find themselves with competing priorities over use of the NHS England team available to support joint and delegated commissioning. If there is insufficient resource, CCGs and NHS England must jointly determine a way forward. *Opportunities* CCG will be able to influence how the staff seconded to a lead CCG /CSU will operate to deliver on their responsibilities.	*Risks* CCGs may find themselves with competing priorities over use of the NHS England team available to support joint and delegated commissioning. If insufficient resource CCGs may need to direct other key CCG staff to pick up functions, for eg complaints handling and transactional contract issues, and may put pressure on CCGs' ability to deliver on the range of responsibilities. *Opportunities* Max influence on the transactional elements and ways of working between staff and practices. Ability to change the way in which the 'transactional' elements work, such that they operate as efficiently and effectively as possible

Assurance of co-commissioning arrangements by NHS England	*Risks & Opportunities* No assurance of primary care commissioning except internal assurance.	*Risks* NHS England retains accountability for the discharge of its statutory duties in relation to primary care commissioning. If CCG and NHS England do not fully outline their mutual assurance responsibilities they may establish an ineffective relationship. If not designed appropriately, assurance of different elements of commissioning may still not be joined up or mutual. *Opportunities* Assurance of primary care commissioning through joint committees – therefore separate to other assurance processes.	*Risks* NHS England may direct a CCG to act, where a CCG fails to secure an adequate supply of high quality primary medical care. If the CCG is directed in this way, this could affect the CCGs desire to commission in this fully delegated form, and the resources to meet this direction would need to come from the CCG's resources. NHS England's assurance of delegated commissioning may be undertaken in such a way (i.e. top down and interventionist) that it actually limits a CCGs actual power to make the right decision for its population. *Opportunities* Assurance of primary and secondary care commissioning is together so enables a rounded and 'mutual' approach to be adopted by NHS England.

The 'issues to consider' listed above are not meant to be exhaustive of those CCGs will need to think about. The document is intended to provide some thoughts about some of the key issues and the potential risks and opportunities. It has, however, been written when not all of the guidance around governance and managing conflicts of interest has been finalised, and therefore potential risks and opportunities as listed may not materialise or in effect become 'real' should the guidance cover them off in different ways.

We hope this document is of use to our members at the point you are at in making your initial decision, and we wish you well in your journey to potentially becoming effective commissioners of general practice services.